

ISU Greek Affairs Medical and Dental Plan Summary

Medical Options

ISU PLAN MEDICAL PLANS 2006

**THIS COMPARISON IS ONLY A SUMMARY OF BENEFITS.
BENEFITS WILL BE ADMINISTERED AS DESCRIBED IN EACH PLAN'S SUBSCRIBER AGREEMENT
OR PLAN DOCUMENT.**

PLAN PROVISIONS	PPO		HMO
	PPO In Network	PPO Out-of-Network	
Deductible	\$0	\$300/contract	\$0
Coinsurance	10% of Maximum Allowable Fee	20% of Maximum Allowable Fee, after deductible	0%
Office visit copays	\$10 copay	\$0	\$0
Out-of-pocket Maximum	\$1500/contract/year and separate Rx of \$1500.	\$1500/contract/year and separate Rx of \$1500	None on medical and separate Rx of \$1500
Lifetime maximum benefit	None	None	None
Preapproval of inpatient admissions	Required	Required	Directed by PCP- preauthorization required
Large case management	Alternative care set up on a case-by-case basis by insurance company	Alternative care set up on a case-by-case basis by insurance company	Directed by PCP
Second surgical opinion	Voluntary-paid at 100%	Voluntary-paid at 100%	Directed by PCP
Outpatient surgery	Mandatory for certain procedures	Mandatory for certain procedures	Directed by PCP- preauthorization required
Benefits from non-participating providers	Considered out-of-network	80% coverage to MAF (maximum allowable fee) after deductible	No coverage-out of area limited to medical emergency or injury
Dependent child age limit	Up to age 19, or no age limit if unmarried and a full-time student or disabled	Up to age 19, or no age limit if unmarried and a full-time student or disabled	Up to age 19, or no age limit if unmarried and a full-time student or disabled
PHYSICIAN SERVICES			
Office visits	100% coverage after \$10 copay	80% coverage to MAF (maximum allowable fee) after deductible	100% coverage - PCP or referred by PCP within network
Routine physicals	100% coverage after \$10 copay	Not covered	100% coverage - PCP
Well child care	100% coverage after \$10 copay	80% coverage to MAF (maximum allowable fee) after deductible	100% coverage - PCP
X-ray and lab	90% coverage	80% coverage after deductible	100% coverage - directed by PCP
Routine eye exam	Covered at 90%, except refraction, one per calendar year	Not covered	100% coverage - one per calendar year, may self-refer to a network provider

benefit

PLAN PROVISIONS	PPO		HMO
	PPO In Network	PPO Out-of-Network	
Routine hearing exam	90% coverage, one per calendar year	Not covered	Not covered
Maternity	90% coverage	80% coverage after deductible	100% coverage - directed by PCP
Contraceptive other than prescription	90% coverage	80% coverage after deductible	100% coverage - directed by PCP
PREVENTATIVE SERVICES			
Allergy testing, CT scan, EEG, EKG, ECG, Holter monitoring, Pathology tests, Stress tests, Ultrasound, X-ray	90% coverage	Not covered	100% coverage - directed by PCP
Routine pap smears, routine mammography	90% coverage	80% coverage after deductible for mammography only, one per calendar year	100% coverage - directed by PCP
INPATIENT SERVICES			
Room and board	90% coverage, preadmission approval required	80% coverage after deductible, preadmission approval required	100% coverage - directed by PCP, preauthorization required
Physician services	90% coverage	80% coverage after deductible	100% coverage - directed by PCP, preauthorization required
Inpatient surgery	90% coverage; preadmission approval and prior approval required for certain procedures	80% coverage after deductible; preadmission approval and prior approval required for certain procedures	100% coverage - PCP or referred by PCP
Other inpatient care	90% coverage	80% coverage after deductible	100% coverage - directed by PCP
MENTAL / NERVOUS / SUBSTANCE ABUSE			
Inpatient hospital room and board	90% coverage; preadmission approval required	80% coverage after deductible; preadmission approval required	100% coverage - limited to 30 days per year, preauthorization required
Inpatient physician care	90% coverage	80% coverage after deductible	100% coverage - limited to 30 days per year

benefit

PLAN PROVISIONS	PPO		HMO
	PPO In Network	PPO Out-of-Network	
Outpatient	\$10 per visit copay then 90% coverage	80% coverage after deductible	100% coverage - limited to 52 days per year, pretreatment review required
MISCELLANEOUS SERVICES			
Accupuncture	Not covered	Not covered	\$10/visit copay then \$500 annual maximum benefit/member, self referral to network provider for up to 5 visits/condition. Over 5 need referral.
Allergy treatment	90% coverage, prior approval for some treatment	80% coverage after deductible, prior approval for some treatment	100% coverage - directed by PCP
Ambulance	90% coverage	80% coverage after deductible	100% coverage - directed by PCP medically necessary
Blood, blood plasma, blood serum	90% coverage	80% coverage after deductible	100% coverage - directed by PCP
Chiropractic care	\$10/visit copay, then 90% coverage	80% coverage after deductible	\$10 per visit copay, then 100% coverage, self referral to network provider
Organ transplants	Kidney, cornea, liver, heart, lung, heart-lung, pancreas, bone marrow covered in limited circumstances, preauthorization required	Kidney, cornea, liver, heart, lung, heart-lung, pancreas, bone marrow covered in limited circumstances, preauthorization required	Bone marrow, cornea, kidney, heart, lung, heart-lung, pancreas, or liver if required for biliary artesia, preauthorization required
Dental accident care	90% coverage, covers repairs to jaw damage and sound natural teeth, treatment must begin and be completed within 6 months of accident	80% coverage after deductible, covers repairs to jaw damage and sound natural teeth, treatment must begin and be completed within 6 months of accident	100% coverage - directed by PCP, treatment within 72 hours after injury only
Durable medical equipment	90% coverage	80% coverage after deductible	100% coverage - directed by PCP, preauthorization required
Emergency room care	\$100 copay then 90% coverage; coinsurance follows copay; copay continues after OPM is met; waived if admitted	80% coverage, does not apply to the plan deductible	\$100 copay then 100% coverage-waived if admitted
Eye glasses	Not Covered	Not Covered	Not Covered
Hearing aids	Not Covered	Not Covered	Not Covered

benefit

PLAN PROVISIONS	PPO		HMO
	PPO In Network	PPO Out-of-Network	
Hemodialysis	90% coverage	80% coverage after deductible	100% coverage - directed by PCP
Home health care	90% coverage, preauthorization required	80% coverage after deductible, preauthorization required	100% coverage - directed by PCP preauthorization required
Hospice care	90% coverage; preauthorization required	80% coverage after deductible, preauthorization required	100% coverage - directed by PCP preauthorization required
Immunizations	90% coverage	80% coverage after deductible	100% coverage - directed by PCP
Infertility treatment	90% coverage, lifetime maximum \$15,000 per person	80% coverage after deductible, lifetime maximum \$15,000 per person	100% coverage - directed by PCP, lifetime maximum of \$15,000 per person - preauthorization required
Outpatient chemotherapy	90% coverage	80% coverage after deductible	100% coverage - directed by PCP
Physical Therapy	90% coverage	80% coverage after deductible	100% coverage - directed by PCP, 20 visits per person per year
Skilled nursing facility	90% coverage, preauthorization required	80% coverage after deductible, preauthorization required	100% coverage - directed by PCP preauthorization required
Speech, occupational and respiratory therapy	90% coverage, prior approval for some treatment	80% coverage after deductible, prior approval for some treatment.	100% coverage - directed by PCP, 20 visits/person/year for each type of therapy
Temporo-mandibular Joint Treatment (TMJ)	90% coverage, preauthorization required.	90% coverage after deductible, preauthorization required.	100% coverage - directed by PCP, preauthorization required.

2006 ISU Plan Medical Rates		
	PPO	HMO
Total Price		
Yourself only	\$351	\$324
Yourself + spouse	\$804	\$744
Yourself + children	\$627	\$582
Yourself + family	\$1029	\$947

Iowa State University Prescription Drug Plan At A Glance

The ISU Plan offers a pharmacy program that is administered separately from your medical plan. You will have a separate benefit card that must be used for your prescription purchases but there is not a separate premium that you pay. The cost of the medical and prescription plans is combined into the single medical premium. The prescription plan is administered by Medco (Pharmacy Benefit Manager).

Deductibles	\$0
Out-of-Pocket Maximum	\$1,500/contract/year Separate from applicable medical plan out-of-pocket
30-day supply – Retail Pharmacy	\$10 co-pay for generic 30% co-pay for preferred brand name 50% co-pay for non-preferred brand name Limited coverage for nonparticipating pharmacies. For prescription medications used on a short-term basis
90-day Supply – Retail Pharmacy	\$30 co-pay for generic 30% x 3 co-pay for preferred brand name 50% x 3 co-pay for non-preferred brand name For prescription medications used on a regular basis (for 3 months or more)
90-day Supply – Medco By Mail (Home Delivery)	\$20 co-pay for generic 20% co-pay for preferred brand name 33% co-pay for non-preferred brand name For prescription medications used on a regular basis (for 3 months or more)

Dental Options

2006 Dental Options – An Overview

The ISU Plan offers you two dental options. You choose the plan that's right for your individual situation. You also elect the level of coverage that's appropriate for you. Your options include:

- ◆ The Basic Dental Plan
- ◆ The Comprehensive Dental Plan

If you wish to enroll yourself, spouse/partner and/or children that were previously eligible but not covered in an ISU Dental Plan, there may be a 12-month waiting period during which the plans will cover only eligible diagnostic/preventative or orthodontic charges. There will be no waiting period if you and eligible dependents are currently covered on ISU dental insurance and you elect to change from one plan to the other.

THIS COMPARISON IS ONLY A SUMMARY OF BENEFITS. BENEFITS WILL BE ADMINISTERED AS DESCRIBED IN EACH PLAN'S SUBSCRIBER AGREEMENT OR PLAN DOCUMENT

ISU Dental Plans		
Plan Provisions	Basic Plan	Comprehensive Plan
Deductibles	None	\$25 annual deductible/contract combined for basic & major restorative
Annual maximum benefit	\$750/person/year	\$1,500/person/year excludes orthodontics
Diagnostic/Preventative		
◆ Check-ups	100% - 2 per year*	100% - 2 per year*
◆ Cleanings	100% - 2 per year*	100% - 2 per year*
◆ X-rays	100%	100%
◆ Topical fluoride – under age 19	1 every 12 months	1 every 12 months
◆ Topical fluoride – adults	1 every 12 months	1 every 12 months
◆ Sealants – under age 14	100%	100%
◆ Space maintainers – under age 14	100%	100%
Basic restorative		
◆ Non-gold fillings	50%	80%, after deductible
◆ Root canal	50%	80%, after deductible
◆ Treatment for gum disease	50%	80%, after deductible
◆ Extractions	50%	80%, after deductible
◆ Anesthesia	50%	80%, after deductible
Major restorative		
◆ Gold & porcelain inlays & onlays	50%	50%, after deductible
◆ Crowns & jackets	50%	50%, after deductible
◆ Bridgework	Not covered	50%, after deductible
◆ Implants	Not covered	50%, after deductible
◆ Dentures	Not covered	50%, after deductible
Orthodontics	Not covered	50% coverage, lifetime maximum benefit \$2,000 after \$50 deductible

*Periodontal Maintenance applies to 2 check-ups/cleanings per year limit, except immediately following complete or conservative periodontal therapy.

Dental 3-Year Lock-in Period Reminder

Enrollment into the Comprehensive Dental Plan requires that you stay in the plan for a minimum of three years. You may switch from the Comprehensive to the Basic Dental or No Coverage option during this Open Change Period, but only if you have been in the Comprehensive Plan for three (3) years. Employees enrolling in the Comprehensive Plan must wait until they have completed 3 years of participation and make the change during the next Open Change Period.

2006 ISU Plan Dental Rates		
	Price Tag	
	Basic	Comprehensive
Total Price		
Yourself only	\$20	\$32
Yourself + spouse	\$45	\$80
Yourself + children	\$50	\$86
Yourself + family	\$56	\$96

Iowa State University does not discriminate on the basis of race, color, age, religion, national origin, sexual orientation, gender identity, sex, marital status, disability, or status as a U.S. veteran. Inquiries can be directed to the Director of Equal Opportunity and Diversity, 3210 Beardshear Hall, (515) 294-7612.