HEALTH BENEFIT COMPARISON

This comparison is ONLY a summary of benefits. Benefits will be administered as described in each plan's subscriber agreement or plan document. For further detail, refer to those documents or call the insurance carrier or MCO.

PLAN PROVISIONS	[1]IOWA SELECT (WELLMARK)	[2]AMERICHOICE ***hawk-i***	[3]ClassicBlue ***hawk-i*** BlueRx™Preferred BlueDental	[4] TITLEXIX MEDICAID/EPSDT	[5]Blue Access ***hawk-i*** BlueRx™Preferred BlueDental
Deductible Single/Family	*Select provider—* $250/$500. Applies to both Inpatient and outpatient Services. Waived for services provided in office/clinic setting of Select provider. *Non-Select provider—* $250/$500. Applies to both Inpatient and outpatient Services.	Eligibility Determination	Eligibility Determination	Not applicable	Eligibility Determination
Coinsurance Percentage	*Select provider—* 10% of maximum allowable fee, In most cases. *Non-Select provider—* 20% of maximum allowable fee, In most cases	Eligibility Determination	Eligibility Determination	Not applicable	Eligibility Determination
Out-of-Pocket Limit Single/Family	*Select and Non-Select provider—* $600/$800. Applies to services provided both in-and out-of-network. All deductibles, coinsurance, and copayments, except $15 office visit copayment, go toward Out-of-Pocket Limit. Emergency Room Copayment contineues to apply after Out-of-Pocket Limit is met. Separate $250/$500 Out-of-Pocket Limit for prescription drugs. Does not apply to medical Out-of-Pocket Limit.	Eligibility Determination	Eligibility Determination	Not applicable	Eligibility Determination
Benefits Available from Non-Participating Providers	*Select provider—* Normal Plan benefits for Select providers. *Non-Select provider—* Normal Plan benefits for non-Select providers.	Covered benefits in the case of a Medical Emergency or Preauthorized Referral	Settlement amounts will be based on the lesser of the maximum allowable fee or the covered charge. Member is liable for any difference between the billed charge and settlement amount. Emergency services will be reimbursed as though the services were received from a participating provider, subject to certain restrictions..		Settlement amounts will be based on the lesser of the maximum allowable fee or the covered charge. Member is liable for any difference between the billed charge and settlement amount. Emergency services will be reimbursed as though the services were received from a participating provider, subject to certain restrictions..
Large Case Management	*Select and Non-Select provider—* Alternative care set up on a Case by case basis by Plan.		*Select provider—* Alternative care set up on a Case by case basis by Plan.		*Select provider—* Alternative care set up on a Case by case basis by Plan.
Lifetime Benefit Maximum	*Select and Non-Select provider—* None	$1,000,000.00	$1,000,000.00 and includes maximums for the following services: 15 days of inpatient hospice respite care. 15 days of outpatient hospice respite care. Respite care must be used in increments of not more than 5 days at a time.		$1,000,000.00 and includes maximums for the following services: 15 days of inpatient hospice respite care. 15 days of outpatient hospice respite care. Respite care must be used in increments of not more than 5 days at a time.
Outpatient Surgery Setting	*Select provider—* Required for certain Procedures. Select provider obtains approval. *Non-Select provider—* Required for certain procedures. Paid according to normal plan benefits when procedure done on an outpatient basis. 50% benefit reduction on all associated hospital and surgical services for noncompliance.	*Participating provider—* Covered with preauthorization	*Participating provider—* Covered. Specified surgical procedures require prior approval.	Covered. Specified surgical procedures require prior approval.	*Participating provider—* Covered. Specified surgical procedures require prior approval.

[1] Iowa Department of Administrative Services Health Insurance Benefits, "Health Benefit Comparison" http://das.hre.iowa.gov/pdfs/Benefits/health_compare.pdf
[2] AMERICHOICE ***hawk-i*** Coverage Contract issued by UnitedHealthcare Plan of the River Valley, Inc., HMO IA HAWKIEOC 0906
[3] Wellmark BlueCross Blue Shield of Iowa Classic**Blue** ***hawk-i*** Benefits Policy, 10/19/2006
[4] The Kaiser Commission on Medicaid and the Uninsured, Medicaid Benefits: Online Database, "Benefits by State Iowa (October 2004)" http://www.kff.org/medicaid/benefits/
[5] Wellmark BlueCross Blue Shield of Iowa **Blue**Access ***hawk-i*** Benefits Policy, 10/19/2006

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Preapproval of Inpatient Admissions	*Select and Non-Select provider—* Required	*Participating provider—* Notification by provider to HMO on admission	*Participating provider—* Required	Prior Approval is required on all non-emergency admissions, including dental and excluding maternity.	*Participating provider—* Required
New Employee Preexisting Condition Waiting Period	*Select and Non-Select provider—* 11 months		Not applicable	Not applicable	Not applicable
Second Surgical Opinion	*Select and Non-Select provider—* Voluntary. Paid according to normal Plan benefits.		*Participating provider—* Covered		*Participating provider—* Covered
PHYSICIAN SERVICES					
Office Calls	*Select and Non-Select provider—* $15 copayment once per date of service for exam only;no coinsurance, no deductibe. copayment does not apply to Out-of-Pocket Limit. *Select provider—* 10% coinsurance, deductible waived in office setting for other office services. *Non-Select provider—* 20% coinsurance, after deductible For other office services.	*Participating provider—* Covered	*Participating provider—* Covered	$3/day copayment No copayment charged for children to age 21.	*Participating provider—* Covered
Routine Physicals	*Select provider—* 10%, deductible waived in office setting, excluding travel, employment or athletic related/required. Limited to one physical per Member per year. *Non-Select provider—* 20%, after deductible excluding travel, employment or athletic related/required. Limited to one physical per Member per year.	*Participating Provider—* Covered	*Participating provider—* Covered	Covered	*Participating provider—* Covered
Maternity	*Select provider—* 10%, deductible waived. In office setting for pre-and post-natal visits. *Non-Select provider—* 20% after deductible.	*Participating provider—* Covered	*Participating provider—* Covered including prenatal and postnatal care, complications, and delivery. In accordance with federal or applicable state law, maternity services include: A minimum of 48 hours of inpatient care following a vaginal delivery, in addition to the day of delivery A minimum of 96 hours of inpatient care following a C section, in addition to the day of delivery Medicaid determination must be made at first validation of pregnancy.	Covered	*Participating provider—* Covered including prenatal and postnatal care, complications, and delivery. In accordance with federal or applicable state law, maternity services include: A minimum of 48 hours of inpatient care following a vaginal delivery, in addition to the day of delivery A minimum of 96 hours of inpatient care following a C section, in addition to the day of delivery Medicaid determination must be made at first validation of pregnancy.
Routine Eye Exams	*Select provider—* 10% deductible waived. limited to one exam per Member per year. *Non-Select provider—* 20% deductible waived. limited to one exam per Member per year.	*Participating provider—* Medical eye exams (excluding refractions) are covered. Limited to one exam per year. Exception for referral from Optometrist to Ophthalmologist within 60 days or first visit.	*Participating provider—* Covered annually up to $50.	$2/day copayment No copayment charged for children to age 21.	*Participating provider—* Covered annually up to $50.
Routine Hearing Exams	*Select provider—* 10% deductible waived. limited to one exam per Member per year. *Non-Select provider—* 20% deductible waived. limited to one exam per Member per year.	*Participating provider—* Limited to no more than 1 audiometric examination, and 1 hearing aid evaluation test per 36 month period	*Participating provider—* Covered	Covered	*Participating provider—* Covered
Well Child Care	*Select provider—* 10% to 7 years. Deductible Waived in office setting. *Non-Select provider—* 20% to 7 years. No deductible.	*Participating provider—* Covered to age 7 years	*Participating provider—* Until the child reaches age 7. Well-child care includes such services as normal newborn care, physical examinations, developmental assessments, immunizations and laboratory services.	Covered as EPSDT Care for Kids guidelines require	*Participating provider—* Until the child reaches age 7. Well-child care includes such services as normal newborn care, physical examinations, developmental assessments, immunizations and laboratory services.

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HOSPITAL SERVICES					
Room & Board	*Select provider—* 10%, after deductible. No limit on medical surgical days. Pre-certification of admission required by Select provider. *Non-Select provider—* 20%, after deductible. No limit on medical surgical days. Pre-certification of admission required by member.	*Participating provider—* Covered (semi-private)	*Participating provider—* Covered	Covered Length of Stay is limited to 50th percentile of published guidelines for region	*Participating provider—* Covered
Physician Services	*Select provider—* 10%, after deductible. *Non-Select provider—* 20%, after deductible.	*Participating provider—* Covered	*Participating provider—* Covered	$3/day copayment No copayment charged for children to age 21.	*Participating provider—* Covered
Inpatient Surgery	*Select provider—* 10%, after deductible. Must be approved as inpatient procedure. *Non-Select provider—* 20%, after deductible. Must be approved as inpatient procedure.	*Participating provider—* Covered	*Participating provider—* Covered	Prior Approval required for all non-emergency admissions, including dental and excluding maternity.	*Participating provider—* Covered
Outpatient Surgery	*Select provider—* 10%, after deductible. Required for certain procedures. Approval obtained by Select provider. *Non-Select provider—* 20%, after deductible. Required for certain procedures.	*Participating provider—* Covered	*Participating provider—* Covered	Covered	*Participating provider—* Covered
Inpatient Supplies, Drugs, Medicines, etc.	*Select provider—* 10%, after deductible. *Non-Select provider—* 20%, after deductible.	*Participating provider—* Covered	*Participating provider—* Covered	$2/day copayment No copayment charged for children to age 21.	*Participating provider—* Covered
Inpatient Tests, ICU, Operating Room, Specialized Care, etc.	*Select provider—* 10%, after deductible. *Non-Select provider—* 20%, after deductible.	*Participating provider—* Covered	*Participating provider—* Covered	Covered	*Participating provider—* Covered
MENTAL/NERVOUS					
Inpatient Hospital Room & Board	*Select provider—* 10%, after deductible. Maximum of 60 days per Member per calendar year. Use of mental health network required. *Non-Select provider—* 20%, after deductible. Maximum of 60 days per Member per calendar year. Use of mental health network required.	*Participating provider—* *A selected treatment program provider must authorize all services in advance.* Covered. Maximum 30 inpatient days per calendar year	*Participating provider—* Covered with restrictions and pre-approval. Maximum 30 days hospitalization.	Covered 10 hospital leave days/hospitalization, 30 therapeutic leave days/year	*Participating provider—* Covered with restrictions and pre-approval. Maximum 30 days hospitalization.
Inpatient Physician Care	*Select provider—* 10%, after deductible. Maximum of 60 days per Member per calendar year. Use of mental health network required. *Non-Select provider—* 20%, after deductible. Maximum of 60 days per Member per calendar year. Use of mental health network required.	*Participating provider—* *A selected treatment program provider must authorize all services in advance.* Covered. Maximum 30 inpatient days per calendar year	*Participating provider—* Covered with restrictions and pre-approval.	Covered	*Participating provider—* Covered with restrictions and pre-approval.
Outpatient	*Select provider—* 10%, deductible waived in office setting. Use of mental health network required. *Non-Select provider—* 20%, deductible waived in office setting. Use of mental health network required.	*Participating provider—* *A selected treatment program provider must authorize all services in advance.* Covered. Maximum 20 inpatient days per calendar year	*Participating provider—* Covered with restrictions and pre-approval. Maximum 30 days hospitalization.	Covered with restrictions varying visit limits	*Participating provider—* Covered with restrictions and pre-approval. Maximum 30 days hospitalization.

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SUBSTANCE ABUSE					
Inpatient Hospital Room & Board	*Select provider—* 10%, after deductible. Maximum of 60 days per Member per calendar year. Use of mental health network required. *Non-Select provider—* 20%, after deductible. Maximum of 60 days per Member per calendar year. Use of mental health network required.	*Participating provider—* *A selected treatment program provider must authorize all services in advance.* Covered. Maximum 30 inpatient days per calendar year	*Participating provider—* Covered with restrictions and pre-approval. Maximum 30 days hospitalization.	Prior approval required	*Participating provider—* Covered with restrictions and pre-approval. Maximum 30 days hospitalization.
Inpatient Physician Care	*Select provider—* 10%, after deductible. Maximum of 60 days per Member per calendar year. Use of mental health network required. *Non-Select provider—* 20%, after deductible. Maximum of 60 days per Member per calendar year. Use of mental health network required.	*Participating provider—* *A selected treatment program provider must authorize all services in advance.* Covered. Maximum 30 inpatient days per calendar year	*Participating provider—* Covered with restrictions and pre-approval.	Prior approval required	*Participating provider—* Covered with restrictions and pre-approval.
Outpatient	*Select provider—* 10%, deductible waived in office setting. Use of mental health network required. *Non-Select provider—* 20%, deductible waived in office setting. Use of mental health network required.	*Participating provider—* *A selected treatment program provider must authorize all services in advance.* Covered. Maximum 20 inpatient days per calendar year	*Participating provider—* Covered with restrictions and pre-approval. Maximum 30 days hospitalization.	Covered with varying visit limits and prior approval	*Participating provider—* Covered with restrictions and pre-approval. Maximum 30 days hospitalization.
MISCELLANEOUS SERVICES					
Prescription Drugs	*Select and Non-Select provider—* $4 preferred generic, $15 preferred brand, $30 of non-preferred brand and non-preferred generic $250/$500 Out-of-Pocket Limit (This limit is separate from the Medical Out-of-Pocket Limit.)	*Network Pharmacy—* No Copayment applies if dispenses: generic drug, insulin syringes, Coumadin®, Dilantin®,Lanoxin®, Synthroid®, or Tegretol®, or brand-name med that does ot have an approved generic. *Non-Network—* Full amount at dispensing, copayment plus the difference between the billed charge and HMO's contracted price after reimbursement.	*Participating provider—* Covered if does not exceed maximum quantity of 30 day supply and falls into the following categories: generic drug, certain brand name drugs covered by ***hawk-i,*** or drugs covered under the medical exception process. *Non-participating provider—* May have payment obligations.	Prior approval for specified drugs $1/generic RX, $.50 - $3/brand RX depending on payment No copayment charged for children to age 21.	*Participating provider—* Covered if does not exceed maximum quantity of 30 day supply and falls into the following categories: generic drug, certain brand name drugs covered by ***hawk-i,*** or drugs covered under the medical exception process. *Non-participating provider—* May have payment obligations.
Mail Order Prescription Drugs	*Select and Non-Select provider—* Covered as above for maintenance drugs for up to a 90 day supply for two copayments instead of three.	Not applicable	*Participating provider—* Covered if does not exceed maximum quantity of 30 day supply for non-maintenance prescriptions or 90 day supply for maintenance prescriptions and falls into the following categories: generic drug, certain brand name drugs covered by hawk-I, drugs covered under the medical exception process. *Non-participating provider—* May have payment obligations..		*Participating provider—* Covered if does not exceed maximum quantity of 30 day supply for non-maintenance prescriptions or 90 day supply for maintenance prescriptions and falls into the following categories: generic drug, certain brand name drugs covered by hawk-I, drugs covered under the medical exception process. *Non-participating provider—* May have payment obligations..
Prescription Oral Contraceptives and Contraceptive Devices	*Select and Non-Select provider—* Covered	*Participating provider—* Not covered	*Participating provider—* Covered	Covered	*Participating provider—* Covered
Accidents	*Select provider—* 10%, deductible waived in office setting. *Non-Select provider—* 20%, after deductible. Emergency care covered at In-Network level.	*Participating provider—* Covered	*Participating provider—* Covered	Covered	*Participating provider—* Covered
Allergy Treatment	*Select provider—* 10%, deductible waived in office setting. *Non-Select provider—* 20% after deductible.	*Participating provider—* Covered	*Participating provider—* Covered	Covered	*Participating provider—* Covered
Ambulance	*Select and Non-Select provider—* 20%, after deductible.	*Participating provider—* Covered in a medical emergency	*Participating provider—* Covered	$2/trip copayment No copayment charged for children to age 21.	*Participating provider—* Covered
Blood, Blood Plasma, Blood Serum	*Select provider—* 10%, after deductible *Non-Select provider—* 20%, after deductible	*Participating provider—* Covered	*Participating provider—* Covered	Covered	*Participating provider—* Covered

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Chiropractor	*Select provider—* 10%, deductible waived in office setting. *Non-Select provider—* 20%, after deductible	*Participating provider—* Covered for acute care. Must have a Preauthorized Referral.	*Participating provider—* Covered for acute care.	$1/day limited to Medicare covered services No copayment charged for children to age 21.	*Participating provider—* Covered for acute care.
Dental Accident Care	*Select provider—* 10%, deductible waived in office setting. Limited to services provided within 72 hours of accident. *Non-Select provider—* 20%, after deductible Limited to services provided within 72 hours of accident.	*Participating provider—* Covered with preapproval	*Participating provider—* Must be initiated within 72 hours of the injury. If so, follow up care is covered for up to 30 days.	Covered with prior approval requirement	*Participating provider—* Must be initiated within 72 hours of the injury. If so, follow up care is covered for up to 30 days.
Durable Medical Equipment	*Select provider—* 10%, after deductible *Non-Select provider—* 20%, after deductible	*Participating provider—* Covered	*Participating provider—* Covered with prior approval.	Covered $2/day No copayment charged for children to age 21. Oxygen systems limited to specific medial conditions, medical supplies limited to 3 month supply	*Participating provider—* Covered with prior approval.
Emergency Room	*Select and Non-Select provider—* $50 copayment; waived if admitted. Copayment and co-insurance apply. Copayment applies after Out-of-Pocket Limit is met.	*Participating Provider—* $25 copayment for non-emergent conditions, no copayment for emergency services	*Participating provider—* Covered when condition is an emergency. Non-emergent conditions require $25 copayment.	Covered	*Participating provider—* Covered when condition is an emergency. Non-emergent conditions require $25 copayment.
Eyeglasses	*Select and Non-Select provider—* Not covered.	*Participating provider—* Maximum benefit of $100 one time in 12 months for contact lenses, lenses, and /or frames.	*Participating provider—* Two lenses and 1 frame per benefit period for each enrollee under 19 yeaars of age and limited to $100.	$2/day No copayment charged for children to age 21. Contact lenses for specified post-surgery conditions, frequency for replacement eyeglasses varies by beneficiary age.	*Participating provider—* Two lenses and 1 frame per benefit period for each enrollee under 19 yeaars of age and limited to $100.
Hearing Aids	*Select and Non-Select provider—* Not covered.	*Participating provider—* 1 per ear per 36 month period covered	*Participating provider—* Covered	$3/day No copayment charged for children to age 21.prior approval required other than monaural hearing aids. 1 hearing aid/4 years, follow-up exam by physician required.	*Participating provider—* Covered
Hemodialysis	*Select provider—* 10%, after deductible *Non-Select provider—* 20%, after deductible	Covered when provided to you as an impatient of a hospital or as an outpatient in a Medicare-approved dialysis center.	*Participating provider—* Covered when provided to you as an impatient of a hospital or as an outpatient in a Medicare-approved dialysis center.	Covered when provided to you as an impatient of a hospital or as an outpatient in a Medicare-approved dialysis center.	*Participating provider—* Covered when provided to you as an impatient of a hospital or as an outpatient in a Medicare-approved dialysis center.
Home Health Care	*Select provider—* 10%, after deductible. Pre-certification required. *Non-Select provider—* 20%, after deductible Pre-certification required.	*Participating provider—* Covered. Must be approved in advance by HMO.	*Participating provider—* Covered with certain requirements and precertification, and subject to case management.	Covered. Oxygen and related equipment covered for specified conditions.	*Participating provider—* Covered with certain requirements and precertification, and subject to case management.
Hospice Care	*Select provider—* 10%, after deductible. Pre-certification required. *Non-Select provider—* 20%, after deductible Pre-certification required.	*Participating provider—* Covered. Must be approved in advance by HMO.	*Participating provider—* Covered with precertification	Covered	*Participating provider—* Covered with precertification
Nursing Facility Providing Skilled Care	*Select provider—* 10%, after deductible. Pre-certification required. *Non-Select provider—* 20%, after deductible Pre-certification required.	*Participating provider—* Covered. Maximum 100 days per calendar year.	*Participating provider—* Covered with maximum 90 days and services must be order and certified by physician.	Covered. 10 hospital leave days/hospitalization, 18 therapeutic leave days/year. Institution for Mental Diseases not included.	*Participating provider—* Covered with maximum 90 days and services must be order and certified by physician.
Occupational Therapy	*Select provider—* 10%, after deductible. Prior approval required. Must be hospital-based billed or as a part of approved home health services. *Non-Select provider—* 20%, after deductible. Prior approval required. Must be hospital-based billed or as a part of approved home health services.	*Participating provider—* Covered. Maximum 60 outpatient treatment days per disability.	*Participating provider—* Only for services to treat the upper extremities, which means the arms from the shoulders to the fingers. No coverage for occupational therapy supplies.	Not covered	*Participating provider—* Only for services to treat the upper extremities, which means the arms from the shoulders to the fingers. No coverage for occupational therapy supplies.

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Organ Transplants	*Select and Non-Select provider—* Heart, hear and lung, lung, pancreas, kidney, simultaneous pancreas/kidney, liver, and cornea transplants covered. Prior approval required.	*Participating provider—* Must be approved in advance by HMO and received from transplant centers approved by HMO. Exception: cornea transplants may be ordered by and performed by a participating provider without prior approval from HMO.	*Participating provider—* Covered for heart, heart/lung, lung, pancreas, kidney, simultaneous pancreas/kidney, small bowel, liver, and certain bone marrow/stem cell transfer transplants. All subject to case management and prior approval.		*Participating provider—* Covered for heart, heart/lung, lung, pancreas, kidney, simultaneous pancreas/kidney, small bowel, liver, and certain bone marrow/stem cell transfer transplants. All subject to case management and prior approval.
Outpatient Chemotherapy	*Select provider—* 10%, deductible waived in office setting. *Non-Select provider—* 20%, after deductible	*Participating provider—* Covered with prior approval from HMO	*Participating provider—* Covered for treatment of a malignancy		*Participating provider—* Covered for treatment of a malignancy
Physical Therapy	*Select provider—* 10%, deductible waived in office setting. *Non-Select provider—* 20%, after deductible	*Participating provider—* Covered with prior approval from HMO	*Participating provider—* Covered	$1/day copayment. No copayment charged for children to age 21. Limited to services meeting Medicare standards	*Participating provider—* Covered
Prosthetic Appliances and Other Devices	*Select provider—* 10%, after deductible *Non-Select provider—* 20%, after deductible	*Participating provider—* Covered with prior approval from HMO	*Participating provider—* Covered appliances used to replace a missing, natural part of the body and braces used to support or restrict movement of weakened or deformed body parts. Does not include dental braces.	$2/day copayment No copayment charged for children to age 21.	*Participating provider—* Covered appliances used to replace a missing, natural part of the body and braces used to support or restrict movement of weakened or deformed body parts. Does not include dental braces.
Respiratory Therapy	*Select provider—* 10%, after deductible Must be hospital- Based billed or as a part of Approved home health services. *Non-Select provider—* 20%, after deductible. Must be hospital- Based billed or as a part of Approved home health services.	*Participating provider—* Covered with prior approval from HMO	*Participating provider—* Covered		*Participating provider—* Covered
Speech Therapy	*Select provider—* 10%, after deductible. Prior approval required. Must be hospital-based billed or as a part of approved home health services. *Non-Select provider—* 20%, after deductible. Prior approval required. Must be hospital-based billed or as a part of approved home health services.	*Participating provider—* Covered with prior approval from HMO	*Participating provider—* Covered with prior approval. Member is not covered when services are provided outside of a facility or not coordinated through home health services. Services are not covered to treat certain developmental, learning disorders, or communication disorders such as stuttering and stammering.		*Participating provider—* Covered with prior approval. Member is not covered when services are provided outside of a facility or not coordinated through home health services. Services are not covered to treat certain developmental, learning disorders, or communication disorders such as stuttering and stammering.
TMJ	*Select provider—* 10%, deductible waived in office setting. *Non-Select provider—* 20%, after deductible	*Participating provider—* Limited to services which are medically necessary in connection with fractures, neoplasm, rheumatoid arthritis, ankylosing spondylitis, disseminated lupus erythematosus, and acute dislocation of the mandible from direct and extrinsic trauma.			
X-ray and Lab	*Select provider—* 10%, deductible waived in office setting. *Non-Select provider—* 20%, after deductible	*Participating provider—* Covered	*Participating provider—* Covered for the diagnosis and treatment of an illness or injury.	Covered	*Participating provider—* Covered for the diagnosis and treatment of an illness or injury.
Dependent Child Age Limit	*Select and Non-Select provider—* Age 19 or unlimited if a full-time student and unmarried	Not specified in contract Program Administrator determines eligibility	*Participating provider—* Until age 19	Up to age 21	*Participating provider—* Until age 19