Health Benefit Comparison

Effective January 1, 2010

Plan	***Indemnity Plan*** **BC/BS Plan 3 Plus**	***Preferred Provider Organization*** **BC/BS Iowa Select**	***Managed Care Plans*** **Blue Access, Blue Advantage**
Access to Providers	Full Access	Full Access; lower level of benefits if not in the Alliance Select network.	Primary Care or Network Only
Deductibles	Inpatient Services Only	Waived for services provided in office setting of Select Provider.	None
Single	$300	$250	
Family	$400	$500	
Coinsurance	20%	10% In Network 20% Out of Network	Varies by Service
Out-of-Pocket Limits			
Single	$600	$600	$750
Family	$800 -$15 Office Visit Co-payment does not apply to the out-of-pocket maximum. -Separate $250/$500 out-of-pocket limit for prescription drugs.	$800 -$15 Office Visit Co-payment does not apply to the out-of-pocket maximum. -Separate $250/$500 out-of-pocket limit for prescription drugs.	$1,500 All co-payments go toward out-of-pocket limit except those for prescription drugs.
Lifetime Benefit Maximum	None	None	None
Physician Office Visits	$15 co-payment for exam only	$15 co-payment for exam only	$10 co-payment per visit
Routine Physicals – excluding travel, employment or athletic related/required.	20%, no deductible, limited to one per year	10%/20%*, limited to one per year	$10 co-payment. Limited to one exam per person per year
Well Child Care	20%, to 7 years	10%/20%*, to 7 years	$10 co-payment per visit
Routine Eye Exam & Routine Hearing Exam	Not covered	10% / 20%* co-insurance deductible waived. Limited to one exam per person per year.	$10 co-payment. Limited to one exam per person per year.
Hospital Services	20% after deductible - pre-certification required by member	10%/20%* after deductible - pre-certification required by select provider	100% paid, if authorized
Emergency Room Services	Paid at 100% - no deductible	$50 co-payment – waived if admitted	$50 co-payment – waived if admitted
Chiropractor	20%, no deductible	10%/20%*	$10.00 co-payment if approved provider.
Mental/Nervous			
Outpatient Treatment	20%, no deductible - Use of mental health network required.	10%/20%*, after deductible - Use of mental health network required.	$10 co-payment per visit.
Inpatient Treatment	20%, after deductible	10%/20%*, after deductible	100% paid, if authorized
Prescription Drugs			
Preferred Generic	$5 co-payment	$5 co-payment	$5 co-payment
Preferred Brand	$15 co-payment	$15 co-payment	$15 co-payment
Non-Preferred Brand & Non-Preferred Generic	$30 co-payment	$30 co-payment	Greater of $30 or 25%
Dependent child age limit/student limit	25 if unmarried or unlimited if a full time student	25 if unmarried or unlimited if a full time student	25 if unmarried or unlimited if a full time student

* 10% coinsurance for in-network providers, 20% coinsurance for out-of-network providers.