

IBBP FREQUENTLY ASKED QUESTIONS

1. Do I need a referral to see a specialist?

No, under the Iowa Bankers Benefit Plan (IBBP) you can make the appointment yourself. The family physician does not need to refer the patient to a specialist. Financially, of course, it's preferable to choose a PPO specialist.

2. When is deductible applied?

All covered services billed in a PPO office setting waive the deductible. Patient will owe 10% coinsurance. Services billed outside an office setting are subject to deductible. Most commonly these are outpatient and inpatient services and durable medical equipment. Office services of non-PPO providers are also subject to deductible and coinsurance of 80%.

3. What does "out-of-pocket maximum" (OPM) mean?

The maximum amount you pay, out of your own pocket, for most covered services in a benefit year. These amounts include deductible and certain coinsurance amounts.

4. What is the difference between coinsurance and co-payment?

Coinsurance is a percentage of charge the patient is responsible for, such as 10% of office visits. Copayment is a predetermined dollar amount owed, such as \$10.00, \$25.00 or \$40.00 per 30 day supply for prescriptions.

5. When is precertification of services required?

All home health services, skilled nursing and acute rehabilitation services, and hospice service need precertification. The providers of service obtain precertification by contacting Wellmark at 1-800-558-4409. This phone number is also on the back of your IBBP/Wellmark ID card.

6. Are routine physicals payable?

Yes

Under age 13 is considered Well Child Care:

All well-child care, including immunizations are payable at 100%.

Over age 13 is considered an Annual Physical:

One routine examination, per benefit year

One routine gynecological examination per benefit year

One mammogram per benefit year

Immunizations, to include shingles and HPV if patient meets age guidelines. Travel immunizations and immunizations required for employment are not payable.

A benefit year is defined as a calendar year. The exams DO NOT need to be a full 365 days apart.

7. Is a colonoscopy covered?

Yes

If billed as a routine screening the deductible is waived as part of the preventative care program.

If billed with a medical diagnosis, the service will be subject to deductible as an outpatient charge.

Whether or not deductible applies to these charges is based on how the claim is submitted. Even if patient goes in for a routine screening (no past history or symptoms), if a diagnosis is found during the procedure and the claim is filed with a diagnosis, the claim becomes a medical (rather than routine or preventative) claim, and will be subject to the deductible.

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