

2017 State of Iowa Retiree Health Insurance Plans

Health plans available to all retirees **except** 1) individuals from an Executive Branch non-contract position who retired after Jan. 1, 2014 and 2) individuals from the Legislative Branch who retired after Jan. 1, 2016.

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2017 Changes are in Red

Blue Access

Iowa Select

Program 3 Plus

Deductible 3 Plus

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	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	\$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 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.
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. (Separate out-of-pocket maximum for prescription drugs.)	\$650 \$1,000 Single \$1,450 \$2,000 Family All deductibles, coinsurance, and copayments go toward out-of-pocket limit. (Separate out-of-pocket maximum for prescription drugs.)	\$650 \$1,000 Single \$1,450 \$2,000 Family All deductibles, coinsurance, and copayments go toward out-of-pocket limit. (Separate out-of-pocket maximum for prescription drugs.)	\$650 \$1,000 Single \$1,450 \$2,000 Family All deductibles and coinsurances go toward out-of-pocket limit.
Lifetime Benefits Maximum	Hospice Respite 15 Days Inpatient/15 Days Outpatient	Hospice Respite 15 Days Inpatient/15 Days Outpatient Infertility - \$25,000	Hospice Respite 15 Days Inpatient/15 Days Outpatient Infertility - \$25,000	Hospice Respite 15 Days Inpatient/15 Days Outpatient Infertility - \$25,000
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. Preventive care from participating providers with Wellmark is not subject to the deductible or coinsurance.
Professional Office Services				
Office Visit	\$10 copay Other office services: 20% (For more details contact Wellmark's customer service at 1-800-622-0043.)	\$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 Services not subject to coinsurance: office surgeries and related x-ray and lab	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 <i>One routine vision exam per calendar year.</i>	\$10 copay	\$15 copay exam only	Not covered	Not covered
Routine Hearing Exam <i>One routine hearing exam per calendar year.</i>	\$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

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Surgery, Radiology & Pathology (office)	\$10 copay X-ray and lab not subject to 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	10%	Network 10% after deductible Non-network 20% after deductible	20% after deductible	20% after deductible
Outpatient Hospital Services				
Ambulatory Surgical Center	10%	Network 10% after deductible Non-network 20% after deductible	20% no deductible	Deductible only
Outpatient Diagnostic Lab, Radiology	10%	Network 10%, Non-network 20%, after deductible	0% 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	10%	Network 10% after deductible Non-network 20% after deductible	20% no deductible	20% after deductible
Urgent Care Center <i>NOTE: Beginning in 2016, Wellmark will recognize urgent care centers as an eligible provider type in their networks. To be eligible as an urgent care center provider, a site will be required to meet specific contracting and credentialing criteria. A clinic, not credentialed as an urgent care center, could still submit a claim as an office visit or outpatient service.</i>	Credentialed as Wellmark urgent care provider: 10% Not Credentialed as Wellmark urgent care provider: The claim would be paid as an office visit or outpatient service.	Credentialed as Wellmark urgent care provider: Network 10% after deductible Non-network 20% after deductible Not Credentialed as Wellmark urgent care provider: The claim would be paid as an office visit or outpatient service.	Credentialed as Wellmark urgent care provider: 20% after deductible Not Credentialed as Wellmark urgent care provider: The claim would be paid as an office visit or outpatient service.	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	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%
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
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Prescription Drug Coverage				
Pharmacy Out-of-Pocket Maximum	Single \$5,850 Family \$11,700	Single \$500 Family \$1,000	Single \$500 Family \$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	30-day supply: \$5.00 copay 90-day supply: \$15.00 copay	30-day supply: \$5.00 copay 90-day supply: \$15.00 copay	30-day supply: \$5.00 copay 90-day supply: \$15.00 copay	20% after deductible
Tier 2 Medications	30-day supply: \$15.00 copay 90-day supply: \$45.00 copay	30-day supply: \$15.00 copay 90-day supply: \$45.00 copay	30-day supply: \$15.00 copay 90-day supply: \$45.00 copay	20% after deductible
Tier 3 Medications	30-day supply: \$30.00 copay or 25%, whichever is greater 90-day supply: \$90.00 copay or 25%, whichever is greater	30-day supply: \$30.00 copay 90-day supply: \$90.00 copay	30-day supply: \$30.00 copay 90-day supply: \$90.00 copay	20% after deductible
Mail Order				
Quantity	90-day supply for maintenance drugs only	90-day supply for maintenance drugs only	90-day supply for maintenance drugs only	Mail order not available
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	
Prescription Drug Coverage - General Information				
Prescription Oral Contraceptives and Contraceptive Devices	Covered	Covered	Covered	Covered
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.		