

Benefit *Summary*

Alliance Select Health Plan

ISEBA (\$100/\$200 deductible)

Customer Service Phone Hours are 7:30 a.m. to 5:00 p.m. CST

Call 1-800-524-9242

This is a general description of coverage. It is not a statement of contract. Actual coverage is subject to terms and conditions specified in the Benefits Certificate you will receive after you enroll and the enrollment regulations in force when the certificate becomes effective. Certain exclusions and limitations apply.

Health Plan Basics

You can receive care from any provider you choose. When you choose a provider who participates in the Alliance Select network, you reduce your out-of-pocket expenses. Refer to the Alliance Select provider directory for a complete list of Alliance Select providers.

Lifetime Benefits Maximum - The maximum amount each covered family member is eligible to receive under this plan for covered services in his or her lifetime.	\$5,000,000
Lifetime Maximum on Infertility Services	\$25,000
Out-of-Pocket Expenses - The amount you pay for certain covered services. There are three types of out-of-pocket expenses: 1) Copayment - a specific amount you pay at the time you receive scheduled services. 2) Deductible - a fixed amount you pay for certain services before Wellmark makes benefit payments. 3) Coinsurance - a fixed percentage you pay for certain services	See the following for your specific out-of-pocket amounts.
Out-of-Pocket Maximum (OPM) - The maximum amount you pay for covered services in any 12-month benefit period. Once your OPM is satisfied, most services are covered in full through the end of the benefit period.	Single: \$500 Family: \$1,000
Benefit Period Deductible	Single: \$100 Family: \$200
Coverage for Care Provided Outside of Iowa	BlueCard® PPO Program benefits apply.

See reverse side for more information about your Alliance Select health plan.

Benefit Summary
Alliance Select Health Plan

When You Receive These Covered Services:	You Pay:	
	Select Providers	Non-Select Providers
Office Visit Services	\$10 copay; <i>coinsurance and deductible waived</i>	20% coinsurance after deductible
Specific Preventive Services – Includes: One routine physical, a separate gynecological exam is also covered, related services (x-rays, lab work, immunizations) per benefit period; well-child care to age 7	\$10 copay; <i>coinsurance and deductible waived</i>	20% coinsurance after deductible*
Mammography – one per benefit period.	\$10 copay; <i>coinsurance and deductible waived</i>	20% coinsurance after deductible
Colonoscopy/Sigmoidoscopy	Office: \$10 copay Outpatient: 10% coinsurance, <i>deductible waived</i>	20% coinsurance, <i>deductible waived</i>
Inpatient Hospital Services	10% coinsurance after deductible	20% coinsurance after deductible
Outpatient Physician Services	10% coinsurance after deductible	20% coinsurance after deductible
Outpatient Hospital Services	10% coinsurance after deductible	20% coinsurance after deductible
Emergency Services ** Physician's office	\$10 copay; <i>coinsurance and deductible waived</i>	20% coinsurance after deductible
Emergency room	10% coinsurance after deductible	20% coinsurance after deductible
Chiropractic Care	\$10 copay; <i>coinsurance and deductible waived</i>	20% coinsurance after deductible
Maternity Care Inpatient/Outpatient	10% coinsurance after deductible	20% coinsurance after deductible
Infertility Treatment Inpatient/Outpatient	10% coinsurance after deductible	20% coinsurance after deductible
Office visit	\$10 copay; <i>coinsurance and deductible waived</i>	20% coinsurance after deductible
Mental Health/Chemical Dependency Inpatient/Outpatient	10% coinsurance after deductible	20% coinsurance after deductible
Office services	\$10 copay; <i>coinsurance and deductible waived</i>	20% coinsurance after deductible

* Deductible waived for well-child care.

** Processed at in-network level if true emergency.
 (Order ID)



Alternate Rate Proposal within the ISEBA Trust
Financial Exhibit

Plan Design

		Delta Dental Premier®
Individual Maximum		\$750
Deductible	Individual	\$25
	Family	\$75
Diagnostic and Preventive Services		
Exams, cleanings, x-ray, fluoride treatments		100%
Sealants, space maintainers		100%
Deductible applies		No
Basic Restorative Services		80%
Fillings, Extractions, & Emergency treatment for pain		80%
Deductible applies		Yes
Endodontics		
Endodontics - nonsurgical		80%
Endodontics - surgical		80%
Deductible applies		Yes
Periodontics		
Periodontics - nonsurgical		80%
Periodontics - surgical		80%
Deductible applies		Yes
Major Restorative Services		
Crowns, inlays, onlays		50%
Bridges and dentures		50%
Repairs and adjustments to bridges and dentures		50%
Deductible applies		Yes
Orthodontic Services		
Coverage coinsurance		50%
Individual lifetime maximum		\$1,000
Dependents eligible to age		19
Full-time students eligible to age		19
Adult orthodontics		No
Deductible applies		No
Dependent Eligibility		
Dependents eligible to age		19
Full-time students eligible to age		25

Match Current Benefits

Employer Contribution	Complete this Section	Participation
	ER Contribution*	
Single	_____	Number of benefit Eligible Employees* _____
Family	_____	

Plan Costs **Contract Period 07/01/2007 through 06/30/2008**

	<u>Single</u>	<u>Family</u>	<u>Annual Expense</u>
Contracts	77	23	
Insured rates (monthly premium)**	\$20.76	\$62.28	\$36,372

**Insured rates include 4.5% broker commissions

* Please update employer contribution and number of benefit eligible employees above and sign below.
Return to Delta Dental of Iowa at fax # 515-261-5573

Signature _____

Date _____