

2015 Comparison of State of Iowa Retirees Health Insurance Plans

Available to executive branch non-contract retirees who retired after Jan 1, 2014
Plans contain required provisions of the Affordable Care Act (ACA)

Managed Care Organization (MCO) Plans Blue Access Blue Advantage

Preferred Provider Organization (PPO) Plans Gold Preferred Iowa Select

Indemnity Plans Deductible 3 Plus

6-Oct-14

General Plan Provisions				
Benefits Available from Non-Participating Providers <i>You are responsible for any amounts between the billed charge and the maximum allowable fee paid by Wellmark. These amounts will not accumulate towards the medical out-of-pocket limit.</i>	None, 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	Normal plan benefits for network/non-network providers	Normal plan benefits
Deductible <i>Family deductible is reached from amounts accumulated on behalf of any family member or combination of family members.</i>	None	\$750 Single \$1,500 Family Applies to services provided both in- and out-of-network. All deductibles, coinsurance, and copayments, go toward out-of-pocket limit. (Separate out-of-pocket limit for prescription drugs.)	\$250 single network/non-network \$500 family network/non-network Applies to both inpatient and outpatient services.	\$300 single \$400 family Applies to most services. The entire family deductible must be met before benefits payments are made.
Medical Out-of-Pocket Maximum <i>Family out-of-pocket is reached from amounts accumulated on behalf of any family member or combination of family members.</i>	\$750 Single \$1,500 Family All copayments go toward out-of-pocket limit with the exception of prescription drug copayments. (Separate out-of-pocket maximum for prescription drugs.)	Single: \$1,500 Family: \$3,000 All health deductibles and coinsurance go toward the health out-of-pocket limit	\$600 Single \$800 Family Applies to services provided both in- and out-of-network. All deductibles, coinsurance, and copayments go toward out-of-pocket limit. (Separate out-of-pocket maximum for prescription drugs.)	\$600 Single \$800 Family All deductibles and coinsurance go toward out-of-pocket limit.
Lifetime Benefits Maximum	None	None	None	None
New Employee Preexisting Condition Waiting Period	No preexisting conditions waiting period.	No preexisting conditions waiting period.	No preexisting conditions waiting period.	No preexisting conditions waiting period.
Preventive Services				
Affordable Care Act (ACA) preventive services	Covered at 100% per ACA guidelines.	Covered at 100% per ACA guidelines. Preventive care from participating providers with Wellmark is not subject to the deductible or coinsurance.	Covered at 100% per ACA guidelines. Preventive care from participating providers with Wellmark is not subject to the deductible.	Covered at 100% per ACA guidelines.
Professional Office Services				
Office Visit	\$10 copay	\$20 copay for primary care physician (PCP) \$40 copay for specialists Once per date of service for exam only	\$15 copay exam only	20%, after deductible
Allergy Testing	\$10 copay	Network 20%, deductible waived in office setting Non-network 30%, after deductible	Network 10%, deductible waived Non-network 20%, after deductible	20%, after deductible
Allergy Serum and Injections	\$10 copay	Network 20%, deductible waived in office setting Non-network 30%, after deductible	Network 10%, deductible waived Non-network 20%, after deductible	20%, after deductible
Chiropractor	\$10 copay, if approved Blue Advantage - 12 self-referred visit limit	\$20 copay for exam only Network 20% deductible waived in office setting Non-network 30% after deductible	Network 10%, deductible waived Non-network 20%, after deductible	20%, after deductible
Routine Eye Exam <i>One routine vision exam per calendar year</i>	\$10 copay	\$40 copay	\$15 copay network/non-network	Not covered
Routine Hearing Exam <i>One routine hearing exam per calendar year</i>	\$10 copay	\$40 copay	\$15 copay network/non-network	Not covered
Surgery, Radiology & Pathology (office)	\$10 copay	Network 20%, deductible waived in office setting Non-network 30%, after deductible	Network 10%, deductible waived Non-network 20%, after deductible	Deductible only

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Hospital Services				
Inpatient Hospital Services				
Preapproval of Inpatient Admissions	Required	Required	Required	Required
Inpatient Hospital Services Room & Board Inpatient Physician Services Inpatient Supplies Inpatient Surgery	0%	Network 20%, after deductible Non-network 30%, after deductible	Network 10% after deductible Non-network 20% after deductible	20% after deductible
Outpatient Hospital Services				
Ambulatory Surgical Center	0%	Network 20%, after deductible Non-network 30%, after deductible	Network 10% after deductible Non-network 20% after deductible	Deductible only
Outpatient Diagnostic Lab, Radiology	0%	Network 20%, after deductible Non-network 30%, after deductible	Network 10%, deductible waived Non-network 20%, after deductible	Deductible only
Emergency Care				
Ambulance	0%	Network 20%, after deductible Non-network 30%, after deductible	Network 10% after deductible Non-network 20% after deductible	20% after deductible
Urgent Care Center	0%	Network 20%, after deductible Non-network 30%, after deductible	Network 10% after deductible Non-network 20% after deductible	20% after deductible
Hospital Emergency Room	\$50.00 copayment; waived if admitted.	\$50.00 copay; waived if admitted. Deductible and 20% coinsurance apply.	\$50.00 copayment; waived if admitted 10% after copayment	0% after deductible
Behavioral Health Services				
Inpatient mental health and substance abuse treatment	0%	Network 20% after deductible Non-network 30% after deductible	Network 10% after deductible Non-network 20% after deductible	20% after deductible
Outpatient mental health and substance abuse treatment	\$0	\$0 copayment	\$0 copayment	0% after deductible
Outpatient Therapy Services				
Chemotherapy Physical Therapy Occupational Therapy Respiratory Therapy Speech Therapy	\$10 copayment per visit 60 visit limit for each of the following services: Physical Therapy (excluding Chiropractic) Occupational Therapy Respiratory Therapy Speech Therapy	Network 20% after deductible Non-network 30% after deductible	Network 10% after deductible Non-network 20% after deductible	20% after deductible
Prescription Drug Coverage				
Deductible	No deductible	\$100 (waived for generic drugs)	No deductible	No separate deductible
Pharmacy Out-of-Pocket Maximum	Single \$5,850 Family \$11,700 Family out-of-pocket is reached from amounts accumulated on behalf of any family member or combination of family members	Single \$5,100 Family \$10,200 Copayments do NOT apply to medical out-of-pocket maximum	Single \$250 Family \$500 Family out-of-pocket is reached from amounts accumulated on behalf of any family member or combination of family members	No separate out-of-pocket maximum
Retail				
Quantity	30-day supply for maintenance and non-maintenance drugs 90-day supply for maintenance drugs.	30-day supply for maintenance and non-maintenance drugs 90-day supply for maintenance drugs	30-day supply for maintenance and non-maintenance drugs 90-day supply for maintenance drugs	30-day supply
Tier 1 Medications	\$5.00 copay - 30-day supply \$15.00 copay - 90-day supply	\$10 copay - 30-day supply \$30 copay - 90-day supply	\$5.00 copay - 30-day supply \$15.00 copay - 90-day supply	20%, after deductible
Tier 2 Medications	\$5.00 copay - 30-day supply \$45.00 copay - 90-day supply	\$25 copay - 30-day supply \$75 copay - 90-day supply	\$15.00 copay - 30-day supply \$45.00 copay - 90-day supply	
Tier 3 Medications	\$30.00 copay or 25%, whichever is greater, - 30-day supply \$90.00 copay or 25%, whichever is greater, - 90-day supply	\$50 copay - 30-day supply \$150 copay - 90-day supply	\$30.00 copay - 30-day supply \$60.00 copay - 90-day supply	

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Tier 4 Medications	Same as Tier 3	\$100 copay - 30-day supply \$300 copay - 90-day supply	Same as Tier 3	
Mail Order				
Quantity	90-day supply for maintenance drugs	90-day supply for maintenance drugs only	90-day supply for maintenance drugs only	Mail order not available
Tier 1 Medications	\$10.00 copay - 90-day supply	\$20 copay	\$10.00 copay - 90-day supply	
Tier 2 Medications	\$30.00 copay - 90-day supply	\$50 copay	\$30.00 copay - 90-day supply	
Tier 3 Medications	\$60.00 copay - 90-day supply	\$100 copay	\$60.00 copay - 90-day supply	
Tier 4 Medications	\$60.00 copay - 90-day supply	\$200 copay	\$60.00 copay - 90-day supply	
Prescription Drug Coverage - General Information				
Prescription Drugs/Items for Smoking Cessation	Covered	Covered	Covered	Covered
		In most cases, when you purchase a brand name drug that has an FDA-approved "A"- rated generic equivalent, Wellmark will pay only what it would have paid for the equivalent generic drug. You will be responsible for your payment obligation for the equivalent generic drug and any remaining cost difference up to the maximum allowed fee for the brand name drug.		

Important Information:

This document provides a general summary of the basic benefit provisions and is not a substitute for the Benefit Booklet. If there are any inconsistencies between this summary and the benefit Booklet will prevail. Please refer to the Benefit Booklet for exact benefits, exclusions, and limitations or contact Wellmark's customer service at 1-800-622-0043.