2016 Comparison of Health Insurance Plans for State of Iowa

Available to AFSCME-covered, UE/IUP-covered and Judicial Branch Employees

2016 changes are indicated in red	Blue Access	Iowa Select	Program 3 Plus	Deductible 3 Plus
General Plan Provisions				
Benefits Available from Non-Participating Providers *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.*	None, unless prescribed and referred by a participating physician and approved by Wellmark, or in an emergency medical situation.	Normal plan benefits for network/non-network providers	Normal plan benefits	Normal plan benefits
Deductible *Family deductible is reached from amounts accumulated on behalf of any family member or combination of family members.*	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. **Single contracts are subject to the single deductible. Family amounts are reached from amounts accumulated on behalf of any covered family member or combination of covered family members. For family contracts, benefits are not available for any family members until the entire family deductible has been met.**	$300 single $400 family Applies to most services. **Single contracts are subject to the single deductible. Family amounts are reached from amounts accumulated on behalf of any covered family member or combination of covered family members. For family contracts, benefits are not available for any family members until the entire family deductible has been met.**
Medical Out-of-Pocket Maximum *Family out-of-pocket is reached from amounts accumulated on behalf of any family member or combination of family members.*	$750 Single $1,500 Family All copayments go toward out-of-pocket limit. (Separate out-of-pocket maximum for prescription drugs.)	~~$600~~ **$650** Single ~~$800~~ **$1,450** Family All deductibles, coinsurance, and copayments go toward out-of-pocket limit. (Separate out-of-pocket maximum for prescription drugs.)	~~$600~~ **$650** Single ~~$800~~ **$1,450** Family All deductibles, coinsurance, and copayments go toward out-of-pocket limit. (Separate out-of-pocket maximum for prescription drugs)	~~$600~~ **$650** Single ~~$800~~ **$1,450** Family All deductibles and copayments 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 or coinsurance.**	**Covered at 100% per ACA guidelines.**
Professional Office Services				
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	20%, after deductible
Allergy Testing	$10 copay	Network 10%, deductible waived Non-network 20%, after deductible	20%, no deductible	20%, after deductible
Allergy Serum and Injections	$10 copay	Network 10%, deductible waived Non-network 20%, after deductible	20%, no deductible	20%, after deductible
Chiropractor	$10 copay, if approved	$15 copay for exam only Network 10%, deductible waived Non-network 20%, after deductible	$15 copay exam only Other office services: 20%, no deductible	20%, after deductible
Routine Eye Exam *One routine vision exam per calendar year.*	$10 copay	$15 copay exam only	Not covered	Not covered
Routine Hearing Exam *One routine hearing exam per calendar year.*	$10 copay	$15 copay exam only	Not covered	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	20%, after 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	Deductible only
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%~~ **10%**	Network 10% after deductible Non-network 20% after deductible	20% after deductible	20% after deductible
Outpatient Hospital Services				
Ambulatory Surgical Center	~~0%~~ **10%**	Network 10% after deductible Non-network 20% after deductible	20%, no deductible	Deductible only

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Outpatient Diagnostic Lab, Radiology	~~0%~~ **10%**	Network 10%, after deductible Non-network 20%, after deductible	20%, no deductible	Deductible only
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.	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%~~ **10%**	Network 10% after deductible Non-network 20% after deductible	20% no deductible	20% after deductible
Urgent Care Center	~~0%~~ **10%**	Network 10% after deductible Non-network 20% after deductible	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	0% after deductible
Behavioral Health Services				
Inpatient mental health and substance abuse treatment	~~0%~~ **10%**	Network 10% after deductible Non-network 20% after deductible	20% after deductible	20% after deductible
Office visit	**$10 copay**	**$15 copay**	**$15 copay**	**$0 copay**
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 10% after deductible Non-network 20% after deductible	20% no deductible	20% after deductible
Prescription Drug Coverage				
Pharmacy Out-of-Pocket Maximum	*Single* **$5,850 *** *Family* **$11,700 ***	Single ~~$250~~ **$500** Family ~~$500~~ **$1,000**	Single ~~$250~~ **$500** Family ~~$500~~ **$1,000**	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 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	20%, after deductible
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	20%, after deductible
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	20%, after deductible
Tier 4 Medications	Same as Tier 3	Same as Tier 3	Same as Tier 3	Same as Tier 3
Mail Order				Mail order not available
Quantity	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	
Prescription Drug Coverage - General Information				
Prescription Oral Contraceptives and Contraceptive Devices	Covered	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.		

*** The out-of-pocket maximum for Blue Access is an ACA requirement. In prior years, Blue Access did not have an out-of-pocket maximum for prescription drug copays.**

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.