2020 Iowa Choice and National Choice Side-by-Side Comparison

	Iowa Choice option	National Choice option
Wellmark network to use when searching for providers	Blue Access network	Alliance Select network
Benefits Available from Non-Participating Providers	**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
Deductible *Family deductible is reached from amounts accumulated on behalf of any family member or combination of family members.*	$250 single $500 family	$250 single $500 family
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.* • *All deductibles, coinsurance, and copayments go toward out-of-pocket limit. (Separate out-of-pocket maximum for prescription drugs.)*	$1,000 Single $2,000 Family	$1,000 Single $2,000 Family
Lifetime Benefits Maximum	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.
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.

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Professional Office Services		
Office Visit - Primary Care Practitioner (PCP) A PCP is one of the following: - advanced registered nurse practitioner (ARNP) - family practitioner - general practitioner - internal medicine practitioner - obstetrician/gynecologist - pediatrician - physician assistant (PA)	$15 copay Office visit copay applies to any office services	$15 copay Office visit copay applies to any office services
Office Visit - Specialist All other practitioners except those listed above are considered specialist	$30 copay Office visit copay applies to any office services	$30 copay Office visit copay applies to any office services
Professional Office Services		
Office Visit - Other Providers (not PCP or Specialist) - chiropractor - occupational therapist - physical therapist - speech pathologists	$15 copay Office visit copay applies to any office services	$15 copay Office visit copay applies to any office services
Routine Eye Exam *One routine vision exam per calendar year.*	$30 copay	$30 copay
Routine Hearing Exam *One routine hearing exam per calendar year.*	$30 copay	$30 copay
Maternity (globally billed at time of delivery)	10% after deductible	10% after deductible
Surgery, Radiology & Pathology (office)	$15 copay (PCP) / $30 copay (Specialist)	$15 copay (PCP) / $30 copay (Specialist)
Doctor on Demand™ (Telemed)	$10 copay	$10 copay

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Hospital Services		**Network**	**Non-network**
Inpatient Hospital Services			
Preapproval of Inpatient Admissions	Required	Required	
Inpatient Hospital Services Room & Board Inpatient Physician Services Inpatient Supplies Inpatient Surgery	10% after deductible	10% after deductible	20% after deductible
Outpatient Hospital Services		**Network**	**Non-network**
Ambulatory Surgical Center	10% after deductible	10% after deductible	20% after deductible
Outpatient Diagnostic Lab, Radiology	10% deductible waived	10% after deductible	20% after deductible
Outpatient Therapy Services		**Network**	**Non-network**
Chemotherapy Physical Therapy Occupational Therapy Respiratory Therapy Speech Therapy	10% after deductible	10% after deductible	20% after deductible
Emergency Care		**Network**	**Non-network**
Ambulance	10% after deductible	10% after deductible	20% after deductible
Urgent Care Center	$15 copay	$15 copay	
Hospital Emergency Room	$100 copayment; waived if admitted	$100 copayment; waived if admitted	

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Behavioral Health Services		**Network**	**Non-network**
Inpatient mental health and substance abuse treatment	10% after deductible	10% after deductible	20% after deductible
Behavioral Health Services		**Network**	**Non-network**
Office visit	$15 copay	$15 copay	
Outpatient mental health and substance abuse treatment	10% after deductible	10% after deductible	20% after deductible
Prescription Drug Coverage (Blue Rx Complete Formulary)			
Pharmacy Out-of-Pocket Maximum	Single $5,850 Family $11,700		
Retail			
Quantity	30-day supply for maintenance and non-maintenance drugs. 90-day supply for maintenance drugs.		
Tier 1 Generic	30-day supply: **$10** copay | 90-day supply: **$30** copay		
Tier 2 Preferred Brand	30-day supply: **$25** copay |90-day supply: **$75** copay		
Tier 3 Non-Preferred Brand	30-day supply: **$50** copay | 90-day supply: **$150** copay		
Tier 4 Preferred Specialty/Non-Preferred Specialty	**$100/$200**		
Mail Order			
Quantity	90-day supply for maintenance drugs only		
Tier 1 Generic	**$20** copay		
Tier 2 Preferred Brand	**$50** copay		
Tier 3 Non-Preferred Brand	**$100** copay		
Prescription Drug Coverage - General Information	Purchase a brand name drug that has an FDA-approved "A"- rated generic equivalent, the State will only pay for the equivalent generic drug. The employee is responsible for the copayment and any remaining cost difference up to the maximum allowed fee for the brand name drug.		