

THE UNIVERSITY OF IOWA

MERIT HEALTH INSURANCE BENEFIT COMPARISON

MONTHLY EMPLOYEE PREMIUM AFTER UI CONTRIBUTION - EFFECTIVE JANUARY 1, 2009				
	WELLMARK <u>BLUE ACCESS</u>	WELLMARK <u>BLUE ADVANTAGE</u>	BC/BS <u>IOWA SELECT</u>	BC/BS <u>PROGRAM III PLUS</u>
Single	\$0.00	\$0.00	\$0.00	\$0.00
Family	\$0.00	\$0.00	\$224.96	\$230.38
PLAN PROVISIONS	WELLMARK BLUE ACCESS & BLUE ADVANTAGE		BC/BS IOWA SELECT	BC/BS PROGRAM III PLUS
Care Providers	Care from network providers ONLY; Life-threatening emergencies covered anywhere		Any provider; Select providers have lower co-insurance percentage and deductible is waived for services in the office setting	Any provider; BlueCross/BlueShield (BC/BS) providers can result in lower out-of-pocket expenses
Benefits Available from Non-member Providers	None without prior approval		Normal plan benefits; For non-BC/BS providers, employee pays charges over usual reasonable and customary limit	Normal plan benefits; For non-BC/BS providers, employee pays charges over usual reasonable and customary limit
Deductible Single/Family	None		\$250/\$500; Deductible is waived for Select providers only if service is in office setting	\$300/\$400 inpatient services only
Co-insurance Percentage	20% in limited situations		Select: 10%; Non-Select: 20%	20%
Out-of-Pocket Limit Single/Family	\$750/\$1500 (except prescription drugs)		\$600/\$800 (\$250/\$500 for prescription drugs)	\$600/\$800 (\$250/\$500 for prescription drugs)
Pre-existing Condition Waiting Period	None		11 months	11 months
Pre-approval of Inpatient Admissions	Required; Plan physician will determine		Required; Subscriber must obtain approval from BC/BS	Required; Subscriber must obtain approval from BC/BS
Second Surgical Opinion	Voluntary		Voluntary	Voluntary

WELLMARK BLUE ACCESS & BLUE ADVANTAGE			
PLAN PROVISIONS	WELLMARK BLUE ACCESS & BLUE ADVANTAGE	BC/BS IOWA SELECT	BC/BS PROGRAM III PLUS
Outpatient Surgery	Plan physician will determine	Mandatory 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 non-compliance	Mandatory 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 non-compliance
Office Calls	\$10 co-payment per visit	Select: \$15 co-payment per visit; Non-Select: \$15 co-payment per visit	\$15 co-payment per visit
Routine Physicals	\$10 co-payment per visit	Select: 10%; Non-Select: deductible then 20%	20%; Limit one physical per member per year
Well Baby Care	\$10 co-payment per visit	Select: 10%; Non-Select: 20% to 7 years of age	20% to 7 years of age
X-Ray and Lab	0%	Select: Deductible waived if in office setting then 10%; Non-Select: deductible then 20%	20%
Routine Eye/Hearing Exam	\$10 co-payment; One exam covered per calendar year	Select: 10%; Non-Select: 20%; One exam covered per calendar year	Not covered
Maternity	\$10 co-payment per visit	Select: 10%; Non-Select: deductible then 20%	20%; No deductible for physician charges for pre-/post-natal visits and delivery
Infertility	Not covered	Select: 10%; Non-Select: deductible then 20%; \$15,000 lifetime maximum	20%; \$25,000 lifetime maximum per couple
HOSPITAL SERVICES	WELLMARK BLUE ACCESS & BLUE ADVANTAGE	BC/BS IOWA SELECT	BC/BS PROGRAM III PLUS
Room & Board	0%; Semi-private basis unless medically necessary to use a private room	Select: 10% after deductible; Non-Select: 20% after deductible; No limit on days; Semi-private basis unless medically necessary to use private room	20% after inpatient services deductible \$300/\$400; No limit on days; Semi-private basis unless medically necessary to use private room
Physicians' Services	0% if authorized	Select: deductible then 10%; Non-Select: deductible then 20%	20%; No deductible
Inpatient Surgery	0% if authorized	Select: deductible then 10%; Non-Select: deductible then 20%	20%; No deductible; Must be approved as inpatient procedures
Outpatient Surgery	0% if authorized	Select: deductible then 10%; Non-Select: deductible then 20%	0%; No deductible required for certain procedures
Inpatient Supplies, Drugs, Medicines, Tests, ICU, OR, Specialized Care, etc.	0% if authorized	Select: deductible then 10%; Non-Select: deductible then 20%	20% after deductible

MISCELLANEOUS SERVICES	WELLMARK BLUE ACCESS & BLUE ADVANTAGE	BC/BS IOWA SELECT	BC/BS PROGRAM III PLUS
Prescription Drugs	\$5 co-payment generic formulary; \$15 co-payment name brand formulary; \$30 or 25% co-payment non-formulary; (does not apply to out-of-pocket maximum)	\$5 co-payment generic formulary; \$15 co-payment name brand formulary; \$30 co-payment non-formulary; Separate \$250/\$500 out-of-pocket maximum	\$5 co-payment generic formulary; \$15 co-payment name brand formulary; \$30 co-payment non-formulary; Separate \$250/\$500 out-of-pocket maximum
Immunizations	0%	Select: 0%; Non-Select: deductible then 10%	20%
Allergy Treatments	\$10 co-payment per visit	Select: 10%; Non-Select: deductible then 20%	20%
Chiropractor	\$10 co-payment per visit; Prior approval may be required	\$15	\$15
Home Health Care	0% if authorized	Select: deductible then 10%; Non-Select: deductible then 20%	20%; Prior approval required
Eyeglasses/Hearing Aids	Not covered	Not covered	Not covered
Ambulance	0% if medically necessary	Deductible then 20%	20%
Organ Transplants	0% if authorized	Prior approval required	Prior approval required
Skilled Nursing Facility	0% for facility; \$10 co-payment for physician visit; Pre-approval required; 120 day maximum	Select: deductible then 10%; Non-Select: deductible then 20%; Pre-approval required; Unlimited days	20% after deductible; \$300 single/\$400 family; No limit on days; Pre-approval required
ER Care	\$50 co-payment per visit (waived if admitted)	\$50 co-payment per visit (waived if admitted)	0%
Physical Therapy	\$10 co-payment per visit; 60 visit maximum	Select: deductible then 10%; Non-Select: deductible then 20%	20%
Accidents	Normal plan benefits	Select: 10%; Non-Select: deductible then 20%	0%; No deductible for treatment within 72 hours
Hospice Care	0%; Prior approval required	Select: deductible then 10%; Non-Select: deductible then 20%	20%; Pre-approval required
Durable Medical Equipment	20%; Prior approval required	Deductible then 20%	20%
Speech, Occupational, and Respiratory Therapy	\$10 co-payment; 60 visit maximum (of each type); Prior approval required	Select: deductible then 10%; Pre-approval required; Non-Select: deductible then 20%; Pre-approval required	20%; Pre-approval required; Must be hospital-based billed
Dental Accident Care	20% if authorized; Within 6 months of injury	Select: 10%; Non-Select: deductible then 20%; Only 72 hours	0%; No deductible; Service must be provided within 72 hours of injury; 20% thereafter to six months of injury
Dependent Child Age Limit	Age 19 or unlimited if a full time single student	Age 19 or unlimited if a full-time single student	Age 19 or unlimited if a full-time single student

MENTAL AND NERVOUS	WELLMARK BLUE ACCESS & BLUE ADVANTAGE	BC/BS IOWA SELECT	BC/BS PROGRAM III PLUS
Inpatient Hospital Room and Board	0%; Maximum of 30 days per year	Select: deductible then 10%; Non-Select: deductible then 20%; Maximum 60 days per year	20% after deductible; \$300 single/\$400 family; Maximum 60 days per member per calendar year
Inpatient Physician Care	0%; 30 days per year	Select: deductible then 10%; Non-Select: deductible then 20%; Maximum 60 days per year	20%; Maximum 60 days per calendar year
Outpatient	\$10 co-payment; 52 visits per year	Select: 10%; Non-Select: deductible then 20%; Use of special network required	20%; Use of mental health network required
Pre-certification	Required	Required	Required
SUBSTANCE ABUSE	WELLMARK BLUE ACCESS & BLUE ADVANTAGE	BC/BS IOWA SELECT	BC/BS PROGRAM III PLUS
Inpatient Hospital Room and Board	20%; Maximum of 30 days per year	Select: deductible then 10%; Non-Select: deductible then 20%; Maximum 60 days per year	20% after deductible; \$300 single/\$400 family; Maximum 60 days per member per calendar year
Inpatient Physician Care	0%; 30 days per year	Select: deductible then 10%; Non-Select: deductible then 20%; Maximum 60 days per year	20%; Maximum 60 days per calendar year
Outpatient	\$20 co-payment; 30 visits per year	Select: 10%; Non-Select: deductible then 20%; Use of special network required	20%; Use of mental health network required
Pre-certification	Required	Required	Required