

## 2. Plan Comparisons and Managed Care Service Area

### STATE OF IOWA HEALTH BENEFIT COMPARISON

Effective January 1, 2009

**THIS COMPARISON IS ONLY A SUMMARY OF BENEFITS. BENEFITS WILL BE ADMINISTERED AS DESCRIBED IN EACH PLAN'S SUBSCRIBER AGREEMENT OR PLAN DOCUMENT. FOR FURTHER DETAIL, REFER TO THOSE DOCUMENTS OR CALL THE INSURANCE CARRIER OR MANAGED CARE PLAN.**

PLAN PROVISIONS	Wellmark BC/BS PROGRAM 3 PLUS	Wellmark BC/BS IOWA SELECT		Managed Care Open Access (Blue Access) & Primary Care (Blue Advantage)
		In-Network (Select Provider)	Out-of-Network (Non-Select Provider)	
Benefits Available From Non-Participating Providers	Normal plan benefits.	Normal plan benefits for Select providers.	Normal plan benefits for Non-Select providers.	None, unless prescribed, referred and approved by a Participating Physician or in Emergency Medical Condition, or with prior authorization from the Plan, when required.
Coinsurance Percentage	20%, all services.	10%	20%	Varies; see below
Deductible Single/Family	\$300/\$400, inpatient services only.	\$250/\$500. Applies to both inpatient and outpatient services. Waived for services provided in office/clinic setting of Select Provider.	\$250/\$500. Applies to both inpatient and outpatient services.	None.
Dependent Child Age Limit	-Unmarried children under age 25 and reside in the state of Iowa. -Unmarried children that are full-time students in an accredited institution of postsecondary education regardless of age -Totally and permanently disabled, physically or mentally, children regardless of age. The disability must have existed before the child turned 25.			
Out-of-Pocket Limit Single/Family	\$600/\$800. All deductibles, coinsurance, and copayments except \$15 office visit copayment go toward out-of-pocket limit. Separate \$250/\$500 out-of-pocket limit for prescription drugs. Does not apply to medical out-of-pocket limit.	\$600/\$800. Applies to services provided both in and out-of-network. All deductibles, coinsurance and copayments except \$15 office visit copayment go toward out-of-pocket limit. Emergency Room Copayment continues to apply after out-of-pocket limit is met. Separate \$250/\$500 out-of-pocket limit for prescription drugs. Does not apply to medical out-of-pocket limit.	\$600/\$800. Applies to services provided both in and out-of-network. All deductibles, coinsurance and copayments except \$15 office visit copayment go toward out-of-pocket limit. Emergency Room Copayment continues to apply after out-of-pocket limit is met. Separate \$250/\$500 out-of-pocket limit for prescription drugs. Does not apply to medical out-of-pocket limit.	\$750/\$1500. All copayments go toward out-of-pocket limit with the exception of prescription drug copayments.

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		In-Network (Select Provider)	Out-of-Network (Non-Select Provider)	
Lifetime Benefit Maximum	None.	None.	None.	None.
New Employee Preexisting Condition Waiting Period	11 months.	11 months.	11 months.	None.
<b>MEDICAL SERVICES</b>				
Accidents	0%, no deductible for all treatment within 72 hours of accident.	10%, deductible waived in office setting.	20%, after deductible. Emergency care covered at In-Network level.	\$10 copayment office visit. \$50 copayment Emergency Room, waived if admitted.
Allergy Treatment	20%, no deductible.	10%, deductible waived in office setting.	20%, after deductible.	\$10 copayment per visit.
Ambulance	20%, no deductible.	20%, after deductible.	20%, after deductible.	0%, if medically necessary/emergency medical services.
Blood, Blood Plasma, Blood Serum	20%, no deductible.	10%, after deductible.	20%, after deductible.	0%, if authorized.
Chiropractor	20%, no deductible.	10%, deductible waived in office setting.	20%, after deductible.	\$10 copayment if approved provider.
Dental Accident Care	0%, no deductible for services provided within 72 hours. 20% thereafter for a maximum of 6 months from injury.	10%, deductible waived in office setting. Limited to services provided within 72 hours of accident.	20%, after deductible. Limited to services provided within 72 hours of accident.	20%, if authorized by Wellmark BCBS for injury to sound natural teeth. Services must be within 6 months of injury and must have occurred while member enrolled in plan.
Durable Medical Equipment	20%, no deductible.	10%, after deductible.	20%, after deductible.	20%, if prescribed by a Participating Provider and obtained from a supplier authorized by Wellmark BCBS.
Emergency Room (ER Care)	0%, no deductible. Also see section on "Accidents."	\$50 copayment waived if admitted. Copayment and coinsurance apply. Copayment applies after out-of-pocket limit is met.	\$50 copayment waived if admitted. Copayment and coinsurance apply. Copayment applies after out-of-pocket limit is met.	\$50 copayment waived if admitted.
Eyeglasses	Not covered.	Not covered.	Not covered.	Not covered.
Hearing Aids	Not covered.	Not covered.	Not covered.	Not covered.
Hemodialysis	20%, no deductible.	10%, after deductible.	20%, after deductible.	0%, if obtained in a Center authorized by Wellmark BCBS.

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Home Health Care	20%, no deductible. Precertification required.	10%, after deductible. Precertification required.	20%, after deductible. Precertification required.	0% if authorized by Wellmark BCBS.
Hospice Care	20%, no deductible. Precertification required.	10%, after deductible. Precertification required.	20%, after deductible. Precertification required.	0%, if medically authorized by Wellmark BCBS.
Inpatient Physician Services	20%, after deductible.	10%, after deductible.	20%, after deductible.	0%, if authorized.
Inpatient Room & Board	20%, after inpatient service deductible. No limit on medical surgical days. Pre certification of admission required.	10%, after deductible. No limit on medical surgical days. Pre Certification of admission required by Select provider.	20%, after deductible. No limit on medical surgical days. Pre Certification of admission required.	0% if authorized. Semi-private basis unless medically necessary to use private room. May require prior approval.
Inpatient Supplies, Drugs, Medicines, etc.	20%, after deductible	10%, after deductible	20%, after deductible	0% if authorized.
Inpatient Surgery	20%, after deductible. Must be approved as inpatient procedure.	10%, after deductible. Must be approved as inpatient procedure.	20%, after deductible. Must be approved as inpatient procedure.	0% if authorized.
Inpatient Tests, ICU, Operating Room, Specialized Care, etc.	20%, after deductible	10%, after deductible	20%, after deductible	0% if authorized.
Large Case Management	Alternative care set up on a case by case basis by Plan.	Alternative care set up on a case by case basis by Plan.	Alternative care set up on a case by case basis by Plan.	Alternative care set up on a case by case basis.
Maternity	20%, no deductible for pre-natal and post-natal visits.	10%, deductible waived in office setting for pre-natal and post-natal visits.	20%, after deductible.	0% for delivery \$10 copayment for initial visit; remaining pre-natal and post-natal visits paid in full.
<b>MENTAL HEALTH/SUBSTANCE ABUSE</b>				
<u>Mental Health</u> Inpatient Hospital Room & Board	20%, after deductible. Maximum 60 days per member per calendar year.	10%, after deductible. Maximum of 60 days per member per calendar year.	20%, after deductible. Maximum of 60 days per member per calendar year.	0%. Maximum of 30 days per member per calendar year.
<u>Mental Health</u> Inpatient Physician Care	20%, after deductible. Maximum 60 days per member per calendar year.	10%, after deductible. Maximum of 60 days per member per calendar year.	20%, after deductible. Maximum of 60 days per member per calendar year.	0%. Maximum of 30 days per member per calendar year.
<u>Mental Health</u> Outpatient	20%, no deductible.	10%, deductible waived in office setting.	20%, after deductible.	\$10.00 copayment per visit. Maximum of 52 visits per member per calendar year.

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Substance Abuse Inpatient Hospital Room & Board	20%, after deductible. Maximum 60 days per member per calendar year.	10%, after deductible. Maximum 60 days per member per calendar year.	20%, after deductible. Maximum 60 days per member per calendar year.	20%, after deductible. Maximum 30 days per member per calendar year.
Substance Abuse Inpatient Physician Care	20%, after deductible. Maximum 60 days per member per calendar year.	10%, after deductible. Maximum 60 days per member per calendar year.	20%, after deductible. Maximum 60 days per member per calendar year.	0%, after deductible. Maximum 30 days per member per calendar year.
Substance Abuse Outpatient	20%, no deductible.	10%, deductible waived in office setting.	20%, after deductible.	\$20.00 copayment per visit. Maximum 30 visits per member per calendar year.
<b>MEDICAL SERVICES</b>				
Nursing Facility Providing Skilled Care	20%, after deductible. Unlimited days. Precertification required.	10%, after deductible. Unlimited days. Precertification required.	20%, after deductible. Unlimited days. Precertification required.	0%, maximum of 120 days per member per calendar year.
Occupational Therapy	20%, payable in or outpatient. Prior approval required. Must be hospital-based billed or as a part of approved home health services.	10%, after deductible. Prior approval required. Must be a hospital-based billed or as a part of approved home health services.	20%, after deductible. Prior approval required. Must be hospital-based billed or as a part of approved home health services.	\$10 copayment per visit. Maximum 60 visits per year for each type of therapy.
Office Visit	\$15 copayment once per date of service for exam only; no coinsurance, no deductible. Copayment does not apply to out-of-pocket limit. 20% coinsurance, no deductible for other office services	\$15 copayment once per date of service for exam only; no coinsurance, no deductible. Copayment does not apply to out-of-pocket limit. 10% coinsurance, no deductible for other office services	\$15 copayment once per date of service for exam only; no coinsurance, no deductible. Copayment does not apply to out-of-pocket limit. 20% coinsurance, no deductible for other office services	\$10 copayment per visit.
Organ Transplants	Heart, heart and lung, lung, pancreas, kidney, simultaneous pancreas/kidney, liver and cornea transplants covered. Prior approval required.	Heart, heart and lung, lung, pancreas, kidney, simultaneous pancreas/kidney, liver and cornea transplants covered. Prior approval required.	Heart, heart and lung, lung, pancreas, kidney, simultaneous pancreas/kidney, liver and cornea transplants covered. Prior approval required.	Heart, heart/lung, lung (single & double), liver, pancreas, kidney/pancreas, kidney, cornea, small intestine, autologous bone marrow and allogeneic bone marrow transplants 100% covered if authorized by Wellmark BCBS. No coverage if experimental or in non authorized facility.

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Outpatient Chemotherapy	20%, no deductible.	10%, deductible waived in office setting.	20%, after deductible.	\$10 copayment per visit.
Outpatient Surgery	0%, no deductible. Required for certain procedures.	10%, after deductible. Required for certain procedures. Approval obtained by Select provider.	20%, after deductible. Required for certain procedures.	0% if authorized.
Outpatient Surgery Setting	Required for certain procedures. Paid according to normal plan benefits when procedure done on outpatient basis. 50% benefit reduction on all associated hospital and surgical services for noncompliance.	Required for certain procedures. Select provider obtains approval.	Required for certain procedures. Paid according to normal plan benefits when procedure done on outpatient basis. 50% benefit reduction on all associated hospital and surgical services for noncompliance.	Participating physician will determine appropriate surgical setting.
Physical Therapy	20%, no deductible.	10%, deductible waived in office setting.	20%, after deductible.	\$10 copayment per visit. Maximum 60 visits per member per year.
Preapproval of Inpatient Admissions	Required.	Required.	Required.	Required.
Prosthetic Appliances and Other Devices	20%, no deductible.	10%, after deductible.	20%, after deductible.	20%, if authorized by Participating physician and obtained from an authorized supplier.
Respiratory Therapy	20% payable inpatient or outpatient. Must be hospital-based billed or as a part of approved home health services.	10% after deductible. Must be hospital-based billed or as a part of approved home health services.	20% after deductible. Must be hospital-based billed or as a part of approved home health services.	\$10 copayment per visit. Maximum 60 visits per year for each type of therapy.
Routine Eye Exam	Not covered.	10%, deductible waived. Limited to one exam per member per year.	20%, deductible waived. Limited to one exam per member per year.	\$10 copayment per visit. Limit of one exam per member per year.
Routine Hearing Exam	Not covered.	10%, deductible waived. Limited to one exam per member per year.	20%, deductible waived. Limited to one exam per member per year.	\$10 copayment per visit. Limit of one exam per member per year.
Routine Physicals	20%, no deductible, excluding travel, employment or athletic related/required. Limited to one physical per member per year.	10%, deductible waived in office setting, excluding travel, employment or athletic related/required. Limited to one physical per member per year.	20%, after deductible, excluding travel, employment or athletic related/required. Limited to one physical per member per year.	\$10 copayment per visit, excluding travel, employment, or athletic related/required.

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Second Surgical Opinion	Voluntary. Paid according to normal plan benefits.	Voluntary. Paid according to normal plan benefits.	Voluntary. Paid according to normal plan benefits.	Voluntary. Paid according to normal plan benefits when received from Plan provider.
Speech	20%, payable in or outpatient. Prior approval required. Must be hospital-based billed or as a part of approved home health services.	10%, after deductible. Prior approval required. Must be a hospital-based billed or as a part of approved home health services.	20%, after deductible. Prior approval required. Must be hospital-based billed or as a part of approved home health services.	\$10 copayment per visit. Maximum 60 visits per year for each type of therapy.
Temporomandibular Joint Treatment (TMJ)	20%, no deductible.	10%, deductible waived in office setting.	20%, after deductible.	Not covered.
Well Child Care	20%, to 7 years. No deductible.	10%, to 7 years. Deductible waived in office setting.	20%, to 7 years. No deductible.	\$10 copayment per visit.
X Ray & Lab	20%, no deductible.	10%, deductible waived in office setting.	20%, after deductible.	0%
<b>PRESCRIPTION DRUGS</b>				
<b>Retail</b>				
Quantity	30 day supply	30 day supply per copay	30 day supply per copay	30 day supply
Preferred Generic Drugs	\$5.00 copay for each prescription or refill.	\$5.00 copay for each prescription or refill.	\$5.00 copay for each prescription or refill.	\$5.00 copay for each prescription or refill.
Preferred Brand Name Drugs	\$15.00 copay for each prescription or refill.	\$15.00 copay for each prescription or refill.	\$15.00 copay for each prescription or refill.	\$15.00 copay for each prescription or refill.
Non-preferred Generic and Non-preferred Brand Name Drugs	\$30.00 copay for each prescription or refill.	\$30.00 copay for each prescription or refill.	\$30.00 copay for each prescription or refill.	\$30.00 copay or 25% whichever is greater for each prescription or refill.
<b>Mail Order through Walgreens Mail Service</b>				
Quantity	90 day supply per copay.	90 day supply per copay.	No out of network coverage available.	90 day supply.
Preferred Generic Drugs	\$10.00 copay for each prescription or refill.	\$10.00 copay for each prescription or refill.		\$10.00 copay for each prescription or refill.
Preferred Brand Name Drugs	\$30.00 copay for each prescription or refill.	\$30.00 copay for each prescription or refill.		\$30.00 copay for each prescription or refill.
Non-preferred Generic and Non-preferred Brand Name Drugs	\$60.00 copay for each prescription or refill.	\$60.00 copay for each prescription or refill.		\$60.00 copay for each prescription or refill.

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<b>Specialty Drugs</b>				
Quantity	30 day supply per copay.	30 day supply per copay.	30 day supply per copay.	30 day supply per copay.
Retail	\$15.00 or \$30.00 copay for each prescription or refill. Copay is based on the drug tier (preferred brand name or non preferred brand name) the specialty drug is located.	\$15.00 or \$30.00 copay for each prescription or refill. Copay is based on the drug tier (preferred brand name or non preferred brand name) the specialty drug is located.	\$15.00 or \$30.00 copay for each prescription or refill. Copay is based on the drug tier (preferred brand name or non preferred brand name) the specialty drug is located.	\$15.00 or \$30.00 copay or 25% whichever is greater for each prescription or refill. Copay is based on the drug tier (preferred brand name or non preferred brand name) the specialty drug is located.
Mail Order	No mail order benefit available.	No mail order benefit available.	No mail order benefit available.	No mail order benefit available.
<b>Prescription Drug Benefit – General Information</b>				
Pharmacy Out of pocket maximum	Single <b>\$250</b> Family: <b>\$500</b> (This limit is separate from the medical out-of-pocket)	Single <b>\$250</b> Family: <b>\$500</b> (This limit is separate from the medical out-of-pocket)	Single <b>\$250</b> Family: <b>\$500</b> (This limit is separate from the medical out-of-pocket)	No separate out-of-pocket maximum. Copayments do <b>NOT</b> apply to medical out-of-pocket maximum.
Prescription Oral Contraceptives and Contraceptive Devices	Covered.	Covered.	Covered.	Covered.
Prescription Drug Coverage – Additional Information	If you purchase a brand name drug when an FDA-approved generic equivalent is available, you are responsible for the copay and any difference between the billed charges for the generic.	If you purchase a brand name drug when an FDA-approved generic equivalent is available, you are responsible for the copay and any difference between the billed charges for the generic.	If you purchase a brand name drug when an FDA-approved generic equivalent is available, you are responsible for the copay and any difference between the billed charges for the generic.	Rx must be for a covered service and from a plan pharmacy. No ancillary charges may be assessed.
<p>**Notice for members of Plans underwritten by Wellmark Blue Cross and Blue Shield of Iowa (BC/BS). Your plan's coverage percentage for hospital and other facility services does not reflect the actual payment to the provider. The actual payment to the provider is based on BC/BS's contract with the provider. The percentage is used in this document for comparison purposes only. On any given claim, the amount represented by the coverage percentage times the Covered Charge may be satisfied by the BC/BS's payment to the provider plus any amounts the Provider agrees to waive under its contract with BC/BS. Please see your Benefit Certificate for more information.</p>				

