Marshalltown Community School District

HEALTH INSURANCE BENEFITS COMPARISON

BENEFITS EFFECTIVE 7/1/2021

	Blue Advantage HMO	**Alliance Select Standard PPO**	
	In Network Only	In Network	Out of Network
Provider Network	Requires designation of a Primary Care Provider (PCP)	PPO and Participating Providers	
Benefit Period Deductible			
Single	$500 Single	$1,000 Single	
Family	$1,000 Family	$2,000 Family	
Out of Pocket Maximum			
Single	$1,000 Single	$2,000 Single	
Family	$2,000 Family	$4,000 Family	
Coinsurance	20%	20%	40%
Office Visit Services			
Physican Office/Urgent Care	$20 copay (deductible & coinsurance waived)	20% coinsurance (deductible waived)	40% coinsurance after deductible
Specialist	$35 copay (deductible & coinsurance waived)	20% coinsurance (deductible waived)	40% coinsurance after deductible
Preventative Care	100% covered if seen by PCP	100% covered	40% coinsurance after deductible
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	20% coinsurance (deductible waived)	40% coinsurance after deductible
Childbirth Professional Services	100% covered	20% coinsurance (deductible waived)	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	$35 copay (deductible & coinsurance waived)	20% coinsurance (deductible waived)	Not Covered
Prescription Drug			
Out of Pocket Max	$3000 Single/$6000 Family	$3000 Single/$6000 Family	
Tier 1	$8 copay	$8 copay	$8 copay
Tier 2	$20 copay	$20 copay	$20 copay
Tier 3	$40 copay	$40 copay	$40 copay
Specialty	$85 copay	$85 copay	Not Covered