

ISU PLAN MEDICAL PLANS 2009

THIS COMPARISON IS ONLY A LIMITED 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 |
| Dependent adult child limit | Must be age 19 – 25, unmarried non-student and reside in Iowa | Must be age 19 – 25, unmarried non-student and reside in Iowa | Must be age 19 – 25, unmarried non-student and reside in Iowa |
| 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 |
| 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 |

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|--|---|---|--|
| | PPO In Network | PPO Out-of-Network | |
| 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 |
| Outpatient | \$10 per visit copay then 90% coverage | 80% coverage after deductible | 100% coverage - limited to 52 days per year. |
| MISCELLANEOUS SERVICES | | | |
| 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 |

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|--|---|--|--|
| | 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 |
| 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 |
| Temporo-mandibular Joint Treatment (TMJ) | 90% coverage, preauthorization required. | 90% coverage after deductible, preauthorization required. | 100% coverage - directed by PCP, preauthorization required. |

Wellmark Blue Cross and Blue Shield, Blue Advantage service area network effective January 1, 2009 will include 90 Iowa Counties. If you are enrolled in Blue Advantage, you may now receive services from participating providers in Douglas and Sarpy Counties in Nebraska as well as Children's Hospital in Omaha. In Northwestern Iowa, the plans include participating facilities in South Dakota. In the Quad Cities, you may go to participating providers with the Genesis Health System or the Iowa Health System – Trinity. REMINDER: It is your responsibility to ensure that providers you seek services from are part of the Blue Advantage network. Services received from non-participating providers will NOT be paid by the insurance carrier.

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