

West Des Moines CSD Plan B POS



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.wellmark.com or call 1-515-633-5076. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-515-633-5076 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u>?	Office services provided by The Iowa Clinic: \$1,250 person/ \$2,500 family per calendar year. In- <u>Network</u> (IN) <u>Provider</u> : \$1,250 person/ \$2,500 family per calendar year. Out-of- <u>Network</u> (OON) <u>Provider</u> : \$2,500 person/ \$5,000 family per calendar year.	Generally, you must pay all the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u>?	Yes. <u>Preventive care</u> , hospice, preventive colonoscopies, in- <u>network</u> prosthetic limbs and services subject to office visit and urgent <u>copayments</u> , out-of- <u>network</u> chiropractic services are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	Pharmacy: \$100 person/ \$200 family - Does not apply to Tier 1 Generics.	
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	Office services provided by The Iowa Clinic: \$3,000 person/ \$6,000 family per calendar year. In- <u>Network</u> (IN) <u>Provider</u> : \$3,000 person/ \$6,000 family per calendar year. Out-of- <u>Network</u> (OON) <u>Provider</u> : \$4,500 person/ \$9,000 family per calendar year. Pharmacy: \$3,000 person/ \$6,000 family per calendar year. The In- <u>Network</u> health and pharmacy <u>out-of-pocket</u> maximum amounts accumulate separately.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.

Important Questions	Answers	Why this Matters:
What is not included in the out-of-pocket limit?	Premiums, <u>balance-billed charges</u> , and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See www.wellmark.com or call 1-800-524-9242 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay Office services provided by The Iowa Clinic (You will pay the least)	What You Will Pay In-Network (IN) Provider (You will pay more)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$0 <u>copay</u> per date of service	\$25 <u>copay</u> per date of service	30% <u>coinsurance</u>	For this <u>plan</u> you must select a Designated <u>Primary Care Provider</u> (PCP). PCP <u>provider</u> types can be found in the What You Pay section of your <u>plan</u> document.
	<u>Specialist</u> visit	\$0 <u>copay</u> per date of service	\$50 <u>copay</u> per date of service	30% <u>coinsurance</u>	Applies to Non-PCP <u>providers</u> . \$25 <u>copay</u> per date of service for in- <u>network</u> chiropractic services. Hearing exams are covered according to ACA guidelines.
	<u>Preventive care/ screening/ immunization</u>	No charge	No charge	30% <u>coinsurance</u>	One preventive exam and one mammogram per calendar year. Well-child care is covered to age 7. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.

For more information about limitations and exceptions, see your plan document or call West Des Moines Community Schools at 1-515-633-5076.

Common Medical Event	Services You May Need	What You Will Pay Office services provided by The Iowa Clinic (You will pay the least)	What You Will Pay In-Network (IN) Provider (You will pay more)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have a test	Diagnostic test (x-ray, blood work)	Independent Lab: \$50 <u>copay</u> per date of service Facility: 20% <u>coinsurance</u>	Independent Lab: \$50 <u>copay</u> per date of service Facility: 20% <u>coinsurance</u>	30% <u>coinsurance</u>	For a test in a <u>provider's</u> office or clinic, your cost is included in the cost-share listed above. Waive cost-share on in-network independent lab services for mental health/chemical dependency.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	For a test in a <u>provider's</u> office or clinic, your cost is included in the cost-share listed above.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.vividclearrx.com	Pharmacy Drugs	Tier 1 Generic	\$5 copay	Not covered	Drugs listed on Vivid Clear Rx's Formulary are covered. Drugs not on the formulary are not covered. Prescriptions filled at Out-of-Network pharmacies are not covered. 1 <u>copay</u> for 30-day supply 3 <u>copays</u> for 90-day supply <u>Specialty drugs</u> are covered only when obtained through the Vivid Clear Rx Specialty Pharmacy Program Contact Vivid Clear Rx at 877-848-4379 for information about drugs and drug quantities that require prior authorization by Vivid Clear Rx to be covered by your plan.
		Tier 2 Preferred Brand	\$30 copay	Not covered	
		Tier 3 Non-Preferred Brand	\$60 copay	Not covered	
		Specialty	Preferred: \$125, Non-Preferred: 50%	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	-----None-----
	Physician/surgeon fees	20% <u>coinsurance</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	-----None-----

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Common Medical Event	Services You May Need	What You Will Pay Office services provided by The Iowa Clinic (You will pay the least)	What You Will Pay In-Network (IN) Provider (You will pay more)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need immediate medical attention	<u>Emergency room care</u>	\$250 <u>copay</u> and 20% <u>coinsurance</u> per date of service for facility and physician(s) combined	\$250 <u>copay</u> and 20% <u>coinsurance</u> per date of service for facility and physician(s) combined	\$250 <u>copay</u> and 20% <u>coinsurance</u> per date of service for facility and physician(s) combined	For <u>emergency medical conditions</u> treated out-of-network, it is likely you may not be balance billed pursuant to the federal rules developed for implementation of the No Surprises Act.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	For covered non-emergent situations, out-of-network ground ambulance services are NOT reimbursed at the in-network level. Benefits for practitioner fees by a non-participating ambulance <u>provider</u> are based on actual amount charged.
	<u>Urgent care</u>	\$0 <u>copay</u> per date of service	\$25 <u>copay</u> per date of service	30% <u>coinsurance</u>	<u>Copay</u> applies per date of service for facility and physician(s) combined.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Services for bariatric surgery are limited to Blue Distinction Centers.
	<u>Physician/surgeon fees</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	-----None-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: \$0 <u>copay</u> per date of service Facility: 20% <u>coinsurance</u>	Office: \$25 <u>copay</u> per date of service Facility: 20% <u>coinsurance</u>	30% <u>coinsurance</u>	-----None-----
	Inpatient services	\$0 <u>copay</u> per date of service	20% <u>coinsurance</u>	30% <u>coinsurance</u>	-----None-----

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Common Medical Event	Services You May Need	What You Will Pay Office services provided by The Iowa Clinic (You will pay the least)	What You Will Pay In-Network (IN) Provider (You will pay more)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you are pregnant	Office visits	\$0 <u>copay</u> per date of service	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Cost sharing does not apply for <u>preventive services</u> . For any in-network services that fall outside of routine obstetric care, the office visit benefits shown above may apply.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Benefits shown reflect OB/GYN practitioner services which are typically globally billed at time of delivery for pre-natal, post-natal and delivery services.
	Childbirth/delivery facility services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	-----None-----
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	-----None-----
	<u>Rehabilitation services</u>	Office: \$0 <u>copay</u> per date of service Facility: 20% <u>coinsurance</u>	Office: \$25 PCP/ \$50 Non-PCP <u>copay</u> per date of service Facility: 20% <u>coinsurance</u>	30% <u>coinsurance</u>	\$25 <u>copay</u> per date of service applies to in-network Physical and Occupational Therapists and Speech Pathologists.
	<u>Habilitation services</u>	Office: \$0 <u>copay</u> per date of service Facility: 20% <u>coinsurance</u>	Office: \$25 PCP/ \$50 Non-PCP <u>copay</u> per date of service Facility: 20% <u>coinsurance</u>	30% <u>coinsurance</u>	\$25 <u>copay</u> per date of service applies to in-network Physical and Occupational Therapists and Speech Pathologists.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	-----None-----
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	-----None-----
	<u>Hospice services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Hospice respite care is limited to 15 inpatient and 15 outpatient days per lifetime.

For more information about limitations and exceptions, see your plan document or call West Des Moines Community Schools at 1-515-633-5076.

Common Medical Event	Services You May Need	What You Will Pay Office services provided by The Iowa Clinic (You will pay the least)	What You Will Pay In-Network (IN) Provider (You will pay more)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If your child needs dental or eye care	Children's eye exam	\$0 <u>copay</u> per date of service	\$50 <u>copay</u> per date of service	30% <u>coinsurance</u>	-----None-----
	Children's glasses	Not covered	Not covered	Not covered	-----None-----
	Children's dental check-up	Not covered	Not covered	Not covered	-----None-----

For more information about limitations and exceptions, see your plan document or call West Des Moines Community Schools at 1-515-633-5076.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Custodial care - in home or facility
- Dental care - Adult
- Dental check-up
- Extended home skilled nursing
- Glasses
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (limited to 12 visits per calendar year)
- Applied Behavior Analysis therapy
- Bariatric surgery
- Chiropractic care
- Infertility treatment (\$25,000 LTM)
- Private-duty nursing - short term intermittent home skilled nursing
- Routine eye care - Adult

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, you can contact: West Des Moines Community Schools at 1-515-633-5076.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

This contains only a partial description of the benefits, limitations, exclusions and other provisions of the health care plan. It is not a contract or policy. It is a general overview only. It does not provide all the details of coverage, including benefits, exclusions, and policy limitations. In the event there are discrepancies between this document and the Coverage Manual, Certificate, or Policy, the terms and conditions of the Coverage Manual, Certificate, or Policy will govern.

About These Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall <u>deductible</u>	\$1,250
■ PCP <u>copayment</u>	\$0
■ Hospital(facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,250
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$1,400
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$2,720

Managing Joe's type 2 Diabetes (a years of routine in-network care of a well-controlled condition)

■ The plan's overall <u>deductible</u>	\$1,250
■ <u>Specialist</u> <u>copayment</u>	\$0
■ Hospital(facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$50
<u>Copayments</u>	\$500
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$570

Mia's Simple Fracture (in-network emergency room visit and follow up care)

■ The plan's overall <u>deductible</u>	\$1,250
■ <u>Specialist</u> <u>copayment</u>	\$0
■ Hospital(facility) <u>copay</u> and <u>coinsurance</u>	\$250 and 20%
■ Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,250
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$90
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,540

The amounts shown in the maternity claim example above are based on amounts using a single per person deductible. Some plans may actually apply a two-person or family deductible to maternity services for the mother and newborn baby.

The plan would be responsible for the other costs of these EXAMPLE covered services.

Wellmark Language Assistance

Discrimination is against the law

Wellmark complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes. Wellmark does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Wellmark

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
 - Qualified interpreters
 - Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, call 800-524-9242.

If you believe that Wellmark has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Wellmark Civil Rights Coordinator, 1331 Grand Avenue, Station 3E417, Des Moines, IA 50309-2901, 515-376-6500, TTY 888-781-4262, Fax 515-376-9055, Email CRC@Wellmark.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Wellmark Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

ATENCIÓN: Si habla español, los servicios de asistencia de idiomas se encuentran disponibles gratuitamente para usted. Comuníquese al 800-524-9242 o al (TTY: 888-781-4262).

注意：如果您说普通话，我们可免费为您提供语言协助服务。 谘打

800-524-9242 或 (听障专线：888-781-4262)。

CHÚ Ý: Nếu quý vị nói tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho quý vị. Xin hãy liên hệ 800-524-9242 hoặc (TTY: 888-781-4262).

NAPOMENA: Ako govorite hrvatski, dostupna Vam je besplatna podrška na Vašem jeziku. Kontaktirajte 800-524-9242 ili (tekstualni telefon za osobu oštećena sluha: 888-781-4262).

ACHTUNG: Wenn Sie deutsch sprechen, stehen Ihnen kostenlose sprachliche Assistenzdienste zur Verfügung. Rufnummer: 800-524-9242 oder (TTY: 888-781-4262).

تنبيه: إذا كنت تتحدث اللغة العربية، فإننا نوفر لك خدمات المساعدة اللغوية، المجانية. اتصل بالرقم 2429-425-008 أو (خدمة الهاتف النصي: 888-781-4262).

ສັງຄວມເຂົາໃຈໃສ່, ພາສາລາວ ຖ້າທ່ານວາ:

ພວກເຮົາມີບັນທຶກຄວາມຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານ ໂດຍບໍ່ເສັຍຄ່າ ຫຼື 800-524-9242 ຕິດຕໍ່ພໍ. (TTY: 888-781-4262).

주의: 한국어 를 사용하시는 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 800-524-9242번 또는 (TTY: 888-781-4262)번으로 연락해 주십시오.

ध्यान रखें: अगर आपकी भाषा हिन्दी है, तो आपकी हिंदी भाषासेवाएँ, हनुमन्ती उपलब्ध हैं। 800-524-9242 पर संपर्क करे या (TTY: 888-781-4262)।

ATTENTION: Si vous parlez français, des services d'assistance dans votre langue sont à votre disposition gratuitement. Appelez le 800 524 9242 (ou la ligne ATS au 888 781 4262).

Geb Acht: Wann du Deutsch schwetze duscht, kannst du Hilf in dei eegni Schprooch koschdefrei griege. Ruf 800-524-9242 odder (TTY: 888-781-4262) uff.

โปรดทราบ: หากคุณพูด ไทย 泰语 คำใช้ง่าย ติดต่อ 800-524-9242 หรือ (TTY: 888-781-4262)

PAG-UKULAN NG PANSIN: Kung Tagalog ang wikang ginagamit mo, may makukuha kang mga serbisyong tulong sa wika na walang bayad. Makipag-ugnayan sa 800-524-9242 o (TTY: 888-781-4262).

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ВНИМАНИЕ! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. Обращайтесь 800-524-9242 (телетайп: 888-781-4262).

सावाधानः याददी तोपाई नेपा ढी बोलुहुन्छ भने, तोपाईकी ढाह्य हनुमन्ती सेवा सयतातो सेवा रु उपलब्ध गराइन्छ । 800-524-9242 वा (TTY: 888-781-4262) मा सम्पर्कीकनुक ढोस् ।

ማሳሰቢያ፡- አማርኛ የሚናገሩ ከሆነ፣ የቅንቋ እገዛ አገልግሎቶች፣ ከክፍያ ነፃ፣ ያገኛሉ። በ 800-524-9242 ወይም (በTTY: 888-781-4262) ደውለው ያነጋግሩን።

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