

Utah State University

Plan Design Options for 2007-2008

Note: "Participating" means preferred in-network facility or physician; "Non-Participating" means non-preferred out-of-network facility or physician.

	White Plan		Blue Plan	
	Participating	Non-Participating	Participating	Non-Participating
GENERAL INFORMATION				
Coinsurance Max	\$3,000/\$6,000	\$4,000/\$8,000	\$2,500/\$5,000	\$3,400/\$6,800
Maximum Benefit	\$2,000,000		\$2,000,000	
First Dollar Deductibles	\$750/\$1,500 (Ded does not apply to coinsurance max)	\$1,500/\$3,000 (Ded does not apply to coinsurance max)	\$250/\$500 (Ded does not apply to coinsurance max)	\$500/\$1,000 (Ded does not apply to coinsurance max)
Prescription Drugs	You pay \$5 Generic; 35% Formulary Brand; 50% Non-Formulary Brand.		You pay \$5 Generic; 35% Formulary Brand; 50% Non-Formulary Brand.	
	<i>Coinsurance applies to the separate prescription coinsurance maximum of \$1500 per year.</i>		<i>Coinsurance applies to the separate prescription coinsurance maximum of \$1250 per year</i>	
Preexisting Condition Limitation	First 8 months of coverage for newly eligible employees		First 8 months of coverage for newly eligible employees	
PREVENTIVE				
Routine Physical Exams	After ded, you pay \$35/visit; limited to one exam per member (\$500/year max benefit)	Not covered	After ded, you pay \$30/visit; limited to one exam per member (\$500/year max benefit)	Not covered
Routine Hearing	After ded, you pay \$35/visit; limited to one per member	Not covered	After ded, you pay \$30/visit; limited to one per member	Not covered
Routine Vision	After ded, you pay \$35/visit; limited to one per member	Not covered	After ded, you pay \$30/visit; limited to one per member	Not covered
Routine Well Baby - up to age 5	After ded, you pay \$35/visit; includes childhood immunizations up to age 18	Not covered	After ded, you pay \$30/visit; includes childhood immunizations up to age 18	Not covered
ACCIDENT BENEFITS				
Ortho due to Accident	After ded, you pay 50%. Does not apply to coinsurance max.		After ded, you pay 50%. Does not apply to coinsurance max.	

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Dental due to Accident	After ded, You pay 50%	After ded, Plan pays 50% of EME	After ded, You pay 50%	After ded, Plan pays 50% of EME
Maximum Benefit for Ortho or Dental due to Accident	Limited to \$1,000 per member per year		Limited to \$1,000 per member per year	
PHYSICIAN AND PROFE				
Office Visits	After ded, You pay \$35; \$40 after hours	After ded, Plan pays 60% of EME	After ded, You pay \$30; \$35 after hours	After ded, Plan pays 70% of EME
Inpatient Physician Visits	After ded, you pay 30% of EME	After ded, Plan pays 60% of EME	After ded, You pay 20% of EME	After ded, Plan pays 70% of EME
Emergency Department	After ded, you pay \$250 per visit.	After ded and \$400, Plan pays 100%	After ded, you pay \$200 per visit.	After ded and \$300, Plan pays 100%
Routine Pre-Natal & Delivery	After ded, you pay onetime \$35 copay then 30% of EME	After ded, Plan pays 60% of EME	After ded, You pay onetime \$30 copay then 20% of EME	After ded, Plan pays 70% of EME
Surgical Expenses	After ded, you pay 30% of EME	After ded, Plan pays 60% of EME	After ded, You pay 20% of EME	After ded, Plan pays 70% of EME
Anesthesia Expenses	After ded, you pay 30% of EME	After ded, Plan pays 60% of EME	After ded, You pay 20% of EME	After ded, Plan pays 70% of EME
Ambulance	After ded, you pay 30% of EME	After ded, Plan pays 70% of billed charges	After ded, You pay 20% of EME	After ded, Plan pays 70% of billed charges
Major Diagnostic Testing	After ded, you pay \$250	After ded, Plan pays 60% of EME	After ded, You pay \$200	After ded, Plan pays 70% of EME
Home Health Care	After ded and \$35 per visit, you pay 30%	After ded, Plan pays 60% of EME	After ded and \$30 per visit, you pay 20% of EME	After ded, Plan pays 70% of EME
Physical and Occupational Therapy	After ded, you pay \$35 per visit	After ded, Plan pays 60% of EME	After ded, You pay \$30 per visit	After ded, Plan pays 70% of EME
	<i>Limited to 20 visits per member per year</i>		<i>Limited to 20 visits per member per year</i>	
Chiropractic	After ded, you pay \$35 per visit	After ded, Plan pays 50% of EME. Does not apply toward coins max	After ded, You pay \$30 per visit	After ded, Plan pays 50% of EME. Does not apply toward coins max
	<i>Limited to 20 visits per member per year</i>		<i>Limited to 20 visits per member per year</i>	
Allergy Serum	After ded, you pay \$250 per member per year	After ded, Plan pays 60% of EME	After ded, You pay \$200 per member per year	After ded, Plan pays 70% of EME
Growth Hormones	After ded, you pay 30% of EME.	After ded, Plan pays 70% of billed charges	After ded, You pay 20% of EME	After ded, Plan pays 80% of billed charges
	\$25,000 per member maximum per plan year		\$25,000 per member maximum per plan year	
HOSPITAL / FACILITY BENEFITS				
Inpatient & Ancillary	After ded, you pay 30% of EME plus a \$250 copay per member per year	After ded and \$250 copay, Plan pays 60% of EME	After ded, You pay 20% of EME after \$200 copay per member per year	After ded and \$200 copay, Plan pays 70% of EME
Extended Care Facility	After ded, you pay 30% of EME	After ded, Plan pays 60% of EME	After ded, You pay 20% of EME	After ded, Plan pays 70% of EME

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	<i>Limited to 60 days per member per year</i>		<i>Limited to 60 days per member per year</i>	
Outpatient Surgery/Facility	After ded, you pay 30% of EME after \$250 copayment per member per year	After ded, Plan pays 60% of EME after you pay \$400 copayment	After ded, You pay 20% of EME after \$200 copayment per member per year	After ded, Plan pays 70% of EME after you pay \$300 copayment
SOLID ORGAN AND BONE MARROW TRANSPLANTS AND MYELOABLATIVE THERAPY				
Solid organ and bone marrow transplants	Covered as any other; subject to certain limitations		Covered as any other; subject to certain limitations	
Myeloablative Therapy	Covered as any other; subject to certain limitations		Covered as any other; subject to certain limitations	
OTHER MEDICAL SERVICES AND SUPPLIES				
Medical & Surgical Supplies	After ded, you pay 30%		After ded, You pay 20%	
Durable Medical	After ded, you pay 30%	After ded, Plan pays 60% of EME	After ded, You pay 20%	After ded, Plan pays 70% of EME
Orthotic Devices	After ded, you pay 30%	After ded, Plan pays 60% of EME	After ded, You pay 20%	After ded, Plan pays 70% of EME
Orthotic Devices for the feet	After ded, you pay 30%	After ded, Plan pays 60% of EME	After ded, You pay 20%	After ded, Plan pays 70% of EME
Prosthetic Devices	After ded, you pay 30%	After ded, Plan pays 60% of EME	After ded, You pay 20%	After ded, Plan pays 70% of EME
Replacements of Prosthetics, Orthotic or DME.	Paid according to applicable category above		Paid according to applicable category above	
MENTAL HEALTH & SUBSTANCE ABUSE SERVICES				
Inpatient Facility (Pre-notification required)	After ded, you pay 30% after \$250 copay per admission	After ded, Plan pays 50% of EME. Does not apply toward coins max	After ded, You pay 20% after \$200 copay per admission	After ded, Plan pays 50% of EME. Does not apply to coins max
	<i>Limited to 21 days per member per year</i>		<i>Limited to 21 days per member per year</i>	
Inpatient Physician Visits	After ded, you pay 30%	After ded, Plan pays 50% of EME. Does not apply to coins max	After ded, You pay 20%	After ded, Plan pays 50% of EME. Does not apply to coins max
	<i>Limited to 21 visits per member per year; 1 visit per day</i>		<i>Limited to 21 visits per member per year; 1 visit per day</i>	
Outpatient Treatment	After ded, you pay \$50 per visit with a psychiatrist; \$25 per visit with any other licensed mental health therapist.	After ded, Plan pays 50% of EME. Do not apply to coins max	After ded, You pay \$50 per visit with a psychiatrist; \$25 per visit with any other licensed mental health therapist.	After ded, Plan pays 50% of EME. Do not apply to coins max
	<i>Limited to 20 visits per member per year; 1 visit per day.</i>		<i>Limited to 20 visits per member per year; 1 visit per day.</i>	

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DaySpring Treatment (Drug/Alcohol Use or Abuse Treatment Program)	After ded, you pay 30%; Plan's payment limited to \$4,400 per member per year.	Not covered	After ded, You pay 20%; Plan's payment limited to \$4,400 per member per year	Not covered
LIMITED BENEFITS - Do not apply to coinsurance maximum				
Orthognathic Procedures	After ded, You pay 50%	After ded, Plan pays 50% of EME	After ded, You pay 50%	After ded, Plan pays 50% of EME
Diagnosis and Treatment of TMJ	After ded, You pay 50%	After ded, Plan pays 50% of EME	After ded, You pay 50%	After ded, Plan pays 50% of EME
	<i>Limited to \$500 lifetime per claimant</i>		<i>Limited to \$500 lifetime per claimant</i>	
Pain Clinics	After ded, You pay 50%	After ded, Plan pays 50% of EME	After ded, You pay 50%	After ded, Plan pays 50% of EME
Primary Infertility	After ded, You pay 50%; limited to \$2000 lifetime per claimant, not to exceed 4 visits	Not covered	After ded, You pay 50%; limited to \$2000 lifetime per claimant, not to exceed 4 visits	Not covered
Adoption Benefit	Plan pays up to \$4,000 of medical and/or legal adoption expenses per child.		Plan pays up to \$4,000 of medical and/or legal adoption expenses per child.	
Hospice Care (Prenotification Required)	After ded, you pay 30%	After ded, Plan pays 60% of EME	After ded, You pay 20%	After ded, Plan pays 80% of EME (not subject to deductible)
	<i>Limited to \$5,000 per member per lifetime</i>		<i>Limited to \$5,000 per member per lifetime</i>	

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