

2015 Comparison of State of Iowa Health Insurance Plans

Available to UE/IUP-covered and the legislative branch employees

29-Oct-14

Blue Access Blue Advantage

Deductible 3 Plus

Iowa Select

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

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Hospital Services			
Inpatient Hospital Services			
Preapproval of Inpatient Admissions	Required	Required	Required
Inpatient Hospital Services Room & Board Inpatient Physician Services Inpatient Supplies Inpatient Surgery	0%	20% after deductible	Network 10% after deductible Non-network 20% after deductible
Outpatient Hospital Services			
Ambulatory Surgical Center	0%	0%, after deductible	Network 10% after deductible Non-network 20% after deductible
Outpatient Diagnostic Lab, Radiology	0%	20%, after deductible	Network 10%, after deductible Non-network 20%, after deductible
Infertility Services	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.
Emergency Care			
Ambulance	0%	20% after deductible	Network 10% after deductible Non-network 20% after deductible
Urgent Care Center	0%	20% after deductible	Network 10% after deductible Non-network 20% after deductible
Hospital Emergency Room	\$50.00 copayment; waived if admitted.	0% after deductible	\$50.00 copayment; waived if admitted 10% after copayment
Behavioral Health Services			
Inpatient mental health and substance abuse treatment	0%	20% after deductible	Network 10% after deductible Non-network 20% after deductible
Outpatient mental health and substance abuse treatment	\$0	0% after deductible	\$0 copayment
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	20% after deductible	Network 10% after deductible Non-network 20% after deductible

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Prescription Drug Coverage			
Pharmacy Out-of-Pocket Maximum	No out-of-pocket maximum. Copayments do NOT apply to medical out-of-pocket maximum.	No separate 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.
Retail			
Quantity	30-day supply for maintenance and non-maintenance drugs. 90-day supply for maintenance drugs.	30-day supply	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	20%, after deductible	\$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
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
Tier 4 Medications	Same as Tier 3		Same as Tier 3
Mail Order			
Quantity	90-day supply for maintenance drugs only	Mail order not available	90-day supply for maintenance drugs only
Tier 1 Medications	\$10.00 copay		\$10.00 copay
Tier 2 Medications	\$30.00 copay		\$30.00 copay
Tier 3 Medications	\$60.00 copay		\$60.00 copay
Tier 4 Medications	\$60.00 copay		\$60.00 copay
Prescription Drug Coverage - General Information			
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.
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.			