



MARSHALLTOWN
COMMUNITY SCHOOL DISTRICT

HEALTH INSURANCE BENEFITS COMPARISON

BENEFITS EFFECTIVE 7/1/2023

Information is illustrative only. While every effort was taken to accurately report benefits, in case of a discrepancy between this comparison and the actual plan documents, the actual plan documents will prevail. Please refer to the carrier's materials for a more complete description.

	Blue Advantage HMO	Blue Choice POS	
	In Network Only	In Network	Out of Network
Provider Network	Requires designation of a Primary Care Provider (PCP)	Requires designation of a Primary Care Provider (PCP)	
Benefit Period Deductible			
Single	\$750 Single	\$1,250 Single	
Family	\$1,500 Family	\$2,500 Family	
Out of Pocket Maximum			
Single	\$1,500 Single	\$2,500 Single	
Family	\$3,000 Family	\$5,000 Family	
Coinsurance	20%	20%	40%
Office Visit Services			
Physican Office/Urgent Care	\$20 copay (deductible & coinsurance waived)	20% coinsurance (deductible waived)	40% coinsurance (deductible waived)
Specialist	\$35 copay (deductible & coinsurance waived)	20% coinsurance (deductible waived)	40% coinsurance (deductible waived)
Preventative Care	100% covered if seen by PCP	100% covered	Not Covered
Inpatient Hospital Services	20% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible
Outpatient Physican Services	20% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible
Outpatient Hospital Services	20% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible
Emergency Services	See SBC for out-of-network coverage details		
Physican Office/Urgent Care	\$20 copay (deductible & coinsurance waived)	20% coinsurance (deductible waived)	40% coinsurance after deductible
Emergency Room	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after deductible
Chiropractic Care	\$20 copay (deductible & coinsurance waived)	20% coinsurance (deductible waived)	40% coinsurance after deductible
Maternity Care/Delivery			
Office visits	100% covered	100% covered	40% coinsurance after deductible
Childbirth Professional Services	100% covered	100% covered	40% coinsurance after deductible
Childbirth Facility Services	20% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible
Mental Health/Chemical Dependency			
Office Services	\$20 copay (deductible & coinsurance waived)	20% coinsurance (deductible waived)	40% coinsurance after deductible
Inpatient/Outpatient	20% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible
Vision Exam			
Routine Eye Exam (1 per calendar year)	\$35 copay (deductible & coinsurance waived)	20% coinsurance (deductible waived)	40% coinsurance after deductible
Prescription Drug - BlueRX Value Plus			
Out of Pocket Max	\$2500 Single/\$5000 Family	\$2500 Single/\$5000 Family	
Tier 1	30% coinsurance	30% coinsurance	30% coinsurance
Tier 2	30% coinsurance	30% coinsurance	30% coinsurance
Tier 3	30% coinsurance	30% coinsurance	30% coinsurance
Specialty	30% coinsurance	30% coinsurance	Not Covered