

Utah State University

Plan Design Options for 2008-2009

Updated 8/7/2008

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

	White Plan		Blue Plan		High Deductible Choice Plan	
	Participating	Non-Participating	Participating	Non-Participating	Participating	Non-Participating
GENERAL INFORMATION						
Coinsurance Max (White & Blue) / Out-of-Pocket Max (HDHP)	\$3,000/\$6,000	\$4,000/\$8,000	\$2,500/\$5,000	\$3,400/\$6,800	\$5,000 Single or \$10,000 Family (see note)	\$10,000 Single or \$20,000 Family (see note)
Maximum Benefit	\$2,000,000		\$2,000,000		\$2,000,000	
First Dollar Deductibles	\$750/\$1,500 (Ded does NOT apply toward the coinsurance max)	\$1,500/\$3,000 (Ded does NOT apply toward the coinsurance max)	\$250/\$500 (Ded does NOT apply toward the coinsurance max)	\$500/\$1,000 (Ded does NOT apply toward the coinsurance max)	\$1,500 Single or \$3,000 Family (see note) (Deductible DOES apply toward the out-of-pocket maximum)	\$3,000 Single or \$6,000 Family (see note) (Deductible DOES apply toward the out-of-pocket maximum)
					Note: The deductible and coinsurance maximum work differently in this high deductible health plan (HDHP) than in the White and Blue plans. If you elect 2-party or family coverage, the full family deductible must be satisfied before any other benefits, other than preventive, will be paid. Also, the full family coinsurance maximum must be satisfied before the Plan pays at 100%. In other words, the single deductible and single coinsurance maximum should be completely ignored if you have 2-party or family coverage.	
Prescription Drugs	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>		You pay \$5 Generic; 35% Formulary Brand; 50% Non-Formulary Brand. <i>Coinsurance applies to the separate prescription coinsurance maximum of \$1250 per year</i>		After the deductible, You pay 20%.	
Preexisting Condition Limitation	First 8 months of coverage for newly eligible employees		First 8 months of coverage for newly eligible employees		First 8 months of coverage for newly eligible employees	
PREVENTIVE						
Routine Physical Exams	You pay \$35 copay per visit, then Plan pays 100% to a maximum of \$500 per member per year. Deductible waived.	Not covered	You pay \$30 copay per visit, then Plan pays 100% to a maximum of \$500 per member per year. Deductible waived.	Not covered	You pay \$35 copay per visit, then Plan pays 100% to a maximum of \$500 per member per year. Deductible waived.	Not covered
Routine Hearing		Not covered		Not covered		Not covered
Routine Vision		Not covered		Not covered		Not covered
Limited Screening Procedures (refer to your SPD booklet under "Preventive Care Services")	You pay \$35 per visit, then Plan pays 100% per member per year. Deductible waived.	Not covered	You pay \$30 per visit, then Plan pays 100% per member per year. Deductible waived.	Not covered	You pay \$35 per visit, then Plan pays 100% per member per year. Deductible waived.	Not covered
Routine Well Baby - up to age 5, and immunizations up to age 18	You pay \$35 copay per visit, then Plan pays 100%. No cap. Deductible waived.	Not covered	You pay \$30 copay per visit, then Plan pays 100%. No cap. Deductible waived.	Not covered	You pay \$35 copay per visit, then Plan pays 100%. No cap. Deductible waived.	Not covered

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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.		After ded, you pay 50%.	
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	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		Limited to \$1,000 per member per year	
PHYSICIAN AND PROFESSIONAL BENEFITS						
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	After ded, You pay 20% of EME	After ded, Plan pays 60% 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	After ded, You pay 20% of EME	After ded, Plan pays 60% 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%	After ded, You pay 20% of EME	After ded, Plan pays 60% of EME
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	After ded, You pay 20% of EME	After ded, Plan pays 60% 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	After ded, You pay 20% of EME	After ded, Plan pays 60% 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	After ded, You pay 20% of EME	After ded, Plan pays 60% 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	After ded, You pay 20% of EME	After ded, Plan pays 60% of EME
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	After ded, You pay 20% of EME	After ded, Plan pays 60% 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%	After ded, Plan pays 70% of EME	After ded, You pay 20% of EME	After ded, Plan pays 60% of EME
Physical and Occupational Therapy	After ded, you pay \$35 per visit <i>Limited to 20 visits per member per year</i>	After ded, Plan pays 60% of EME	After ded, You pay \$30 per visit <i>Limited to 20 visits per member per year</i>	After ded, Plan pays 70% of EME	After ded, You pay 20% of EME <i>Limited to 20 visits per member per year</i>	After ded, Plan pays 60% of EME <i>Limited to 20 visits per member per year</i>
Chiropractic	After ded, you pay \$35 per visit <i>Limited to 20 visits per member per year</i>	After ded, Plan pays 50% of EME. Does not apply toward coins max	After ded, You pay \$30 per visit <i>Limited to 20 visits per member per year</i>	After ded, Plan pays 50% of EME. Does not apply toward coins max	After ded, You pay 20% of EME <i>Limited to 20 visits per member per year</i>	After ded, Plan pays 60% of EME <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	After ded, You pay 20% of EME	After ded, Plan pays 60% of EME
Growth Hormones	After ded, you pay 30% of EME. <i>\$25,000 per member maximum per plan year</i>	After ded, Plan pays 70% of billed charges	After ded, You pay 20% of EME <i>\$25,000 per member maximum per plan year</i>	After ded, Plan pays 80% of billed charges	After ded, You pay 20% of EME <i>\$25,000 per member maximum per plan year</i>	After ded, Plan pays 60% of EME <i>\$25,000 per member maximum per plan year</i>
HOSPITAL / FACILITY BENEFITS						
Inpatient & Ancillary	After ded, you pay 30% of EME plus a \$250 copay per admission	After ded and \$250 copay, Plan pays 60% of EME	After ded, You pay 20% of EME after \$200 copay per admission	After ded and \$200 copay, Plan pays 70% of EME	After ded, You pay 20% of EME	After ded, Plan pays 60% of EME
Extended Care Facility	After ded, you pay 30% of EME <i>Limited to 60 days per member per year</i>	After ded, Plan pays 60% of EME	After ded, You pay 20% of EME <i>Limited to 60 days per member per year</i>	After ded, Plan pays 70% of EME	After ded, You pay 20% of EME <i>Limited to 60 days per member per year</i>	After ded, Plan pays 60% of EME <i>Limited to 60 days per member per year</i>

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Outpatient Surgery/Facility	After ded and \$250 copayment per member per visit, Plan pays 100%	After ded, Plan pays 60% of EME after you pay \$400 copayment	After ded and \$200 copayment per member per visit, Plan pays 100%	After ded, Plan pays 70% of EME after you pay \$300 copayment	After ded, You pay 20% of EME	After ded, Plan pays 60% of EME
Hospice Care (Prenotification Required)	After ded, you pay 30% <i>Limited to \$5,000 per member per lifetime</i>	After ded, Plan pays 60% of EME	After ded, You pay 20% <i>Limited to \$5,000 per member per lifetime</i>	After ded, Plan pays 80% of EME	After ded, You pay 20% <i>Limited to \$5,000 per member per lifetime</i>	After ded, Plan pays 60% of EME
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		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		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%		After ded, You pay 20% of EME	After ded, Plan pays 60% of EME
Durable Medical	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	After ded, You pay 20% of EME	After ded, Plan pays 60% of EME
Orthotic Devices for the feet	After ded, you pay 30% of EME. Limited to \$200 per claimant per year. Over-the-counter orthotics excluded.	After ded, Plan pays 60% of EME	After ded, You pay 20% of EME. Limited to \$200 per claimant per year. Over-the-counter orthotics excluded.	After ded, Plan pays 70% of EME	After ded, You pay 20% of EME. Limited to \$200 per claimant per year. Over-the-counter orthotics excluded.	After ded, Plan pays 60% of EME
Prosthetic Devices	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	After ded, You pay 20% of EME	After ded, Plan pays 60% of EME
Replacements of Prosthetics, Orthotic or	Paid according to applicable category above		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 <i>Limited to 21 days per member per year</i>	After ded, Plan pays 50% of EME. Does not apply toward coins max	After ded, You pay 20% after \$200 copay per admission <i>Limited to 21 days per member per year</i>	After ded, Plan pays 50% of EME. Does not apply to coins max	After ded, You pay 20% of EME <i>Limited to 21 days per member per year</i>	After ded, Plan pays 60% of EME
Inpatient Physician Visits	After ded, you pay 30% <i>Limited to 21 visits per member per year; 1 visit per day</i>	After ded, Plan pays 50% of EME. Does not apply to coins max	After ded, You pay 20% <i>Limited to 21 visits per member per year; 1 visit per day</i>	After ded, Plan pays 50% of EME. Does not apply to coins max	After ded, You pay 20% of EME <i>Limited to 21 visits per member per year; 1 visit per day</i>	After ded, Plan pays 60% of EME
Outpatient Treatment	After ded, you pay \$50 per visit with a psychiatrist; \$35 per visit with any other licensed mental health therapist. <i>Limited to 20 visits per member per year; 1 visit per day.</i>	After ded, Plan pays 50% of EME. Do not apply to coins max	After ded, You pay \$50 per visit with a psychiatrist; \$30 per visit with any other licensed mental health therapist. <i>Limited to 20 visits per member per year; 1 visit per day.</i>	After ded, Plan pays 50% of EME. Do not apply to coins max	After ded, You pay 20% of EME <i>Limited to 20 visits per member per year; 1 visit per day.</i>	After ded, Plan pays 60% of EME
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	After ded, You pay 20% of EME	Not covered

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LIMITED BENEFITS - Do not apply to coinsurance maximum					Does apply toward coinsurance maximum on HDHP Plan.	
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	After ded, You pay 50%	After ded, Plan pays 50% of EME
Diagnosis and Treatment of TMJ	After ded, You pay 50% <i>Limited to \$500 lifetime per claimant</i>	After ded, Plan pays 50% of EME	After ded, You pay 50% <i>Limited to \$500 lifetime per claimant</i>	After ded, Plan pays 50% of EME	After ded, You pay 50% <i>Limited to \$500 lifetime per claimant</i>	After ded, Plan pays 50% of EME
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	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	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.		Plan pays up to \$4,000 of medical and/or legal adoption expenses per child.	

EME = Eligible Medical Expenses

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