

## 2015 Comparison of State of Iowa Health Insurance Plans

Available to AFSCME-covered and judicial branch employees

29-Oct-14

### Blue Access Blue Advantage

### Iowa Select

### Program 3 Plus

#### General Plan Provisions

<b>Benefits Available from Non-Participating Providers</b> <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
<b>Deductible</b> <i>Family deductible is reached from amounts accumulated on behalf of any family member or combination of family members.</i>	None	\$250 single network/non-network \$500 family network/non-network Applies to both inpatient and outpatient services.	\$300 single \$400 family Inpatient services only. The entire family deductible must be met before benefits payments are made.
<b>Medical Out-of-Pocket Maximum</b> <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.	\$600 Single \$800 Family Applies to services provided both in- and out-of-network. All deductibles and coinsurance 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. (Separate out-of-pocket maximum for prescription drugs)
<b>Lifetime Benefits Maximum</b>	None	None	None
<b>New Employee Preexisting Condition Waiting Period</b>	No preexisting conditions waiting period.	No preexisting conditions waiting period.	No preexisting conditions waiting period.
<b>Professional Office Services</b>			
Office Visit	\$10 copay	\$15 copay Once per date of service for exam only Other office services: Network 10%, deductible waived Non-network 20%, after deductible	\$15 copay Once per date of service for exam only Other office services: 20%, no deductible
Allergy Testing	\$10 copay	Network 10%, deductible waived Non-network 20%, after deductible	20%, no deductible
Allergy Serum and Injections	\$10 copay	Network 10%, deductible waived Non-network 20%, after deductible	20%, no deductible
Chiropractor	\$10 copay, if approved Blue Advantage - 12 self-referred visit limit	\$15 copay for exam only Network 10%, deductible waived Non-network 20%, after deductible	\$15 copay exam only Other office services: 20%, no deductible
Routine Eye Exam <i>One routine vision exam per calendar year.</i>	\$10 copay	\$15 copay exam only	Not covered
Routine Hearing Exam <i>One routine hearing exam per calendar year.</i>	\$10 copay	\$15 copay exam only	Not covered
Maternity	\$10 copayment for initial visit	\$15 copay Once per date of service for exam only Other office services: Network 10%, deductible waived Non-network 20%, after deductible	\$15 copay exam only Other office services: 20%, no deductible
Surgery, Radiology & Pathology (office)	\$10 copay	Network 10%, deductible waived Non-network 20%, after deductible	Surgery 0%, no deductible Radiology & Pathology related to surgery 0%, no deductible Radiology & Pathology non-surgery related 20%, no deductible

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<b>Hospital Services</b>			
<b>Inpatient Hospital Services</b>			
Preapproval of Inpatient Admissions	Required	Required	Required
Inpatient Hospital Services Room & Board Inpatient Physician Services Inpatient Supplies Inpatient Surgery	0%	Network 10% after deductible Non-network 20% after deductible	20% after deductible
<b>Outpatient Hospital Services</b>			
Ambulatory Surgical Center	0%	Network 10% after deductible Non-network 20% after deductible	20%, no deductible
Outpatient Diagnostic Lab, Radiology	0%	Network 10%, after deductible Non-network 20%, after deductible	20%, no deductible
<b>Infertility Services</b>	Not covered	Artificial insemination, IVF, GIFT, ZIFT, and other transfer procedures, including cryopreservation of an embryo are covered up to a lifetime maximum of \$25,000.	Artificial insemination, IVF, GIFT, ZIFT, and other transfer procedures, including cryopreservation of an embryo are covered up to a lifetime maximum of \$25,000.
<b>Emergency Care</b>			
Ambulance	0%	Network 10% after deductible Non-network 20% after deductible	20% no deductible
Urgent Care Center	0%	Network 10% after deductible Non-network 20% after deductible	20% after deductible
Hospital Emergency Room	\$50.00 copayment; waived if admitted.	\$50.00 copayment; waived if admitted 10% after copayment	0% no deductible
<b>Behavioral Health Services</b>			
Inpatient mental health and substance abuse treatment	0%	Network 10% after deductible Non-network 20% after deductible	20% after deductible
Outpatient mental health and substance abuse treatment	\$0	\$0 copayment	\$0 copayment
<b>Outpatient Therapy Services</b>			
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 10% after deductible Non-network 20% after deductible	20% no deductible

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<b>Prescription Drug Coverage</b>			
<b>Pharmacy Out-of-Pocket Maximum</b>	No out-of-pocket maximum. Copayments do <b>NOT</b> 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.	Single \$250 Family \$500 Family out-of-pocket is reached from amounts accumulated on behalf of any family member or combination of family members.
<b>Retail</b>			
<b>Quantity</b>	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.
Tier 1 Medications	\$5.00 copay - 30-day supply \$15.00 copay - 90-day supply	\$5.00 copay - 30-day supply \$15.00 copay - 90-day supply	\$5.00 copay - 30-day supply \$15.00 copay - 90-day supply
Tier 2 Medications	\$15.00 copay - 30-day supply \$45.00 copay - 90-day supply	\$15.00 copay - 30-day supply \$45.00 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	\$30.00 copay for a 30-day supply \$90.00 copay for a 90-day supply	\$30.00 copay for a 30-day supply \$90.00 copay for a 90-day supply
Tier 4 Medications	Same as Tier 3	Same as Tier 3	Same as Tier 3
<b>Mail Order</b>			
<b>Quantity</b>	90-day supply for maintenance drugs only	90-day supply for maintenance drugs only	90-day supply for maintenance drugs only
Tier 1 Medications	\$10.00 copay	\$10.00 copay	\$10.00 copay
Tier 2 Medications	\$30.00 copay	\$30.00 copay	\$30.00 copay
Tier 3 Medications	\$60.00 copay	\$60.00 copay	\$60.00 copay
Tier 4 Medications	\$60.00 copay	\$60.00 copay	\$60.00 copay
<b>Prescription Drug Coverage - General Information</b>			
Prescription Oral Contraceptives and Contraceptive Devices	Covered	Covered	Covered
Prescription Drugs/Items for Smoking Cessation	Not Covered	Not Covered	Not 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.	
<b>Important Information:</b>			
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.			