

## 2022 Iowa Choice and National Choice Side-by-Side Comparison

	Iowa Choice option	National Choice option
<b>Wellmark network to use when searching for providers</b>	HMO Blue Access network	PPO Alliance Select network
<b>Benefits Available from Non-Participating Providers</b>	<b>None</b> , unless prescribed and referred by a participating physician <u>and</u> approved by Wellmark, or in an emergency medical situation.	Normal plan benefits for network/non-network providers
<b>Deductible</b> <i>Family deductible is reached from amounts accumulated on behalf of a combination of family members. Member has benefits after single deductible is met.</i>	\$250 single \$500 family	\$250 single \$500 family
<b>Medical Out-of-Pocket Maximum</b> <ul style="list-style-type: none"> <li>• <i>Family out-of-pocket is reached from amounts accumulated on behalf of a combination of family members. Member has benefits after single out-of-pocket is met.</i></li> <li>• <i>All deductibles, coinsurance, and copayments go toward out-of-pocket limit. (Separate out-of-pocket maximum for prescription drugs.)</i></li> </ul>	\$1,000 Single \$2,000 Family	\$1,000 Single \$2,000 Family
<b>Lifetime Benefits Maximum</b>	Hospice Respite 15 Days Inpatient 15 Days Outpatient  Infertility - \$25,000	Hospice Respite 15 Days Inpatient 15 Days Outpatient  Infertility - \$25,000
<b>New Employee Preexisting Condition Waiting Period</b>	No preexisting conditions waiting period.	No preexisting conditions waiting period.
<b>Preventive Services</b>		
Affordable Care Act (ACA) preventive services	Covered at 100% per ACA guidelines.	Covered at 100% per ACA guidelines. Preventive care from non-participating providers with Wellmark are subject to the deductible or coinsurance.

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Professional Office Services		
<b>Office Visit - Primary Care Practitioner (PCP)</b> A PCP is one of the following: - advanced registered nurse practitioner (ARNP) - family practitioner - general practitioner - internal medicine practitioner - obstetrician/gynecologist - pediatrician - physician assistant (PA)	<b>\$15 copay</b> Office visit copay applies to any office services	<b>\$15 copay</b> Office visit copay applies to any office services
<b>Office Visit - Specialist</b> All other practitioners except those listed above are considered specialist	<b>\$30 copay</b> Office visit copay applies to any office services	<b>\$30 copay</b> Office visit copay applies to any office services
<b>Office Visit - Other Providers (not PCP or Specialist)</b> - chiropractor - occupational therapist - physical therapist - speech pathologists	<b>\$15 copay</b> Office visit copay applies to any office services	<b>\$15 copay</b> Office visit copay applies to any office services
Routine Eye Exam <i>One routine vision exam per calendar year.</i>	<b>\$30 copay</b>	<b>\$30 copay</b>
Routine Hearing Exam <i>One routine hearing exam per calendar year.</i>	<b>\$30 copay</b>	<b>\$30 copay</b>
Maternity (globally billed at time of delivery)	10% after deductible	10% after deductible
Surgery, Radiology & Pathology (office)	\$15 copay (PCP) / \$30 copay (Specialist)	\$15 copay (PCP) / \$30 copay (Specialist)
Telehealth (Doctor on Demand)	<b>\$10 copay</b>	<b>\$10 copay</b>

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<b>Hospital Services</b>		<b>Network</b>	<b>Non-network</b>
<b>Inpatient Hospital Services</b>			
Preapproval of Inpatient Admissions	Required		Required
Inpatient Hospital Services Room & Board	10% after deductible	10% after deductible	20% after deductible
Inpatient Physician Services			
Inpatient Supplies			
Inpatient Surgery			
<b>Outpatient Hospital Services</b>		<b>Network</b>	<b>Non-network</b>
Ambulatory Surgical Center	10% after deductible	10% after deductible	20% after deductible
Outpatient Diagnostic Lab, Radiology	10% deductible waived	10% deductible waived	20% after deductible
<b>Outpatient Therapy Services</b>		<b>Network</b>	<b>Non-network</b>
Chemotherapy	10% after deductible	10% after deductible	20% after deductible
Physical Therapy		deductible	deductible
Occupational Therapy			
Respiratory Therapy			
Speech Therapy			
<b>Emergency Care</b>		<b>Network</b>	<b>Non-network</b>
Ambulance	10% after deductible	10% after deductible	20% after deductible
Urgent Care Center	\$15 copay		\$15 copay
Hospital Emergency Room	\$100 copayment; waived if admitted		\$100 copayment; waived if admitted

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Behavioral Health Services		Network	Non-network
Inpatient mental health and substance abuse treatment	10% after deductible	10% after deductible	20% after deductible
Behavioral Health Services		Network	Non-network
Office visit	\$15 copay	\$15 copay	
Outpatient mental health and substance abuse treatment	10% after deductible	10% after deductible	20% after deductible
Prescription Drug Coverage (Blue Rx Complete Formulary)			
	<b>Retail</b>	<b>Retail</b>	<b>Mail Order</b>
Quantity	30-day supply (maintenance & non-maintenance drugs)	90-day supply (maintenance drugs)	90-day supply
Tier 1	<b>\$10</b> copay	<b>\$30</b> copay	<b>\$20</b> copay
Tier 2	<b>\$25</b> copay	<b>\$75</b> copay	<b>\$50</b> copay
Tier 3	<b>\$50</b> copay	<b>\$150</b> copay	<b>\$100</b> copay
Tier 4	<b>\$75</b> copay	<b>\$225</b> copay	<b>\$150</b> copay
Specialty Drugs	<b>\$100</b> (Preferred/Biosimilar)/ <b>\$200</b> (Non-Preferred)		
<i>*CVS Pharmacy is required provider for specialty drugs.</i>			
<b>Pharmacy Out-of-Pocket Maximum</b>	Single \$5,850 / Family \$11,700		

### Prescription Drug Coverage - General Information

Purchase a brand name drug that has an FDA-approved "A"- rated generic equivalent, the State will only pay for the equivalent generic drug. The employee is responsible for the copayment and any remaining cost difference up to the maximum allowed fee for the brand name drug.

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