

## ISU PLAN MEDICAL PLANS 2008

**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 (Alliance Select)		HMO (Blue Advantage)
	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
<b>PHYSICIAN SERVICES</b>			
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
Routine hearing exam	90% coverage, one per calendar year	Not covered	100% coverage – one per calendar year, self refer to network provider.
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

PLAN PROVISIONS	PPO (Alliance Select)		HMO (Blue Advantage)
	PPO In Network	PPO Out-of-Network	
<b>PREVENTATIVE SERVICES</b>			
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
<b>INPATIENT SERVICES</b>			
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
<b>MENTAL / NERVOUS / SUBSTANCE ABUSE</b>			
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
Outpatient	\$10 per visit copay then 90% coverage	80% coverage after deductible	100% coverage - limited to 52 days per year.
<b>MISCELLANEOUS SERVICES</b>			
Acupuncture	Not covered	Not covered	\$10/visit copay then \$500 annual maximum benefit/member, self referral to 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

PLAN PROVISIONS	PPO (Alliance Select)		HMO (Blue Advantage)
	PPO In Network	PPO Out-of-Network	
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
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.