

# 2018 State Health Plan

## Frequently Asked Questions

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### General plan and open enrollment information

#### 1. When is open enrollment?

**Open enrollment will be held Oct. 16-Nov. 17, 2017.** During this time, all benefit-eligible State of Iowa employees must actively elect or decline medical coverage for 2018.

#### 2. What is the 2018 health plan?

For 2018, all State employees will be offered the same health coverage (one plan), with a choice between two network options:

- **Iowa Choice:** Offers benefits through the Wellmark Blue Cross and Blue Shield Blue Access® network (with providers in Iowa and in counties sharing a border with Iowa.)
- **National Choice:** Offers benefits through the Wellmark Alliance Select<sup>SM</sup> network (with providers in Iowa and across the nation.)

All of the health care services covered today will continue to be covered next year (though the cost share amounts you pay for services may differ.)

#### 3. What are the monthly premium rates for the 2018 plan?

**Iowa Choice** has a provider network for in-state care, with a large selection of providers within the state and counties sharing a border with Iowa. Employee pricing for the Iowa Choice plan is:

Single coverage	\$40 per month
Family coverage	\$150 per month

**National Choice** offers an expanded network, with the option to receive services from Iowa-based providers as well as providers throughout the U.S. Employee pricing for the National Choice plan is:

Single coverage	\$93 per month
Family coverage	\$273 per month

**4. Will the Double Spouse Credit still be available?**

The double spouse credit will be available but there will be no reduction in the employee pricing. Employees cannot be covered as both an employee and a dependent under the state's health and dental insurance plans.

**5. Will the health insurance opt-out be available in 2018?**

In 2018, an employee can elect to opt-out of coverage in a state-sponsored health insurance plan and receive a payment of \$125 monthly. To be eligible for health insurance opt-out, an employee must be:

- Full-time (work 30 or more hours per week) benefit-eligible employee and
- Not be covered by any state-sponsored (active, retiree, and Board of Regents) health insurance plan through a family member, including a domestic partner.

**6. In addition to the premium, what other costs will I have to pay?**

You will also have copays, deductibles, and coinsurance. For specifics, review the side-by-side comparison of the two options on the DAS website at <https://das.iowa.gov/human-resources/employee-and-retiree-benefits/employee-and-retiree-benefits/2018-health-insurance>. More information is also available in the *Copays, deductibles and out-of-pocket maximums* section.

**7. What are the major differences between Iowa Choice and National Choice?**

In short, **Iowa Choice** covers care in Iowa and in counties sharing a border with Iowa. **National Choice** covers care in Iowa and across the United States.

**Iowa Choice** covers care in Iowa as well as in counties sharing a border with Iowa. The provider network includes 100 percent of Iowa hospitals and 96 percent of Iowa doctors. Out-of-network coverage is not available except in an emergency or if services are not available in-network and an out-of-network referral has been submitted and approved by Wellmark in advance.

With **National Choice**, you may seek health care from any provider located in the United States. In Iowa, in-network care can be received at 100 percent of hospitals and with 99 percent of doctors. Outside of the state, you'll have access to 96 percent of hospitals and 93 percent of doctors. Keep in mind with this option you can see any provider you choose, but you will have lower out-of-pocket expenses if you choose a network provider.

**8. What do I need to do during open enrollment?**

If you want health coverage in 2018, you must enroll in either Iowa Choice or National Choice. Open enrollment will be held from Oct. 16-Nov. 17, 2017. **If you do not enroll during this time period, you will not have coverage in 2018.**

### 9. What will happen to the Healthy Opportunities Wellness Program in 2018?

The Healthy Opportunities Wellness Program will not continue as it currently exists. Except for SPOC-covered employees, no screenings, health assessments or coaching will be required in 2018. The health plan will continue to focus on wellness and offers many value-added services to assist employees and their families to improve and maximize their good health.

### 10. What do I do if I have questions?

- Visit the DAS website at <https://das.iowa.gov/human-resources/employee-and-retiree-benefits/employee-and-retiree-benefits/2018-health-insurance>
- Contact the Wellmark customer service team at 1-800-622-0043
- Logon to your Wellmark member portal [wellmark.com/mywellmark](http://wellmark.com/mywellmark) to search for costs, locate a provider, view your claims, and more
- Send an email to [employee.benefits@iowa.gov](mailto:employee.benefits@iowa.gov)

## Network and provider access

### 1. Do Iowa Choice and National Choice use the same network?

No, the provider networks are different. When looking for a doctor or provider on the Wellmark website, Iowa Choice uses the Blue Access provider network and National Choice uses the Alliance Select network. You can search for providers using the Find A Doctor link at [www.wellmark.com](http://www.wellmark.com).

### 2. Can I see any provider with the National Choice option?

Yes, with **National Choice** you may get health care from any provider. Keep in mind, choosing an in-network provider will reduce your out-of-pocket costs.

### 3. How do I find out whether my health care provider is an in-network provider under the new plan?

Go to the *Find a Doctor or Hospital* tool on [Wellmark.com](http://Wellmark.com). Enter your Wellmark ID number found on the back of your ID card or you can select your network name. Choose *Blue Access* to find a provider or facility in the Iowa Choice network or *Alliance Select* to find a provider or facility in the National Choice network.

### 4. Do I have to designate a primary care provider?

No. Choosing a primary care provider (PCP) is not required with either Iowa Choice or National Choice but developing a relationship with your doctor can lead to better health outcomes and more organized care.

### 5. Do I need a referral from my personal doctor or primary care provider to see a specialist under the new plan?

No, you do not need a referral to see a specialist. However, you should make sure the specialist is in-network.

### 6. How do referrals work if I am referred to a doctor outside of my network?

If you need care that can't be performed by a provider in the Iowa Choice network, your in-network provider will need to submit a request to Wellmark on your behalf. Wellmark will then review the request. If Wellmark confirms the services cannot be completed by an in-network provider, Wellmark will approve your referral.

**7. Which health care providers are considered primary care providers (PCP) under the new plan?**

The following are considered primary care providers, or PCPs:

- Family practitioners
- General practitioners
- Internal medicine practitioners
- Obstetricians/gynecologists
- Pediatricians
- Physician assistants
- Advanced registered nurse practitioners

A PCP office visit is a \$15 copay.

Other providers (not PCPs) requiring a \$15 copay include: chiropractors, speech pathologists, occupational therapists and physical therapists. For Doctor on Demand virtual visits, the copay is \$10 per visit.

**All other providers are considered specialists.** Examples of these include cardiologists, dermatologists, and orthopedists.

**8. I have a child attending school out of state. Can he/she be covered under the Iowa Choice option?**

Yes, Guest Membership is available for a child residing outside of the state. For members on the **Iowa Choice** plan, Guest Membership is designed to address your health care needs in the following situations:

- Dependent students attending school out-of-state in an accredited institution of higher learning
- Family members residing in another state but covered under the same health plan
- Retirees with dual residence, one of which is outside Iowa
- Members traveling for work or pleasure for at least 90 consecutive days

To locate a Guest Membership health care provider, call 1-800-622-0043 or visit the *Find a Doctor or Hospital* tool on [Wellmark.com](http://Wellmark.com).

For additional information or to sign up for Guest Membership, contact Wellmark Customer Service at 1-800-622-0043.

**9. If I have an accident outside of Iowa and I have the Iowa Choice option, will I be covered?**

Yes, Iowa Choice will provide out-of-area coverage for emergencies and accidental injuries. Please note follow-up visits to any provider outside of Iowa need an approved Out-of-Network referral.

**10. How does the Iowa Choice option define “emergency” treatment?**

An emergency is a medical situation you suspect could cause serious bodily harm if it’s not treated immediately.

## Copays, deductibles and out-of-pocket maximums

### 1. What do these terms mean, and how do they apply to the new plan?

- **Deductible:** This is the annual amount you pay for health care services before your medical benefits start. The single deductible is \$250 and the family is \$500. Services subject to copay will not apply to a deductible. [Understanding Jargon: Deductible](#) (Wellmark YouTube video)
- **Copay:** This is the amount you pay each time you receive care. The copay for primary care providers is \$15, while the specialist copay is \$30.
- **Coinsurance:** This is the amount you pay for certain covered services. With Iowa Choice and National Choice, in-network coinsurance is 10 percent. Out-of-network care for **National Choice** is 20 percent.
- **Out-of-pocket maximum (OPM):** This figure is the maximum amount you'll pay for health care services in a benefit year. Your OPM includes deductibles, copays, and coinsurance. The annual medical OPM is \$1,000 for single coverage and \$2,000 for family coverage. The annual pharmacy OPM is separate and is \$5,850 for single coverage or \$11,700 for family coverage. Once you reach your out-of-pocket maximum, your out-of-pocket costs are 100 percent covered.

### 2. Will I have to pay the deductible before the new plan covers services?

No, you do not need to meet the deductible before the new plan begins to cover services.

### 3. My family is covered under my health plan. Do all the covered family members need to meet the \$250 deductible under the new plan?

The family deductible is reached from amounts accumulated by any family member or combination of family members. The family deductible can be met by two or more family members. Once the \$500 family deductible has been met by a combination of family members, all family members will have met the deductible and coinsurance will apply.

### 4. What are examples of "other office services" under the new plan?

Examples could include lab work, office-based surgery, injections, tests, etc. The office visit copay applies to any office services as long as they are billed under the office visit. For example, if you have lab work done at a PCP office you will have one copay of \$15. If the lab is taken during a visit to a specialist the copay would be \$30.

### 5. What will I pay for lab services at an independent lab when there is no associated office visit?

You will be responsible for 10 percent coinsurance for independent labs when you see an in-network provider.

### 6. Is the \$100 emergency room (ER) copay waived if I am admitted under the new plan?

Yes, this copay is waived if you are admitted as an inpatient to the hospital.

### 7. What are my out-of-pocket costs for maternity coverage under the new plan?

Maternity services are typically billed all at once at the time of delivery. Assuming a normal delivery, you will be responsible for the deductible and coinsurance up to your medical out-of-pocket maximum of \$1,000. There may be additional costs for lab work and newborn care which would be billed separately but would apply toward your out-of-pocket maximum.

Should additional services be required, the newborn may be subject to a separate \$1,000 out-of-pocket maximum. Keep in mind that the maximum your family will pay out-of-pocket for medical services is \$2,000 in any calendar year.

**8. Is vision care covered?**

Yes. Your plan includes one routine vision exam per year and is subject to the office visit copay of \$15 for a PCP or \$30 for a specialist.

**9. How are urgent care centers or walk-in clinics covered under the new plan?**

The urgent care copay is \$15.

**10. How are chiropractic services covered under the new plan?**

Chiropractic services are covered and subject to a \$15 copay.

**11. Are there limits on the number of chiropractic visits under the new plan?**

There is no limit on the number of visits, but your chiropractor may need to submit a treatment plan in order to demonstrate that services are medically necessary.

**12. Are infertility services covered under the new plan?**

Infertility benefits are covered under both **Iowa Choice** and **National Choice** as follows:

- Artificial insemination, IVF, GIFT, ZIFT and other transfer procedures, along with cryopreservation of embryo, are covered up to a lifetime maximum of \$25,000
- Donor egg and sperm are covered and included in the lifetime maximum

**13. Is bariatric surgery covered under the new plan?**

Bariatric surgery and related treatments are covered if deemed medically necessary.

**14. Is there a lifetime benefit maximum under the new plan?**

There is not a lifetime benefit maximum. However, there are lifetime maximums on hospice respite care (15 days inpatient/15 days outpatient) and infertility services (\$25,000).

**15. How does the fourth quarter deductible carry-over work under the new plan?**

The amount you pay toward your deductible during the last three months of a benefit year carries over as credits to meet your deductible for the next benefit year.

## **Telemed (Doctor On Demand) – a new benefit**

**1. How does telemed (Doctor On Demand) work?**

Virtual visits through telemed (Doctor On Demand) allow you to visit a doctor on your smartphone or tablet from almost anywhere. Through this new service, you may get treatment for cold and flu, bronchitis and sinus infections, urinary tract infections, sore throats, allergies, fever, headache, pink eye, skin conditions, and more. Telemed (Doctor On Demand) also

provides mental health services. To register, download the free app or learn more, visit [DoctorOnDemand.com](http://DoctorOnDemand.com). [Learn More](#)

**2. What is the cost of using Doctor On Demand under the new plan?**

Doctor on Demand is subject to a \$10 copay.

## Preventive Care

**1. Are preventive services with no copay covered under the new plan?**

Yes. Preventive services, as defined by the Affordable Care Act, are generally covered at no cost to you.

**2. What are preventive services under the new plan?**

For a list of covered preventive services, visit <http://www.healthcare.gov/coverage/preventive-care-benefits/>

**3. How are routine mammograms covered?**

Age-appropriate preventive mammograms received in-network are covered at 100 percent.

**4. How are colonoscopies covered?**

A colonoscopy that is preventive would be paid at 100 percent when an in-network provider is used. Diagnostic colonoscopies would apply the outpatient facility and practitioner benefit. Please contact your provider and/or Wellmark to discuss your particular health situation.

**5. Are products/services to help me stop smoking (tobacco cessation) covered under the new plan?**

Prescription drugs/items for tobacco cessation are covered under the pharmacy program, while related exams are covered under the medical plan. In addition, tobacco cessation consultations are included as part of preventive care.

## Pharmacy coverage

**1. Are there changes in the network pharmacies under the new plan?**

No, there is no change to the current pharmacy network.

**2. How can I find out what tier my prescriptions are on under the new plan?**

Drugs on the lower tiers are less expensive than higher-tier medications. If you are concerned about the cost of your medication, it's important to consult with your prescribing physician to find out if equivalent, lower-tiered options are available.

To find out which tier your prescription is on, visit [Wellmark.com](http://Wellmark.com). Scroll to the bottom of the page and click on *Prescription Drug Info*. Next, you will click on *Wellmark Drug List* and select *Blue Rx Complete* from the Formulary Drug List. Here you can type in your prescription and the results will show you which tier the drug is on and the prior authorization or quantity limits that

apply. You can also log in to myWellmark at [Wellmark.com/myWellmark](http://Wellmark.com/myWellmark) and use the pharmacy tools to find your actual costs for prescription drugs.

**3. I take a brand name drug. Will the plan change how this is covered?**

The prescription drug formulary is not changing. However, there may be changes to out-of-pocket costs for brand name drugs that have a generic equivalent. You will be responsible for paying the generic copay and any remaining cost difference, up to the maximum allowed fee for the brand name drugs.

**4. Do my prescription drug copays go toward the medical out-of-pocket maximum under the new plan?**

No, your plan has a separate out-of-pocket maximum for pharmacy drug benefits. That out-of-pocket maximum is \$5,850 for single coverage and \$11,700 for family coverage.

**5. Is the mail order prescription drug option still available under the new plan?**

Yes, mail order for a 90-day supply of maintenance drugs is still available. [Learn more.](#)

**6. With the mail order option, can I still receive a 90-day supply for just two copays under the new plan?**

Yes, two copays will apply for a 90 -day supply through mail order.

**7. Can I receive a 90-day supply at a retail pharmacy for three copays under the new plan?**

Yes, you may get a 90-day supply at your local pharmacy when you pay three copays.

**8. What are specialty drugs?**

Specialty drugs require special handling, administration or monitoring. These drugs treat complex, chronic and often costly conditions. To find out if your drug is a specialty drug, go to [Wellmark.com](http://Wellmark.com) and click on the *Individuals and Families* tab. Next, select *My Employer Provides My Insurance*. Select *Prescription Drug Information* and then *Wellmark Drug List*. Finally, select your pharmacy plan, *Blue RX Complete*, and search by drug name. [Learn more](#)

**9. Is insulin considered a specialty drug under the new plan?**

No, most insulins are not considered specialty drugs.

**10. Can I go to any network pharmacy to fill a prescription for a specialty drug under the new plan?**

As long as the pharmacy has the specialty drug you need, you are not restricted to any network. However, it's important to note that specialty drugs usually require special handling, so they are not available at all pharmacies. Wellmark does offer a convenient mail order option through Hy-Vee Pharmacy Solutions or CVS/Caremark Specialty Pharmacy. For more information on the specialty drug program, visit the *Specialty Drug* page on [Wellmark.com](http://Wellmark.com) or contact Wellmark Customer Service at the number on the back of your Wellmark ID card.

## Post-enrollment

### 1. What can I expect after I enroll?

In December, you will receive a new ID card that you will want to share with your doctor and pharmacist. In January, the coverage manual will be available. You will also have access to your plan information and additional tools through the DAS website and [Wellmark.com](http://Wellmark.com).

### 2. Can I use my current ID card?

You will receive a new ID card in December. Please be sure to show your doctors and pharmacy your new ID card before receiving care. You can also download the free mobile app and register for myWellmark to view and email your ID card on your phone.

## For More Information

### 1. Where can I get more information?

- Visit the DAS website at <https://das.iowa.gov/human-resources/employee-and-retiree-benefits/employee-and-retiree-benefits/2018-health-insurance>
- Contact the Wellmark customer service team at 1-800-622-0043
- Logon to your Wellmark member portal [wellmark.com/mywellmark](http://wellmark.com/mywellmark) to search for costs, locate a provider, view your claims, and more
- Send an email to [employee.benefits@iowa.gov](mailto:employee.benefits@iowa.gov)

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*This document is intended as an overview of benefits and should not be construed as a guarantee of services covered. If the wording in this document contradicts any plan documents, laws, regulations, administrative rules, insurance policies, or other legal agreements, the wording in the official documents and agreements will govern.*