

THE UNIVERSITY OF IOWA

MERIT HEALTH INSURANCE BENEFIT COMPARISON

PLAN PROVISIONS	BC/BS PROGRAM III PLUS	BC/BS IOWA SELECT	WELLMARK BLUE ADVANTAGE & BLUE ACCESS
Care Providers	Any provider; BlueCross/BlueShield (BC/BS) providers can result in lower out-of-pocket expenses	Any provider; Select providers have lower co-insurance percentage and deductible is waived for services in the office setting	Care from network providers ONLY; Life-threatening emergencies covered anywhere
Benefits Available from Non-member Providers	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	None without prior approval
Deductible Single/Family	\$300/\$400 inpatient services only	\$250/\$500; Deductible is waived for Select providers only if service is in office setting	None
Co-insurance Percentage	20%	Select: 10%; Non-Select: 20%	20% in limited situations
Out-of-Pocket Limit Single/Family	\$600/\$800 (\$250/\$500 for prescription drugs)	\$600/\$800 (\$250/\$500 for prescription drugs)	\$750/\$1500 (except prescription drugs)
Pre-existing Condition Waiting Period	11 months; 18 months for late enrollees	11 months; 18 months for late enrollees	None during open enrollment or at hire; 18 months for late enrollees
Pre-approval of Inpatient Admissions	Required; Subscriber must obtain approval from BC/BS	Required; Subscriber must obtain approval from BC/BS	Required; Plan physician will determine
Second Surgical Opinion	Voluntary	Voluntary	Voluntary

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

MISCELLANEOUS SERVICES	BC/BS PROGRAM III PLUS	BC/BS IOWA SELECT	WELLMARK BLUE ADVANTAGE & BLUE ACCESS
Prescription Drugs	\$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	\$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)
Immunizations	20%	Select: 0%; Non-Select: deductible then 10%	0%
Allergy Treatments	20%	Select: 10%; Non-Select: deductible then 20%	\$10 co-payment per visit
Chiropractor	\$15	\$15	\$10 co-payment per visit; Prior approval may be required
Home Health Care	20%; Prior approval required	Select: deductible then 10%; Non-Select: deductible then 20%	0% if authorized
Eyeglasses/Hearing Aids	Not covered	Not covered	Not covered
Ambulance	20%	Deductible then 20%	0% if medically necessary
Organ Transplants	Prior approval required	Prior approval required	0% if authorized
Skilled Nursing Facility	20% after deductible; \$300 single/\$400 family; No limit on days; Pre-approval required	Select: deductible then 10%; Non-Select: deductible then 20%; Pre-approval required; Unlimited days	0% for facility; \$10 co-payment for physician visit; Pre-approval required; 120 day maximum
ER Care	0%	\$50 co-payment per visit (waived if admitted)	\$50 co-payment per visit (waived if admitted)
Physical Therapy	20%	Select: deductible then 10%; Non-Select: deductible then 20%	\$10 co-payment per visit; 60 visit maximum
Accidents	0%; No deductible for treatment within 72 hours	Select: 10%; Non-Select: deductible then 20%	Normal plan benefits
Hospice Care	20%; Pre-approval required	Select: deductible then 10%; Non-Select: deductible then 20%	0%; Prior approval required
Durable Medical Equipment	20%	Deductible then 20%	20%; Prior approval required
Speech, Occupational, and Respiratory Therapy	20%; Pre-approval required; Must be hospital-based billed	Select: deductible then 10%; Pre-approval required; Non-Select: deductible then 20%; Pre-approval required	\$10 co-payment; 60 visit maximum (of each type); Prior approval required
Dental Accident Care	0%; No deductible; Service must be provided within 72 hours of injury; 20% thereafter to six months of injury	Select: 10%; Non-Select: deductible then 20%; Only 72 hours	20% if authorized; Within 6 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			
	BC/BS PROGRAM III PLUS	BC/BS IOWA SELECT	WELLMARK BLUE ADVANTAGE & BLUE ACCESS
Inpatient Hospital Room and Board	20% after deductible; \$300 single/\$400 family; Maximum 60 days per member per calendar year	Select: deductible then 10%; Non-Select: deductible then 20%; Maximum 60 days per year	0%; Maximum of 30 days per year
Inpatient Physician Care	20%; Maximum 60 days per calendar year	Select: deductible then 10%; Non-Select: deductible then 20%; Maximum 60 days per year	0%; 30 days per year
Outpatient	20%; Use of mental health network required	Select: 10%; Non-Select: deductible then 20%; Use of special network required	\$10 co-payment; 52 visits per year
Pre-certification	Required	Required	Required
SUBSTANCE ABUSE			
	BC/BS PROGRAM III PLUS	BC/BS IOWA SELECT	WELLMARK BLUE ADVANTAGE & BLUE ACCESS
Inpatient Hospital Room and Board	20% after deductible; \$300 single/\$400 family; Maximum 60 days per member per calendar year	Select: deductible then 10%; Non-Select: deductible then 20%; Maximum 60 days per year	20%; Maximum of 30 days per year
Inpatient Physician Care	20%; Maximum 60 days per calendar year	Select: deductible then 10%; Non-Select: deductible then 20%; Maximum 60 days per year	0%; 30 days per year
Outpatient	20%; Use of mental health network required	Select: 10%; Non-Select: deductible then 20%; Use of special network required	\$20 co-payment; 30 visits per year
Pre-certification	Required	Required	Required