

**Human Resources Committee Memorandum**  
Board of Regents, State of Iowa

**Subject:** Health Insurance Plan Summaries, Enrollments and Rates  
**Prepared by:** Marcia R. Brunson  
**Date:** November 18, 2004

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**Recommended Action:**

Receive the information on the health insurance plans offered at the Regent institutions.

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**Executive Summary:**

The following information is provided in response to questions raised by Regent Neil at the September HR Committee meeting relative to health insurance plan summaries, enrollments and rates.

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State Health Plans All employees of the special schools and AFSCME employees at the universities are covered by the state health insurance plans.

Contribution rates and plan design are negotiable with the statewide unions. Currently, the employer pays 100% of single coverage and 82% (\$777.90) of the cost of family coverage for the Iowa Select plan. This amount may applied be toward the cost of family coverage for any of the state plans. The amount will increase to 85% (\$881.06) in calendar year 2005.

Premium increases for the state Wellmark plans ranged from 9.3% to 9.5% for the 2005 year. The managed care plans increases ranged from 6.9% to 15.3%.

Enrollments and premiums for the state plans are shown on Attachments A and B. Summaries of the benefits provided by the plans are shown in Attachment C.

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University of Iowa	<p>The University offers its faculty, P&amp;S staff, and supervisory merit staff the choice between four health insurance plans. The plans are offered as part a component of the University's flexible benefits program.</p> <p>Overall, the University's premiums will increase 12% in calendar year 2005.</p> <p>Enrollments and premiums for the four University plans are shown on Attachment D. A summary of the benefits offered by the plans is shown on Attachment E.</p>
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Iowa State University	<p>The University offers its faculty, P&amp;S staff and supervisory merit staff three health insurance programs – an indemnity plan, a PPO and HMO.</p> <p>The overall rate increase for the University's indemnity plan for 2005 is 10% and 6% for the HMO and PPO.</p> <p>Enrollments and premiums for the four University plans are shown on Attachment F. A summary of the benefits offered by the plans is shown on Attachment G.</p>
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University of Northern Iowa	<p>The University offers its organized faculty one health insurance plan – an indemnity plan. Nonorganized faculty, administrators, P&amp;S staff and supervisory merit staff have the option of selecting from either the indemnity plan or a managed care plan.</p> <p>The University's premium structure is on a fiscal year basis. The rate increase for FY 2005 was 9%.</p> <p>In accordance with the collective bargaining agreement with the UNI-United Faculty, the employer pays 75% of family coverage and the total cost of single coverage. The employer pays 80% of the cost of family coverage for P&amp;S and other nonorganized staff covered by the University plans.</p> <p>Enrollments and premiums for the two University plans are shown on Attachment H. A summary of the benefits offered by the plans is shown on Attachment I.</p>

**Calendar Year 2005  
State Health Insurance Rates**

PLAN	TOTAL COST (monthly)	EMPLOYER SHARE	EMPLOYEE SHARE
<b>PROGRAM 3 PLUS</b>			
Single	471.63	471.63	0
Family	1,103.62	881.06	222.56
<b>DEDUCTIBLE 3 PLUS</b>			
Single	470.18	470.18	0
Family	1,100.24	792.18	308.06
<b>IOWA SELECT</b>			
Single	442.95	442.95	0
Family	1,036.54	881.06	155.48
<b>BLUE ADVANTAGE</b>			
Single	311.26	311.26	0
Family	746.96	746.96	0
<b>COVENTRY PRIMARY CARE</b>			
Single	376.90	376.90	0
Family	904.38	881.06	23.32
<b>UHC OF THE MIDLANDS</b>			
Single	381.46	381.46	0
Family	915.48	881.06	34.42
<b>JOHN DEERE OPEN ACCESS</b>			
Single	455.60	455.60	0
Family	1,093.42	881.06	212.36
<b>COVENTRY OPEN ACCESS</b>			
Single	390.22	390.22	0
Family	936.42	881.06	55.36
<b>JOHN DEERE PRIMARY CARE</b>			
Single	355.48	355.48	0
Family	853.16	853.16	0

Attachment B

ENROLLMENTS IN STATE HEALTH PLANS SEPTEMBER 2004

AFSCME Staff at the universities	SUI					ISU				
	Single	Family	Double Spouse	Total in Plan	% in each plan	Single	Family	Double Spouse	Total in Plan	% in each plan
<b>State Wellmark Plans</b>										
Plan 3 Plus	1,451	1,058	238	2,747	55.3%	535	301	-	836	48.1%
Deductible 3 Plus	-	-	-	-	0.0%	1	6	-	7	0.4%
Iowa Select	314	484	21	819	16.5%	265	319	-	584	33.6%
IUP Select	-	-	-	-	0.0%	-	-	-	-	0.0%
<b>State Managed Care</b>										
Blue Advantage	213	848	25	1,086	21.8%	33	154	1	188	10.8%
Coventry Open Access	-	2	-	2	0.0%	30	79	7	116	6.7%
Coventry Primary Care	-	-	-	-	0.0%	-	-	-	-	0.0%
John Deere Open Access	92	74	9	175	3.5%	4	2	-	6	0.3%
John Deere Primary Care	12	130	-	142	2.9%	-	-	-	-	0.0%
United Health Care	-	-	-	-	0.0%	-	-	-	-	0.0%
<b>Total Contracts</b>				<b>4,971</b>					<b>1,737</b>	

AFSCME Staff at the universities	UNI				
	Single	Family	Double Spouse	Total in Plan	% in each plan
<b>State Wellmark Plans</b>					
Plan 3 Plus	195	63	34	292	48.1%
Deductible 3 Plus	-	-	-	-	0.0%
Iowa Select	38	55	4	97	16.0%
IUP Select	-	-	-	-	0.0%
<b>State Managed Care</b>					
Blue Advantage	12	137	-	149	24.5%
Coventry Open Access	1	1	-	2	0.3%
Coventry Primary Care	3	-	-	3	0.5%
John Deere Open Access	49	13	-	62	10.2%
John Deere Primary Care	-	2	-	2	0.3%
United Health Care	-	-	-	-	0.0%
<b>Total Contracts</b>				<b>607</b>	

All staff at ISD and IBSSS	ISD					IBSSS				
	Single	Family	Double Spouse	Total in Plan	% in each plan	Single	Family	Double Spouse	Total in Plan	% in each plan
<b>State Wellmark Plans</b>										
Plan 3 Plus	10	2	3	15	9.5%	8	9	2	19	19.4%
Deductible 3 Plus	6	5	4	15	9.5%	-	-	-	-	0.0%
Iowa Select	16	14	2	32	20.3%	14	2	1	17	17.3%
IUP Select	-	-	-	-	0.0%	-	-	-	-	0.0%
<b>State Managed Care</b>										
Blue Advantage	2	10	-	12	7.6%	8	44	-	52	53.1%
Coventry Open Access	-	-	-	-	0.0%	-	1	-	1	1.0%
Coventry Primary Care	-	-	-	-	0.0%	-	-	-	-	0.0%
John Deere Open Access	-	-	-	-	0.0%	3	1	1	5	5.1%
John Deere Primary Care	-	-	-	-	0.0%	-	-	-	-	0.0%
United Health Care	33	49	2	84	53.2%	2	2	-	4	4.1%
<b>Total Contracts</b>				<b>158</b>					<b>98</b>	

State Wellmark Plans	TOTAL STATEWIDE AFSCME CONTRACTS					ALL STATE CONTRACTS				
	Single	Family	Double Spouse	Total in Plan	% in each plan	Single	Family	Double Spouse	Total in Plan	% in each plan
Plan 3 Plus	5,898	2,681	845	9,424	48.5%	6,348	3,010	864	10,222	37.3%
Deductible 3 Plus	-	-	-	-	0.0%	1,121	817	112	2,050	7.5%
Iowa Select	1,573	2,042	147	3,762	19.4%	2,245	2,913	202	5,360	19.6%
IUP Select	-	-	-	-	0.0%	448	338	19	805	2.9%
<b>State Managed Care</b>										
Blue Advantage	356	2,694	42	3,092	15.9%	457	3,782	52	4,291	15.7%
Coventry Open Access	399	400	34	833	4.3%	690	670	57	1,417	5.2%
Coventry Primary Care	165	170	10	345	1.8%	238	261	16	515	1.9%
John Deere Open Access	406	119	26	551	2.8%	541	149	31	721	2.6%
John Deere Primary Care	11	184	2	197	1.0%	20	212	3	235	0.9%
United Health Care	213	976	41	1,230	6.3%	306	1,398	54	1,758	6.4%
<b>Total Contracts</b>				<b>19,434</b>					<b>27,374</b>	

**SUMMARY OF BENEFITS OF STATE PLANS**

<b>PLAN PROVISIONS</b>	<b>BC/BS PLAN 3 PLUS</b>	<b>BC/BS IOWA SELECT</b>	<b>MANAGED CARE ORGANIZATIONS</b>
Care Providers	Any provider; BlueCross BlueShield (BC/BS) providers can result in lower out-of-pocket expenses	Any provider; select providers have lower co-insurance percentage and deductible is waived for services in the office setting	Care from network providers ONLY; life-threatening emergencies covered anywhere
Benefits Available from Non-member Providers	Normal plan benefits; for non BC/BS providers, employee pays charges over usual reasonable and customary limit	Normal plan benefits; for non BC/BS providers, employee pays charges over usual reasonable and customary limit	None without prior approval
Deductible Single/Family	\$300/\$400 inpatient services only	\$250/\$500; deductible is waived for select providers only if service is in office setting	None
Coinsurance Percentage	20%	Select: 10%; Non-Select: 20%	Varies
Out-of-Pocket Limit Single/Family	\$600/\$800 (\$250/\$500 for prescription drugs)	\$600/\$800 (\$250/\$500 for prescription drugs)	\$750/\$1500 (except prescription drugs)
Pre-existing Condition Waiting Period	11 months	11 months	None during open enrollment or at hire 18 months for late enrollees
Pre-approval of Inpatient Admissions	Required; subscriber must obtain approval from BC/BS	Required; subscriber must obtain approval from BC/BS	Required; plan physician will determine
Second Surgical Opinion	Voluntary	Voluntary	Voluntary
Outpatient Surgery	Mandatory 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	Mandatory 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	Plan physician will determine

<b>PLAN PROVISIONS</b>	<b>BC/BS PLAN 3 PLUS</b>	<b>BC/BS IOWA SELECT</b>	<b>MANAGED CARE ORGANIZATIONS</b>
Office Calls	\$15 co-payment, then 20%	Select: \$15 co-payment, then 10% Non-Select: \$15 co-payment, deductible, then 20%	\$10 co-payment per visit
Routine Physicals	\$15 co-payment, then 20%; Limit one physical per member per year	Select: \$15 co-payment, then 10% Non-Select: \$15 co-payment, deductible, then 20%	\$10 co-payment per visit
Well Baby Care	\$15 co-payment, then 20% to 7 years of age	Select: \$15 co-payment, then 10% Non-Select: \$15 co-payment then, 20% to 7 years of age	\$10 co-payment per visit
X-Ray and Lab	20%	Select: deductible waived if in office setting then 10% Non-Select: deductible then 20%	0%
Routine Eye/Hearing Exam	Not covered	Select: \$15 co-payment, then 10%; Non-Select: \$15 co-payment, then 20% One exam covered per calendar year	\$10 co-payment One exam covered per calendar year
Maternity	\$15 co-payment, then 20%; no deductible for physician charges for pre-/post-natal visits and delivery	Select: \$15 co-payment, then 10% Non-Select: \$15 co-payment, then deductible then 20%	\$10 co-payment per visit
Infertility	\$15 co-payment, then 20% \$25,000 lifetime maximum per couple	Select: \$15 co-payment, then 10%; Non-Select: \$15 co-payment, then deductible then 20% \$15,000 lifetime maximum	Not covered
<b>HOSPITAL SERVICES</b>			
Room & Board	20% after inpatient services deductible \$300/\$400; no limit on days; semi-private basis unless medically necessary to use private room	Select: 10% after deductible; Non-Select: 20% after deductible No limit on days; semi-private basis unless medically necessary to use private room	0%; semi-private basis unless medically necessary to use a private room
Physicians' Services	20%; no deductible	Select: deductible then 10%; Non-Select: deductible then 20%	0% if authorized

<b>PLAN PROVISIONS</b>	<b>BC/BS PLAN 3 PLUS</b>	<b>BC/BS IOWA SELECT</b>	<b>MANAGED CARE ORGANIZATIONS</b>
Inpatient Surgery	20%; no deductible; must be approved as inpatient procedures	Select: deductible then 10%; Non-Select: deductible then 20%	0% if authorized
Outpatient Surgery	0%; no deductible required for certain procedures	Select: deductible then 10%; Non-Select: deductible then 20%	0% if authorized
Inpatient Supplies, Drugs, Medicines, Tests, ICU, OR, Specialized Care, Etc.	20%; after deductible	Select: deductible then 10%; Non-Select: deductible then 20%	0% if authorized
<b>MISC. SERVICES</b>			
Prescription Drugs	\$5 co-payment generic formulary; \$15 co-payment name brand formulary; \$30 co-payment non-formulary; separate \$250/\$500 out-of-pocket maximum	\$5 co-payment generic formulary; \$15 co-payment name brand formulary; \$30 co-payment non-formulary; separate \$250/\$500 out-of-pocket maximum	\$5 co-payment generic formulary \$15 co-payment name brand formulary \$30 or 25% co-payment non formulary (does not apply to out-of-pocket maximum)
Immunizations	20%	Select: 0%; Non-Select: deductible then 10%	0%
Allergy Treatments	20%	Select: 10%; Non-Select: deductible then 20%	\$10 co-payment per visit
Chiropractor	\$15 co-payment, then 20%	Select: \$15 co-payment, then 10%; Non-Select: \$15 co-payment, deductible, then 20%	\$10 co-payment per visit; prior approval required
Home Health Care	20%; prior approval required	Select: deductible then 10%; Non-Select: deductible then 20%	0% if authorized
Eyeglasses/Hearing Aids	Not covered	Not covered	Not covered
Ambulance	20%	Deductible then 20%	0% if medically necessary

<b>PLAN PROVISIONS</b>	<b>BC/BS PLAN 3 PLUS</b>	<b>BC/BS IOWA SELECT</b>	<b>MANAGED CARE ORGANIZATIONS</b>
Organ Transplants	Prior approval required	Prior approval required	0% if authorized
Skilled Nursing Facility	20% after deductible \$300/\$400 No limit on days; pre-approval required	Select: deductible then 10% Non-Select: deductible then 20% Pre-approval required; unlimited days	0% for facility; \$10 co-payment for physician visit; pre-approval required; 120 day maximum
ER Care	0%	\$50 co-payment per visit (waived if admitted)	\$50 co-payment per visit (waived if admitted)
Physical Therapy	20%	Select: deductible then 10%; Non-Select: deductible then 20%	\$10 co-payment per visit; 60 visit maximum
Accidents	0%; no deductible for treatment within 72 hours	Select: 10%; Non-Select: deductible then 20%	Normal plan benefits
Hospice Care	20%; pre-approval required	Select: deductible then 10%; Non-Select: deductible then 20%	0%; prior approval required
Durable Medical Equipment	20%	Deductible then 20%	20%; prior approval required
Speech, Occupational, and Respiratory Therapy	20%; pre-approval required; must be hospital based billed	Select: deductible then 10%, pre-approval required Non-Select: deductible then 20%, pre-approval required	\$10 co-payment; 60 visit maximum (of each type); prior approval required
Dental Accident Care	0%; no deductible; service must be provided within 72 hours of injury; 20% thereafter to six months of injury	Select: 10%; Non-Select: deductible then 20% Only 72 hours	20% if authorized; Within 6 months of injury
Dependent Child Age Limit	Age 19 or unlimited if a full-time single student	Age 19 or unlimited if a full-time single student	Age 19 or unlimited if a FT single student

<b>PLAN PROVISIONS</b>	<b>BC/BS PLAN 3 PLUS</b>	<b>BC/BS IOWA SELECT</b>	<b>MANAGED CARE ORGANIZATIONS</b>
<b>MENTAL /NERVOUS/ SUBSTANCE ABUSE</b>			
Inpatient Hospital Room and Board	20% after deductible; \$300/\$400; maximum 60 days per member, per calendar year	Select: deductible then 10% Non-Select: deductible then 20% Maximum 60 days per year	20%; maximum of 30 days per year
Inpatient Physician Care	20%; maximum 60 days per calendar year	Select: deductible then 10% Non-Select: deductible then 20% Maximum 60 days per year	0%; 30 days per year
Outpatient	\$15 co-payment, then 20%; use of mental health network required	Select: \$15 co-payment, then 10% Non-Select: \$15 co-payment, deductible, then 20% Use of special network required	\$20 co-payment; 30 visits per year
Pre-certification	Required	Required	Required

**UNIVERSITY OF IOWA  
Calendar Year 2005  
RATES -- UNIVERSITY HEALTH PLANS**

PLAN	TOTAL COST (monthly)	EMPLOYER SHARE	EMPLOYEE SHARE
<b>UI CARE</b>			
Single	358.00	305.00	53.00
Employee/Spouse	675.00	489.00	186.00
Employee/Children	500.00	378.00	122.00
Family	713.00	534.00	179.00
<b>UI SELECT</b>			
Single	232.00	232.00	0
Employee/Spouse	550.00	489.00	61.00
Employee/Children	454.00	378.00	76.00
Family	695.00	534.00	161.00
<b>CHIP II</b>			
Single	256.00	256.00	0
Employee/Spouse	633.00	489.00	144.00
Employee/Children	358.00	358.00	0
Family	593.00	534.00	59.00
<b>CHIP III</b>			
Single	400.00	305.00	95.00
Employee/Spouse	868.00	489.00	379.00
Employee/Children	618.00	378.00	240.00
Family	982.00	534.00	448.00

**UNIVERSITY OF IOWA  
PLAN CONTRACTS  
SEPTEMBER 2004**

<b>SUI Plans</b>	Single	Family	Employee Children	Employee Spouse	Total in Plan	% in Plan
CHIP II	306	827	63	687	1,883	19.2%
CHIP III	452	578	84	639	1,753	17.9%
UI CARE	837	1,633	162	1,010	3,642	37.1%
UI SELECT	1,036	703	141	651	2,531	25.8%
Total SUI Employee Plans					9,809	

THE UNIVERSITY OF IOWA  
**HEALTH INSURANCE OPTIONS**  
**Effective January 1, 2005**

	<b>UICare</b>	<b>UISelect</b>	<b>CHIP II</b>	<b>CHIP III</b>
<b>PLAN PROVISIONS</b>				
Care Providers	UICare providers ONLY; life-threatening emergencies covered in a hospital ER	Blue Access providers ONLY; life-threatening emergencies covered in a hospital ER	Any provider; BlueCross/BlueShield (BC/BS) providers can result in lower out-of-pocket costs	Any provider; BlueCross/BlueShield (BC/BS) providers can result in lower out-of-pocket costs
Benefits Available from Non-member Providers	None without prior approval	None without prior approval	Normal plan benefits; for non BC/BS providers, employee pays charges over reasonable and customary limit	Normal plan benefits; for non BC/BS providers, employee pays charges over reasonable and customary limit
Deductible Single/Family	None	None	\$1,200 / \$3,600	\$200-\$600 depending on services received; see plan for details
Coinsurance Percentage Out-of-Pocket Maximum (OPM) Single/Family	10% \$1,500 / \$3,000; Prescription drugs \$1,100 / \$1,700	10% \$1,700 / \$3,300; Prescription drugs \$1,100 / \$1,700	10% \$4,200 / \$6,300	20% \$2,100 / \$3,200
Pre-existing Condition Waiting Period	None	None	None	None
Pre-approval of Inpatient Admissions	Required	Required	Required	Required
Second Surgical Option	Voluntary	Voluntary	Voluntary	Voluntary
Prior Approval for Outpatient Surgery	Physician Discretion	Physician Discretion	Mandatory for certain procedures; 25% reduction for non-compliance	Mandatory for certain procedures; 25% reduction for non-compliance
Dependent Child Age Limit	Age 18 or unlimited for full time student	Age 18 or unlimited for full time student	Age 18 or unlimited for full time student	Age 18 or unlimited for full time student
Domestic Partner	Yes, same and opposite sex	Yes, same and opposite sex	Yes, same and opposite sex	Yes, same and opposite sex

<b>OFFICE CARE</b>	<b>UICare</b>	<b>UISelect</b>	<b>CHIP II</b>	<b>CHIP III</b>
Office Calls	\$0	\$10 co-payment	10% coinsurance after \$1,200 deductible	20% coinsurance
Routine Physicals	\$0	\$0	10% coinsurance After \$1,200 deductible	20% coinsurance
X-ray and Lab	10% coinsurance	10% coinsurance	10% coinsurance after \$1,200 deductible	20% coinsurance after \$200 deductible
Well-Child Care	\$0, including required immunizations	\$0, including required immunizations	10% coinsurance	20% coinsurance
Routine Eye Exam	\$10 co-payment (\$0 at UIHC)	\$10 co-payment	10% coinsurance after 1,200 deductible	20% coinsurance
Hearing Exam	\$10 co-payment	\$10 co-payment	10% coinsurance after \$1,200 deductible	20% coinsurance
<b>HOSPITAL SERVICES</b>	<b>UICare</b>	<b>UISelect</b>	<b>CHIP II</b>	<b>CHIP III</b>
Emergency Room Care	10% coinsurance after \$50 co-payment	10% coinsurance after \$50 co-payment	10% coinsurance after \$50 co-payment and \$1,200 deductible	20% coinsurance after \$50 co-payment
Room and Board	10% coinsurance after \$125 daily co-payment; semi-private room	10% coinsurance after \$400 co-payment per admission; semi-private room; limited to 3 co-payments per person per benefit period	10% coinsurance after \$1,200 deductible; semi-private room	20% coinsurance after \$600 deductible; semi-private room
Physicians Services	10% coinsurance	10% coinsurance	10% coinsurance after \$1,200 deductible	20% coinsurance
Inpatient and Outpatient Surgery	10% coinsurance	10% coinsurance	10% coinsurance after \$1,200 deductible	20% coinsurance
Inpatient Supplies, Drugs, Medicines, etc.	10% coinsurance	10% coinsurance	10% coinsurance after \$1,200 deductible	20% coinsurance
<b>MISCELLANEOUS</b>	<b>UICare</b>	<b>UISelect</b>	<b>CHIP II</b>	<b>CHIP III</b>
Prescription Drugs and Contraceptives	3 tier	3 tier	10% coinsurance after \$1,200 deductible	20% coinsurance after \$200 deductible
Immunizations	\$10 co-payment; \$0 required child immunizations	\$10 co-payment; \$0 required child immunizations	10% coinsurance after \$1,200 deductible	20% coinsurance
Allergy Treatments	\$10 co-payment	\$10 co-payment	10% coinsurance after \$1,200 deductible	20% coinsurance
Chiropractor	\$10 co-payment; referral for over 12 visits	\$10 co-payment	10% coinsurance after \$1,200 deductible	20% coinsurance
Home Health Care	10% coinsurance	10% coinsurance	10% coinsurance after \$1,200 deductible	20% coinsurance after \$200 deductible
Eyeglasses	Not Covered	Not Covered	Not Covered	Not Covered
Hearing Aid	20% coinsurance Max benefit of \$1,000 every 3 years	20% coinsurance Max benefit of \$1,000 every 3 years	10% coinsurance after \$1,200 deductible Max benefit of \$1,000 every 3 years	20% coinsurance after \$200 deductible Max benefit of \$1,000 every 3 years

MISCELLANEOUS	UICare	UISelect	CHIP II	CHIP III
Infertility Treatment Lifetime Maximum of \$25,000 (does not apply towards OPM)	10% coinsurance	10% coinsurance	10% coinsurance, after \$1,200 deductible	20% coinsurance
Ambulance	10% coinsurance	10% coinsurance	10% coinsurance after \$1,200 deductible	20% coinsurance after \$200 deductible
Skilled Nursing Facility	10% coinsurance after \$125 daily copayment; semi-private room	10% coinsurance after \$400 co-payment per admission; semi-private room	10% coinsurance after \$1,200 deductible; semi-private room	20% coinsurance after \$600 deductible; semi-private room
Physical Therapy	10% coinsurance	10% coinsurance	10% coinsurance after \$1,200 deductible	20% coinsurance after \$200 deductible
Hospice Care	10% coinsurance	10% coinsurance	10% coinsurance after \$1,200 deductible	20% coinsurance after \$200 deductible
Durable Medical Equipment	20% coinsurance	20% coinsurance	10% coinsurance after \$1,200 deductible	20% coinsurance after \$200 deductible
Speech, Occupational and Respiratory Therapy	10% coinsurance	10% coinsurance	10% coinsurance after \$1,200 deductible	20% coinsurance after \$200 deductible
Dental Accident Care	10% coinsurance within 6 months of injury	10% coinsurance, within 6 months of injury	10% coinsurance after a \$1,200 deductible within 6 months of injury	20% coinsurance within 6 months of injury
Organ Transplants	Prior approval required	Prior approval required	Prior approval required	Prior approval required

MENTAL HEALTH SUBSTANCE ABUSE	UICare	UISelect	CHIP II	CHIP III
Inpatient Hospital Room and Board	10% coinsurance after \$125 daily copayment; pre-approval of admission required; semi-private room	30 day limit per benefit period; 10% coinsurance after \$400 copayment per admission; preapproval of admission required; semi-private room; limit of 3 copayments per person per benefit period	10% coinsurance after \$1,200 deductible; pre-approval of admission required; semi-private room	20% coinsurance after \$600 deductible pre-approval of admission required; semi-private room
Inpatient Physician Care	10% coinsurance	10% coinsurance	10% coinsurance after \$1,200 deductible	20% coinsurance
Outpatient Mental Health (does not apply towards OPM)	10% coinsurance for University providers, otherwise 50% for non-University providers; 50 visit limit annually (combined with substance abuse)	10% coinsurance; pre approval required, 50% for out of network providers; 50 visit limit annually (combined with substance abuse)	50% coinsurance after \$1,200 deductible; limit 50 visits annually	50% coinsurance; limit 50 visits annually
Outpatient Substance Abuse (does not apply towards OPM)	10% coinsurance for University providers; otherwise 50% for non University providers; (combined with mental health)	10% coinsurance; pre-approval required for benefits to be paid; 50% for out of network providers (combined with mental health)	10% Coinsurance after \$1,200 deductible	20% coinsurance

**Iowa State University  
Health Insurance Monthly Rates  
Calendar Year 2005**

	<b>SINGLE</b>	<b>EMPLOYEE WITH SPOUSE</b>	<b>EMPLOYEE WITH CHILDREN</b>	<b>FAMILY</b>
Indemnity	\$405	\$928	\$726	\$1,185
PPO	\$319	\$731	\$570	\$935
HMO	\$287	\$658	\$515	\$838
ISU Contribution	\$308	\$541	\$445	\$722
Opt-out	\$75	\$75	\$75	\$75

**Iowa State University  
Health Plan Contracts  
September 2004**

<b>ISU Plans</b>	Single	Family	Employee Children	Employee Spouse	Total in Plan	% in Plan
Indemnity	118	75	9	57	259	6.8%
PPO	788	797	142	340	2,067	54.1%
HMO	509	714	109	161	1,493	39.1%
<b>Total ISU Plans</b>	<b>3,819</b>					

## ISU PLAN MEDICAL PLANS 2005

**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	INDEMNITY	PPO		HMO
		PPO In Network	PPO Out-of-Network	
Deductible	\$300/contract	\$0	\$300/contract	\$0
Coinsurance	20% of Maximum Allowable Fee	10% of billed charge	20% of Maximum Allowable Fee, after deductible	0%
Office visit copays	\$0	\$10 copay	\$0	\$0
Out-of-pocket Maximum	\$1500/contract/year and separate Rx of \$1500.	\$1500/contract/year and separate Rx of \$1500.	\$1500/contract/year and separate Rx of \$1500	None
Lifetime maximum benefit	None	None	None	None
Preapproval of inpatient admissions	Required	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	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%	Voluntary-paid at 100%	Directed by PCP
Outpatient surgery	Mandatory for certain procedures	Mandatory for certain procedures	Mandatory for certain procedures	Directed by PCP-preauthorization required
Benefits from non-participating providers	80% coverage to MAF (maximum allowable fee) after deductible	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	Up to age 19, or no age limit if unmarried and a full-time student or disabled

PLAN PROVISIONS	INDEMNITY	PPO		HMO
		PPO In Network	PPO Out-of-Network	
<b>PHYSICIAN SERVICES</b>				
Office visits	80% coverage to MAF (maximum allowable fee) after deductible	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	80% coverage to \$500 maximum after deductible	100% coverage after \$10 copay	Not covered	100% coverage - PCP
Well child care	80% coverage through age 6 after deductible	100% coverage after \$10 copay	80% coverage to MAF (maximum allowable fee) after deductible	100% coverage - PCP
X-ray and lab	80% coverage after deductible	90% coverage	80% coverage after deductible	100% coverage - directed by PCP
Routine eye exam	Covered at 80% after deductible, except refraction, one per calendar year	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	80% coverage after deductible, one per calendar year	90% coverage, one per calendar year	Not covered	Not covered
Maternity	80% coverage after deductible, preadmission approval required for planned C-section	90% coverage	80% coverage after deductible	100% coverage - directed by PCP
Contraceptive other than prescription	80% coverage after deductible	90% coverage	80% coverage after deductible	100% coverage - directed by PCP
<b>PREVENTATIVE SERVICES</b>				
Allergy testing, CT scan, EEG, EKG, ECG, Holter monitoring, Pathology tests, Stress tests, Ultrasound, X-ray	80% coverage after deductible	90% coverage	Not covered	100% coverage - directed by PCP
Routine pap smears, routine mammography	80% coverage after deductible, one per calendar year	90% coverage	80% coverage after deductible for mammography only, one per calendar year	100% coverage - directed by PCP

PLAN PROVISIONS	INDEMNITY	PPO		HMO
		PPO In Network	PPO Out-of-Network	
<b>INPATIENT SERVICES</b>				
Room and board	80% coverage after deductible, preadmission approval required	90% coverage, preadmission approval required	80% coverage after deductible, preadmission approval required	100% coverage - directed by PCP, preauthorization required
Physician services	80% coverage after deductible	90% coverage	80% coverage after deductible	100% coverage - directed by PCP, preauthorization required
Inpatient surgery	80% coverage after deductible; preadmission approval and prior approval required for certain procedures	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	80% coverage after deductible	90% coverage	80% coverage after deductible	100% coverage - directed by PCP
<b>MENTAL/NERVOUS/SUBSTANCE ABUSE</b>				
Inpatient hospital room and board	80% coverage after deductible; preadmission approval required	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	80% coverage after deductible	90% coverage	80% coverage after deductible	100% coverage - limited to 30 days per year, preauthorization required
Outpatient	80% coverage, after deductible pretreatment review required	\$10 per visit copay then 90% coverage, pretreatment review required	80% coverage after deductible pretreatment review required	100% coverage - limited to 20 days per year, pretreatment review required
<b>MISCELLANEOUS SERVICES</b>				
Accupuncture	Not covered	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	80% coverage , prior approval for some treatment	90% coverage, prior approval for some treatment	80% coverage after deductible, prior approval for some treatment	100% coverage - directed by PCP
Ambulance	80% coverage after deductible	90% coverage	80% coverage after deductible	100% coverage - directed by PCP medically necessary
Blood, blood plasma, blood serum	80% coverage after deductible	90% coverage	80% coverage after deductible	100% coverage - directed by PCP

PLAN PROVISIONS	INDEMNITY	PPO		HMO
		PPO In Network	PPO Out-of-Network	
Chiropractic care	80% coverage after deductible	\$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	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	80% coverage, covers repairs to jaw damage and sound natural teeth, treatment must begin and be completed within 6 months of accident	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	80% coverage after deductible	90% coverage	80% coverage after deductible	100% coverage - directed by PCP, preauthorization required
Emergency room care	80% coverage after deductible	\$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	Not Covered
Hearing aids	Not Covered	Not Covered	Not Covered	Not Covered
Hemodialysis	80% coverage after deductible	90% coverage	80% coverage after deductible	100% coverage - directed by PCP
Home health care	80% coverage after deductible, preauthorization required	90% coverage, preauthorization required	80% coverage after deductible, preauthorization required	100% coverage - directed by PCP preauthorization required
Hospice care	80% coverage after deductible, preauthorization required	90% coverage; preauthorization required	80% coverage after deductible, preauthorization required	100% coverage - directed by PCP preauthorization required
Immunizations	80% coverage after deductible	90% coverage	80% coverage after deductible	100% coverage - directed by PCP
Infertility treatment	80% coverage after deductible, lifetime maximum \$15,000 per person	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

PLAN PROVISIONS	INDEMNITY	PPO		HMO
		PPO In Network	PPO Out-of-Network	
Outpatient chemotherapy	80% coverage after deductible	90% coverage	80% coverage after deductible	100% coverage - directed by PCP
Physical Therapy	80% coverage after deductible	90% coverage	80% coverage after deductible	100% coverage - directed by PCP, 20 visits per person per year
Skilled nursing facility	90% coverage after deductible, preauthorization required	90% coverage, preauthorization required	80% coverage after deductible, preauthorization required	100% coverage - directed by PCP preauthorization required
Speech, occupational and respiratory therapy	80% coverage after deductible, prior approval for some treatment.	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)	80% coverage after deductible, preauthorization required.	90% coverage, preauthorization required.	90% coverage after deductible, preauthorization required.	100% coverage - directed by PCP, preauthorization required.

**University of Northern Iowa  
Health Insurance Rates  
Fiscal Year 2005**

	<b>UNIVERSITY PLAN</b>	<b>UNI BLUE ADVANTAGE</b>
SINGLE	\$387.00	\$368.75
Employer	\$387.00	\$368.75
Employee	0	0
FAMILY	\$1,010.00	\$921.88
Employer (unit faculty)	\$757.50	n/a
Employer (P&S, nonunit fac.)	\$808.00	\$737.50
Employee (unit faculty)	\$252.00	n/a
Employee (P&S nonunit fac.)	\$202.00	\$184.38

**University of Northern Iowa  
Health Plan Contracts  
September 2004**

<b>UNI Plans</b>	Single	Family	Employee Children	Employee Spouse	Total in Plan	% in Plan
Indemnity	629	710	n/a	n/a	1,339	94.4%
Blue Advantage	43	36	n/a	n/a	79	5.6%
<b>Total UNI Plans</b>	1,418					

**University of Northern Iowa  
Summary of the Health Insurance Programs**

<b>UNI Health - Wellmark Blue Cross/Blue Shield (Indemnity Plan)</b>	
<i>Inpatient Coverage</i>	Deductible - first two days room and board charges 90% of UCR
<i>Outpatient Coverage</i>	90% of UCR - no deductible or copayment
<i>Other Covered Services</i>	Prescription drugs, Physical therapy, Ambulance Deductible - \$100 per year per contract Coverage - 90% of UCR
<i>Nervous/Mental, Drug/Alcohol Abuse Services</i>	Outpatient - 50% coverage to 34 visits per calendar year Inpatient - Inpatient benefits up to maximum of 45 days per person per year.
<i>Maximum Out of Pocket</i>	\$500 per contract per year

<b>UNI Blue Advantage (HMO)</b> Requires designation of Primary Care Physician (PCP) from the Blue Advantage Network	
<i>Inpatient Coverage</i>	90% in-network facility
<i>Outpatient Coverage</i>	Provided by PCP, with referral from PCP or self-referred when allowed
<i>Office visits</i>	100% after \$10 copayment
<i>Preventive Care</i>	100%
<i>Routine eye exams</i>	100% after \$10 copayment
<i>Chiropractic care</i>	100% after \$10 copayment to maximum of 12 per year
<i>Nervous/Mental, Drug/Alcohol Abuse Services</i>	Outpatient - Maximum 34 visits per person per calendar year Inpatient - Maximum 45 days per person per calendar year
<i>Prescription Drugs</i>	\$5 copayment for generic drugs, \$10 copayment for others
<i>Other Covered Service</i>	90% coverage
<i>Maximum Out of Pocket</i>	Single Contract - \$500 per year Family Contract - \$1,000 per year
<i>Maximum Benefits</i>	\$2,000,000 per person per lifetime