Need help deciding which health plan to offer your employees? We're here to help.

This side-by-side comparison makes it easier for you to choose the right plan.

	GOLD METALLIC TIER — ENHANCEDBLUE℠ PLANS					PLATINUM METALLIC TIER — PREMIERBLUE℠ PLANS		
Plan Name	EnhancedBlue℠ 1500	EnhancedBlue℠ 1000	EnhancedBlue℠ 1250	EnhancedBlue℠ 500	myBlue HSA℠ Gold 2000	PremierBlue℠ 750	PremierBlue℠ 500 B	PremierBlue℠ 500 A
Network Type	PPO	PPO	POS	HMO	PPO	PPO	PPO	HMO
Annual Benefit — Deductible[1]								
Single	$1,500	$1,000	$1,250	$500	$2,000	$750	$500	$500
Family[2]	$3,000	$2,000	$2,500	$1,000	$4,000	$1,500	$1,000	$1,000
Coinsurance								
In-Network Providers	20%	20%	Level 1 & Level 2 – 20%	20%	0%	10%	10%	10%
Out-of-Network Providers	30%	30%	Level 3 – 30%	N/A	30%	20%	20%	N/A
Annual Benefit — Out-of-Pocket Maximum[1]								
In-Network Providers	$3,000/$6,000	$4,000/$8,000	$4,000/$8,000	$3,750/$7,500	$2,000/$4,000	$1,500/$3,000	$1,000/$2,000	$1,000/$2,000
Out-of-Network Providers	$6,000/$12,000	$8,000/$16,000	$8,000/$16,000	N/A	$4,000 /$8,000	$3,000/$6,000	$2,000/$4,000	N/A
Office Services								
In-Network Providers	20% coinsurance; deductible waived	$20 copay for PCP[3] $40 copay for non-PCP	$25 copay for Level 1 (PCP)[3] $50 copay for Level 2 (non-PCP)	$30 copay for PCP[3] $60 copay for non-PCP	Deductible applies	10% coinsurance; deductible waived	$15 copay for PCP[3] $30 copay for non-PCP	$15 copay for PCP[3] $30 copay for non-PCP
Out-of-Network Providers	30% after deductible	30% after deductible	30% after deductible	No out-of-network benefits unless emergency	30% after deductible	20% after deductible	20% after deductible	No out-of-network benefits unless emergency
Prescription Drugs — Blue Rx Essentials℠	Deductible waived Tier 1: $5 Tier 2: $35 Tier 3/Preferred specialty: $70 Non-preferred specialty: 50%	Deductible waived Tier 1: $5 Tier 2: $35 Tier 3/Preferred specialty: $70 Non-preferred specialty: 50%	Deductible waived Tier 1: $5 Tier 2: $35 Tier 3/Preferred specialty: $70 Non-preferred specialty: 50%	Deductible waived Tier 1: $5 Tier 2: $35 Tier 3/Preferred specialty: $70 Non-preferred specialty: 50%	Applies to medical deductible 0% after deductible	Deductible waived Tier 1: $5 Tier 2: $35 Tier 3/Preferred specialty: $70 Non-preferred specialty: 50%	Deductible waived Tier 1: $5 Tier 2: $35 Tier 3/Preferred specialty: $70 Non-preferred specialty: 50%	Deductible waived Tier 1: $5 Tier 2: $35 Tier 3/Preferred specialty: $70 Non-preferred specialty: 50%
Inpatient Services / Outpatient Surgery	20% after deductible	20% after deductible	20% after deductible	20% after deductible	Deductible applies	10% after deductible	10% after deductible	10% after deductible
Emergency Room Waive copay if admitted immediately following visit	$250 copay	$250 copay	$250 copay	$250 copay	Deductible applies	$200 copay	$200 copay	$200 copay
Preventive Care/Screenings/Immunizations Includes gynecological exam, preventive exam, screening mammography, well-child care and newborn care[5]	$0	$0	$0	$0	$0	$0	$0	$0
Laboratory and X-Ray Services Includes routine diagnostic lab and x-ray, and advanced radiological imaging (CT, MRIs, MRAs, PET, nuclear medicine and radiation therapy)[6]	Office Lab & X-Ray: 20% coinsurance; deductible waived Independent Lab: 20% coinsurance; deductible waived	Office Lab & X-Ray: Included in office visit Independent Lab: 20% coinsurance; deductible waived	Office Lab & X-Ray: Included in office visit Independent Lab: 20% coinsurance; deductible waived	Office Lab & X-Ray: Included in office visit Independent Lab: 20% coinsurance; deductible waived	Office Lab & X-Ray: Deductible applies Independent Lab: Deductible applies	Office Lab & X-Ray: 10% coinsurance; deductible waived Independent Lab: 10% coinsurance; deductible waived	Office Lab & X-Ray: Included in office visit Independent Lab: 10% coinsurance; deductible waived	Office Lab & X-Ray: Included in office visit Independent Lab: 10% coinsurance; deductible waived
Mental Health and Chemical Dependency	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Spinal Manipulation	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered
Pediatric Dental[7]	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Vision[7]	Covered	Covered	Covered	Covered	Covered	Covered	Covered	Covered

[1] Both in-network and out-of-network services apply to the deductible but the out-of-pocket maximum for in-network and out-of-network services are separate. PPO and participating providers apply out-of-network coinsurance level when applicable but accumulate to the in-network out-of-pocket maximum.

[2] For all plans except myBlue HSA, the family deductible can be met through any combination of family members. No one member will be required to meet more than the single deductible amount to receive benefits for covered services during a benefit period. For myBlue HSA plans the family deductible amount is reached from amounts accumulated on behalf of any family member or combination of family members and the entire family deductible must be met before benefits are payable.

[3] The primary care office copay applies to Family Practitioners, General Practitioners, Internal Medicine Practitioners, Obstetricians/Gynecologists, Pediatricians, Physicians Assistants and Advanced Registered Nurse Practitioners. The lower office copays also apply to in-network chiropractors and in some cases mental health or chemical dependency visits. All other in-network practitioners are subject to the non-primary care office copay. The copay applies per practitioner, per date of service.

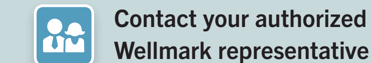
[4] Preventive visits do not apply to the office visit limit.

[5] All costs waived when using in-network, participating or PPO providers on PPO and POS plans. With HMO, designated PCP must be seen for preventive care/screenings and immunizations. One preventive exam with separate gynecological exam per member per benefit period. Well-child care up to age 7 (includes normal newborn care, physical examinations, assessments and immunizations).

[6] Advanced radiological imaging and outpatient labs & X-rays will always apply deductible and coinsurance. Cost-share for labs and X-rays may vary if visit is for mental health or chemical dependency.

[7] Essential Health Benefit pediatric vision benefits, under this medical plan are administered by Avēsis for members under 19. This policy does not include pediatric dental services as required under the Federal Patient Protection and Affordable Care Act. This coverage is available in the insurance market and can be purchased as a stand-alone product. Please contact your insurance carrier, producer, or Iowa's Partnership Marketplace Exchange if you wish to purchase pediatric dental coverage or a stand-alone dental services product.

CONTACT US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Avēsis is an independent vision insurance company that does not provide Wellmark Blue Cross and Blue Shield of Iowa products and services. Avēsis is underwritten by Fidelity Life Insurance. Hearing Discount Savings Plan provided by EPIC Hearing Healthcare.

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OPTIONS FOR EVERY BUSINESS BUDGET

Health plan quick guide for groups 1 – 50

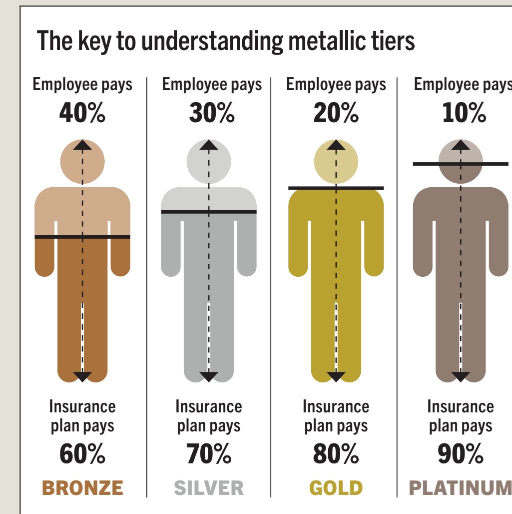
Comprehensive coverage options to fit your needs and your budget

As a small business owner, every decision you make has an impact on your bottom line, including what health insurance plan to offer.

With 19 new ACA-compliant health plans created just for small businesses, Wellmark delivers an affordable mix of comprehensive coverage options, ranging from traditional copay and coinsurance plans to HSA-compatible plans — all designed to meet your needs and the needs of your employees.

Choose from four basic coverage levels

Each level — Bronze, Silver, Gold and Platinum — is defined by the portion of the claims paid by the insurer as illustrated below.



When every decision you make impacts your bottom line, choice is good. Especially when it comes to health insurance.

CONTACT US. Call your Wellmark licensed representative for assistance finding the right coverage or visit Wellmark.com.

Need help deciding which health plan to offer your employees? We're here to help.

This side-by-side comparison makes it easier for you to choose the right plan.

	BRONZE METALLIC TIER — SIMPLYBLUE℠ PLANS				
Plan Name	SimplyBlue℠ 5500	SimplyBlue℠ 5000	SimplyBlue℠ 4750	SimplyBlue℠ Max 6250	myBlue HSA℠ Bronze 3500
Network Type	PPO	POS	HMO	HMO	PPO
Annual Benefit — Deductible[1]					
Single	$5,500	$5,000	$4,750	$6,250	$3,500
Family[2]	$11,000	$10,000	$9,500	$12,500	$7,000
Coinsurance					
In-Network Providers	50%	Level 1 & Level 2 – 50%	40%	0%	30%
Out-of-Network Providers	60%	Level 3 – 60%	N/A	N/A	40%
Annual Benefit — Out-of-Pocket Maximum[1]					
In-Network Providers	$6,250/$12,500	$6,250/$12,500	$6,250/$12,500	$6,250/$12,500	$6,250/$12,500
Out-of-Network Providers	$9,500/$18,500	$9,500/$18,500	N/A	N/A	$12,500 /$25,000
Office Services					
In-Network Providers	$50 for PCP[3] 50% after deductible for non-PCP	$0 for the first visit in a benefit period. Subsequent visits, 50% after deductible.[4]	$0 for the first visit in a benefit period. Subsequent visits, 40% after deductible.[4]	$50 per visit for the first 3 visits in a benefit period. Subsequent visits, deductible applies.[4]	30% after deductible
Out-of-Network Providers	60% after deductible	60% after deductible	No out-of-network benefits unless emergency	No out-of-network benefits unless emergency	40% after deductible
Prescription Drugs — Blue Rx Essentials℠	Applies to your medical deductible Tier 1: $15 (deductible waived) Tier 2, Tier 3/Preferred specialty, Non-preferred specialty: 50% after deductible	Applies to your medical deductible Tier 1: $15 (deductible waived) Tier 2, Tier 3/Preferred specialty, Non-preferred specialty: 50% after deductible	Applies to your medical deductible Tier 1: $15 (deductible waived) Tier 2, Tier 3/Preferred Specialty, Non-preferred specialty: 40% after deductible	Applies to your medical deductible 0% after deductible	Applies to your medical deductible 30% after deductible
Inpatient Services / Outpatient Surgery	50% after deductible	50% after deductible	40% after deductible	Deductible applies	30% after deductible
Emergency Room Waive copay if admitted immediately following visit	50% after deductible	50% after deductible	40% after deductible	Deductible applies	30% after deductible
Preventive Care/Screenings/Immunizations Includes gynecological exam, preventive exam, screening mammography, well-child care and newborn care[5]	$0	$0	$0	$0	$0
Laboratory and X-Ray Services Includes routine diagnostic lab and x-ray, and advanced radiological imaging (CT, MRIs, MRAs, PET, nuclear medicine and radiation therapy)[6]	Office Lab & X-Ray: 50% after deductible Independent Lab: 50% after deductible	Office Lab & X-Ray: 50% after deductible Independent Lab: 50% after deductible	Office Lab & X-Ray: 40% after deductible Independent Lab: 40% after deductible	Office Lab & X-Ray: Deductible applies Independent Lab: Deductible applies	Office Lab & X-Ray: 30% after deductible Independent Lab: 30% after deductible
Mental Health and Chemical Dependency	Covered	Covered	Covered	Covered	Covered
Spinal Manipulation	Covered	Covered	Covered	Covered	Covered
Pediatric Dental[7]	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Vision[7]	Covered	Covered	Covered	Covered	Covered

	SILVER METALLIC TIER — COMPLETEBLUE℠ PLANS					
Plan Name	CompleteBlue℠ 2000 (Coinsurance)	CompleteBlue℠ 2000 B	CompleteBlue℠ 1750	CompleteBlue℠ 1500	CompleteBlue℠ 2000 A	myBlue HSA℠ Silver 2000
Network Type	PPO	PPO	PPO	POS	HMO	HMO
Annual Benefit — Deductible[1]						
Single	$2,000	$2,000	$1,750	$1,500	$2,000	$2,000
Family[2]	$4,000	$4,000	$3,500	$3,000	$4,000	$4,000
Coinsurance						
In-Network Providers	30%	30%	40%	Level 1 & Level 2 – 40%	30%	20%
Out-of-Network Providers	40%	40%	50%	Level 3 – 50%	N/A	N/A
Annual Benefit — Out-of-Pocket Maximum[1]						
In-Network Providers	$6,250/$12,500	$6,250/$12,500	$6,250/$12,500	$6,250/$12,500	$6,250/$12,500	$6,000/$12,000
Out-of-Network Providers	$9,500/$18,500	$9,500/$18,500	$9,500/$18,500	$9,500/$18,500	N/A	N/A
Office Services						
In-Network Providers	30% coinsurance; deductible waived	$40 copay for PCP[3] $80 copay for non-PCP	$45 copay for PCP[3] $90 copay for non-PCP	$40 copay for Level 1 (PCP)[3] $80 copay for Level 2 (non-PCP)	$40 copay for PCP[3] $80 copay for non-PCP	20% after deductible
Out-of-Network Providers	40% after deductible	40% after deductible	50% after deductible	50% after deductible	No out-of-network benefits unless emergency.	No out-of-network benefits unless emergency.
Prescription Drugs — Blue Rx Essentials℠	Applies to your medical deductible Tier 1: $15 (deductible waived) Tier 2, Tier 3/Preferred specialty, Non-preferred specialty: 30% after deductible	Deductible waived Tier 1: $5 Tier 2: $35 Tier 3/Preferred specialty: $70 Non-preferred specialty: 50%	Deductible waived Tier 1: $5 Tier 2: $35 Tier 3/Preferred specialty: $70 Non-preferred specialty: 50%	Deductible waived Tier 1: $5 Tier 2: $35 Tier 3/Preferred specialty: $70 Non-preferred specialty: 50%	Deductible waived Tier 1: $5 Tier 2: $35 Tier 3/Preferred specialty: $70 Non-preferred specialty: 50%	Applies to your medical deductible 20% after deductible
Inpatient Services / Outpatient Surgery	30% after deductible	30% after deductible	40% after deductible	40% after deductible	30% after deductible	20% after deductible
Emergency Room Waive copay if admitted immediately following visit	$350 copay	30% after deductible	$300 copay	40% after deductible	30% after deductible	20% after deductible
Preventive Care/Screenings/Immunizations Includes gynecological exam, preventive exam, screening mammography, well-child care and newborn care[5]	$0	$0	$0	$0	$0	$0
Laboratory and X-Ray Services Includes routine diagnostic lab and x-ray, and advanced radiological imaging (CT, MRIs, MRAs, PET, nuclear medicine and radiation therapy)[6]	Office Lab & X-Ray: 30% coinsurance; deductible waived Independent Lab: 30% coinsurance; deductible waived	Office Lab & X-Ray: Included in office visit Independent Lab: 30% coinsurance; deductible waived	Office Lab & X-Ray: Included in office visit Independent Lab: 40% coinsurance; deductible waived	Office Lab & X-Ray: Included in office visit Independent Lab: 40% coinsurance; deductible waived	Office Lab & X-Ray: Included in office visit Independent Lab: 30% coinsurance; deductible waived	Office Lab & X-Ray: 20% after deductible Independent Lab: 20% after deductible
Mental Health and Chemical Dependency	Covered	Covered	Covered	Covered	Covered	Covered
Spinal Manipulation	Covered	Covered	Covered	Covered	Covered	Covered
Pediatric Dental[7]	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Vision[7]	Covered	Covered	Covered	Covered	Covered	Covered

[1] Both in-network and out-of-network services apply to the deductible but the out-of-pocket maximum for in-network and out-of-network services are separate. PPO and participating providers apply out-of-network coinsurance level when applicable but accumulate to the in-network out-of-pocket maximum.
[2] For all plans except myBlue HSA, the family deductible can be met through any combination of family members. No one member will be required to meet more than the single deductible amount to receive benefits for covered services during a benefit period. For myBlue HSA plans the family deductible amount is reached from amounts accumulated on behalf of any family member or combination of family members and the entire family deductible must be met before benefits are payable.
[3] The primary care office copay applies to Family Practitioners, General Practitioners, Internal Medicine Practitioners, Obstetricians/Gynecologists, Pediatricians, Physicians Assistants and Advanced Registered Nurse Practitioners. The lower office copays also apply to in-network chiropractors and in some cases mental health or chemical dependency visits. All other in-network practitioners are subject to the non-primary care office copay. The copay applies per practitioner, per date of service.
[4] Preventive visits do not apply to the office visit limit.
[5] All costs waived when using in-network, participating, or PPO providers on PPO and POS plans. With HMO, designated PCP must be seen for preventive care/screenings and immunizations. One preventive exam with separate gynecological exam per member per benefit period. Well-child care up to age 7 (includes normal newborn care, physical examinations, assessments and immunizations).
[6] Advanced radiological imaging and outpatient labs & X-rays will always apply deductible and coinsurance. Cost-share for labs and X-rays may vary if visit is for mental health or chemical dependency.
[7] Essential Health Benefit pediatric vision benefits, under this medical plan, are administered by Avēsis for members under 19. This policy does not include pediatric dental services as required under the Federal Patient Protection and Affordable Care Act. This coverage is available in the insurance market and can be purchased as a stand-alone product. Please contact your insurance carrier, producer, or Iowa's Partnership Marketplace Exchange if you wish to purchase pediatric dental coverage or a stand-alone dental services product.

NOTES:
- This is a brief summary of policies presented which are subject to exclusions, limitations, reductions in benefits, and terms under which the policies may be renewed or discontinued. For costs and complete details of the coverage, contact your authorized Wellmark representative. This is a general description of coverage. It is not a statement of contract. Actual coverage is subject to the terms and conditions specified in the policy items and enrollment regulations in force when the policy becomes effective.
- The premiums for these plans include PPACA fees and taxes, which are added to the base rate. Carriers are required to pay these fees and taxes, and they are passed on through the monthly premiums.