

Plan Comparisons and Managed Care Service Area

STATE OF IOWA HEALTH BENEFIT COMPARISON

Effective January 1, 2007
(2007 changes in bold print in column)

THIS COMPARISON IS ONLY A SUMMARY OF BENEFITS. BENEFITS WILL BE ADMINISTERED AS DESCRIBED IN EACH PLAN'S SUBSCRIBER AGREEMENT OR PLAN DOCUMENT. FOR FURTHER DETAIL, REFER TO THOSE DOCUMENTS OR CALL THE INSURANCE CARRIER OR MANAGED CARE PLAN.

PLAN PROVISIONS	Wellmark BC/BS PROGRAM 3 PLUS	Wellmark BC/BS IOWA SELECT		Open and Closed Managed Care Plans
		In-Network (Select Provider)	Out-of-Network (Non-Select Provider)	
Deductible Single/Family	\$300/\$400, inpatient services only.	\$250/\$500. Applies to both inpatient and outpatient services. Waived for services provided in office/clinic setting of Select Provider.	\$250/\$500. Applies to both inpatient and outpatient services.	None.
Coinsurance Percentage	20% of maximum allowable fee. All services.	10% of maximum allowable fee, in most cases.	20% of maximum allowable fee, in most cases.	Varies; see below
Out-of-Pocket Limit Single/Family	\$600/\$800. All deductibles, coinsurance, and copayments except \$15 office visit copayment go toward out-of-pocket limit. Separate \$250/\$500 out-of-pocket limit for prescription drugs. Does not apply to medical out-of-pocket limit.	\$600/\$800. Applies to services provided both in and out-of-network. All deductibles, coinsurance and copayments except \$15 office visit copayment go toward out-of-pocket limit. Emergency Room Copayment continues to apply after out-of-pocket limit is met. Separate \$250/\$500 out-of-pocket limit for prescription drugs. Does not apply to medical out-of-pocket limit.	\$600/\$800. Applies to services provided both in and out-of-network. All deductibles, coinsurance and copayments except \$15 office visit copayment go toward out-of-pocket limit. Emergency Room Copayment continues to apply after out-of-pocket limit is met. Separate \$250/\$500 out-of-pocket limit for prescription drugs. Does not apply to medical out-of-pocket limit.	\$750/\$1500. All copayments go toward out-of-pocket limit with the exception of prescription drug copayments.
New Employee Preexisting Condition Waiting Period	11 months.	11 months.	11 months.	None.
Preapproval of Inpatient Admissions	Required.	Required.	Required.	Required.
Large Case Management	Alternative care set up on a case by case basis by Plan.	Alternative care set up on a case by case basis by Plan.	Alternative care set up on a case by case basis by Plan.	Alternative care set up on a case by case basis.

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Prescription Drugs	(tier 1)\$5 preferred generic (tier 2)\$15 preferred brand (tier 3)\$30 non-preferred brand and non-preferred generic. Separate \$250/\$500 out-of-pocket limit for prescription drugs. (Does not apply to medical out-of-pocket limit.)	(tier 1)\$5 preferred generic (tier 2)\$15 preferred brand (tier 3)\$30 non-preferred brand and non-preferred generic. Separate \$250/\$500 out-of-pocket limit for prescription drugs. (Does not apply to medical out-of-pocket limit.)	(tier 1)\$5 preferred generic (tier 2)\$15 preferred brand (tier 3)\$30 non-preferred brand and non-preferred generic. Separate \$250/\$500 out-of-pocket limit for prescription drugs. (Does not apply to medical out-of-pocket limit.)	(tier 1)\$5 preferred generic, (tier 2)\$15 preferred brand, (tier 3)\$30 or 25% of non-preferred brand and non-preferred generic, whichever is greater. RX must be for a covered service and from a plan pharmacy. No ancillary charges may be assessed. (Copayments do NOT apply toward out-of-pocket maximum.)
Second Surgical Opinion	Voluntary. Paid according to normal plan benefits.	Voluntary. Paid according to normal plan benefits.	Voluntary. Paid according to normal plan benefits.	Voluntary. Paid according to normal plan benefits when received from Plan provider.
Lifetime Benefit Maximum	None.	None.	None.	None.
Outpatient Surgery Setting	Required 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 noncompliance.	Required for certain procedures. Select provider obtains approval.	Required 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 noncompliance.	Participating physician will determine appropriate surgical setting.
Benefits Available From Non-Participating Providers	Normal plan benefits.	Normal plan benefits for Select providers.	Normal plan benefits for Non-Select providers.	None, unless prescribed, referred and approved by a Participating Physician or in Emergency Medical Condition, or with prior authorization from the Plan, when required.

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PHYSICIAN SERVICES				
Office Calls	\$15 copayment once per date of service for exam only; no coinsurance, no deductible. Copayment does not apply to out-of-pocket limit. 20% coinsurance, no deductible for other office services	\$15 copayment once per date of service for exam only; no coinsurance, no deductible. Copayment does not apply to out-of-pocket limit. 10% coinsurance, no deductible for other office services	\$15 copayment once per date of service for exam only; no coinsurance, no deductible. Copayment does not apply to out-of-pocket limit. 20% coinsurance, no deductible for other office services	\$10 copayment per visit.
Routine Physicals	20%, no deductible, excluding travel, employment or athletic related/required. Limited to one physical per member per year.	10%, deductible waived in office setting, excluding travel, employment or athletic related/required. Limited to one physical per member per year.	20%, after deductible, excluding travel, employment or athletic related/required. Limited to one physical per member per year.	\$10 copayment per visit, excluding travel, employment, or athletic related/required.
Well Child Care	20%, to 7 years. No deductible.	10%, to 7 years. Deductible waived in office setting.	20%, to 7 years. No deductible.	\$10 copayment per visit.
X Ray & Lab	20%, no deductible.	10%, deductible waived in office setting.	20%, after deductible.	0%
Routine Eye Exam	Not covered.	10%, deductible waived. Limited to one exam per member per year.	20%, deductible waived. Limited to one exam per member per year.	\$10 copayment per visit. Limit of one exam per member per year.
Routine Hearing Exam	Not covered.	10%, deductible waived. Limited to one exam per member per year.	20%, deductible waived. Limited to one exam per member per year.	\$10 copayment per visit. Limit of one exam per member per year.
Maternity	20%, no deductible for pre-natal and post-natal visits.	10%, deductible waived in office setting for pre-natal and post-natal visits.	20%, after deductible.	0% for delivery \$10 copayment for initial visit; remaining pre-natal and post-natal visits paid in full.
HOSPITAL SERVICES				
Physician Services	20%, no deductible.	10%, after deductible.	20%, after deductible.	0% if authorized.
Inpatient Surgery	20%, after deductible. Most be approved as inpatient procedure.	10%, after deductible. Must be approved as inpatient procedure.	20%, after deductible. Most be approved as inpatient procedure.	0% if authorized.

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Room & Board	20%, after inpatient service deductible. No limit on medical surgical days. Pre certification of admission required.	10%, after deductible. No limit on medical surgical days. Pre Certification of admission required by Select provider.	20%, after deductible. No limit on medical surgical days. Pre Certification of admission required.	0% if authorized. Semi-private basis unless medically necessary to use private room. May require prior approval.
Outpatient Surgery	0%, no deductible. Required for certain procedures.	10%, after deductible. Required for certain procedures. Approval obtained by Select provider.	20%, after deductible. Required for certain procedures.	0% if authorized.
Inpatient Supplies, Drugs, Medicines, etc.	20%, after deductible	10%, after deductible	20%, after deductible	0% if authorized.
Inpatient Tests, ICU, Operating Room, Specialized Care, etc.	20%, after deductible	10%, after deductible	20%, after deductible	0% if authorized.
MENTAL/NERVOUS/SUBSTANCE ABUSE				
Inpatient Hospital Room & Board	20%, after deductible. Maximum 60 days per member per calendar year. Use of mental health network required.	10%, after deductible. Maximum of 60 days per member per calendar year. Use of mental health network required.	20%, after deductible. Maximum of 60 days per member per calendar year. Use of mental health network required.	<u>Mental/Nervous:</u> 0% <u>SubstanceAbuse:</u> 20% Both have maximum of 30 days per calendar year.
Inpatient Physician Care	20%. Maximum 60 days per member per calendar year. Use of mental health network required.	10%, after deductible. Maximum of 60 days per member per calendar year. Use of mental health network required.	20%, after deductible. Maximum of 60 days per member per calendar year. Use of mental health network required.	0%. Maximum of 30 days per member per calendar year.
Outpatient	20%, use of mental health network required.	10%, deductible waived in office setting. Use of mental health network required.	20%, after deductible. Use of mental health network required.	<u>Mental/Nervous:</u> \$10 copayment per visit, maximum of 52 visits/calendar year. <u>SubstanceAbuse:</u> \$20 Copayment per visit, maximum of 30 days/calendar year
Oral Contraceptives	Covered.	Covered.	Covered.	Covered.

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MISCELLANEOUS SERVICES				
Mail Order Prescription	Coverage as defined under prescription drugs for maintenance drugs for up to a 90 day supply for two copayments instead of three.	Coverage as defined under prescription drugs for maintenance drugs for up to a 90 day supply for two copayments instead of three.	Coverage as defined under prescription drugs for maintenance drugs for up to a 90 day supply for two copayments instead of three.	(tier 1)\$10 generic, (tier 2)\$30 preferred brand, (tier 3)\$60 non-preferred brand for up to a three (3) month supply. No ancillary charges may be assessed. Copayments do NOT apply toward out-of-pocket maximum.
Allergy Treatment	20%, no deductible.	10%, deductible waived in office setting.	20%, after deductible.	\$10 copayment per visit.
Chiropractor	20%, no deductible.	10%, deductible waived in office setting.	20%, after deductible.	\$10 copayment per visit with approved referral. First 12 visits no referral but in network provider.
Home Health Care	20%, no deductible. Precertification required.	10%, after deductible. Precertification required.	20%, after deductible. Precertification required.	0% if authorized by the Company.
Eyeglasses	Not covered.	Not covered.	Not covered.	Not covered.
Hearing Aids	Not covered.	Not covered.	Not covered.	Not covered.
Ambulance	20%, no deductible.	20%, after deductible.	20%, after deductible.	0%, if medically necessary/emergency medical services.
Nursing Facility Providing Skilled Care	20%, after deductible. Unlimited days. Precertification required.	10%, after deductible. Unlimited days. Precertification required.	20%, after deductible. Unlimited days. Precertification required.	0%, maximum of 120 days per member per calendar year.
Emergency Room (ER Care)	0%, no deductible. Also see section on "Accidents."	\$50 copayment waived if admitted. Copayment and coinsurance apply. Copayment applies after out-of-pocket limit is met.	\$50 copayment waived if admitted. Deductible, copayment and coinsurance apply. Copayment applies after out-of-pocket limit is met.	\$50 copayment waived if admitted.
Physical Therapy	20%, no deductible.	10%, deductible waived in office setting.	20%, after deductible.	\$10 copayment per visit. Maximum 60 visits per member per year.
Temporomandibular Joint Treatment (TMJ)	20%, no deductible.	10%, deductible waived in office setting.	20%, after deductible.	Not covered.
Blood, Blood Plasma, Blood Serum	20%, no deductible.	10%, after deductible.	20%, after deductible.	0%, if authorized.

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Accidents	0%, no deductible for all treatment within 72 hours of accident.	10%, deductible waived in office setting.	20%, after deductible. Emergency care covered at In-Network level.	\$10 copayment office visit. \$50 copayment Emergency Room, waived if admitted.
Dependent Child Age Limit	Age 19 or unlimited if a full time student and unmarried.	Age 19 or unlimited if a full time student and unmarried.	Age 19 or unlimited if a full time student and unmarried.	Age 19 or unlimited if a full time student and unmarried.
Durable Medical Equipment	20%, no deductible.	10%, after deductible.	20%, after deductible.	20%, if prescribed by a Participating Provider and obtained from a supplier authorized by the Company.
Hospice Care	20%, no deductible. Precertification required.	10%, after deductible. Precertification required.	20%, after deductible. Precertification required.	0%, if medically authorized by the Company.
Hemodialysis	20%, no deductible.	10%, after deductible.	20%, after deductible.	0%, if obtained in a Center authorized by the Company.
Outpatient Chemotherapy	20%, no deductible.	10%, deductible waived in office setting.	20%, after deductible.	\$10 copayment per visit.
Dental Accident Care	0%, no deductible for services provided within 72 hours. 20% thereafter for a maximum of 6 months from injury.	10%, deductible waived in office setting. Limited to services provided within 72 hours of accident.	20%, after deductible. Limited to services provided within 72 hours of accident.	20%, if authorized for injury to sound natural teeth. Services must be within 6 months of injury and must have occurred while member enrolled in plan.
Organ Transplants	Heart, heart and lung, lung, pancreas, kidney, simultaneous pancreas/kidney, liver and cornea transplants covered. Prior approval required.	Heart, heart and lung, lung, pancreas, kidney, simultaneous pancreas/kidney, liver and cornea transplants covered. Prior approval required.	Heart, heart and lung, lung, pancreas, kidney, simultaneous pancreas/kidney, liver and cornea transplants covered. Prior approval required.	Heart, heart/lung, lung (single & double), liver, pancreas, kidney/pancreas, kidney, cornea, small intestine, autologous bone marrow and allogeneic bone marrow transplants 100% covered if authorized by the Company. No coverage if experimental or in nonauthorized facility.

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Prosthetic Appliances and Other Devices	20%, no deductible.	10%, after deductible.	20%, after deductible.	20%, if authorized by Participating physician and obtained from an authorized supplier.
Speech & Occupational Therapy	20%, payable in or outpatient. Prior approval required. Must be hospital-based billed or as a part of approved home health services.	10%, after deductible. Prior approval required. Must be a hospital-based billed or as a part of approved home health services.	20%, after deductible. Prior approval required. Must be hospital-based billed or as a part of approved home health services.	\$10 copayment per visit. Maximum 60 visits per year for each type of therapy.
Respiratory Therapy	20% payable inpatient or outpatient. Must be hospital-based billed or as a part of approved home health services.	10% after deductible. Must be hospital-based billed or as a part of approved home health services.	20% after deductible. Must be hospital-based billed or as a part of approved home health services.	\$10 copayment per visit. Maximum 60 visits per year for each type of therapy.
<p>**Notice for members of Plans underwritten by Wellmark Blue Cross and Blue Shield of Iowa (BC/BS). Your plan's coverage percentage for hospital and other facility services does not reflect the actual payment to the provider. The actual payment to the provider is based on BC/BS's contract with the provider. The percentage is used in this document for comparison purposes only. On any given claim, the amount represented by the coverage percentage times the Covered Charge may be satisfied by the BC/BS's payment to the provider plus any amounts the Provider agrees to waive under its contract with BC/BS. Please see your Benefit Booklet for more information.</p>				

There are four Managed Care Plans in two categories available for selection during Open Change time:

- The first category is a “closed” plan. These plans require that you select a primary care physician (PCP). The PCP will need to refer you to in-network specialists. The two plans in the “closed” category are, United Healthcare Heritage Select and Wellmark Blue Advantage.
- The second category is an “open” plan. These plans do not require a PCP referral. You may self-refer to the providers participating in the network. The two plans in this “open” category are, United Healthcare Choice and new for 2007, Wellmark Blue Access.

Social Security Numbers Are Required for Dependent Health & Dental Coverage

If you are enrolled for Family Coverage in the State of Iowa health and/or dental plans, we need your dependents Social Security Numbers. Social Security numbers provide unique identifiers for your dependents that aid in processing enrollment information between the vendors and Iowa State University. You will be receiving a Benefit Confirmation Statement after November 20, 2006, please review the Statement and notify the Benefits Office with missing dependent information. Please call the Benefits Office at (515) 294-7680 or e-mail the numbers to benefits@iastate.edu.