ISU PLAN MEDICAL PLANS - Effective January 1, 2024

This is a limited comparison of benefits. The Summary of Benefit and Coverage for each plan is available on the ISU web page. Benefits will be administered as described in each plan coverage manual. Refer to those documents or call Wellmark Blue Cross/Blue Shield. If there are discrepancies between this comparison and Wellmark's Coverage Manual, the Manuel will govern in all cases.

NOTE: For retiree plan participants, eligible for Medicare, Medicare is your primary insurance.
The ISU Plan, following Medicare, usually leaves no patient liability, such as the copay or coinsurance shown below. Some exceptions may occur.

PLAN PROVISIONS	BluePPO		BlueHMO
	In-Network	Out-of-Network	*Primary Care Physician designation required
Benefits from non-participating providers	Limited: *You are responsible for any amounts between the billed charge and the maximum allowable fee paid by Wellmark. These amounts will not accumulate towards the medical out-of-pocket limit.*	60% coverage to MAF (maximum allowable fee) after deductible *You are responsible for any amounts between the billed charge and the maximum allowable fee paid by Wellmark. These amounts will not accumulate towards the medical out-of-pocket limit.*	None, unless prescribed and referred by a participating physician and approved by Wellmark, or in an emergency medical situation
Yearly Deductible (Member pays)	$400 single / $800 other levels	$800 single / $1,600 other levels ***Does not aggregate with in-network deductible**	$250 single / $500 other levels
Copayment (Member pays)	$25	N/A – deductible/coinsurance	$15
Coinsurance (Member pays)	20% of Maximum Allowable Fee, after deductible	40% of Maximum Allowable Fee, after deductible	10% of Maximum allowable fee, after deductible
Yearly Out-of-Pocket (OOP) Maximum **Copays, deductible & coinsurance apply to yearly OOP maximum.**	$2,000 single / $4,000 other levels *Separate OOP for prescription	$4,000 single / $8,000 other levels ***Does not aggregate with in-network OOP maximum** *Separate OOP for prescription	$1,500 single / $3,000 other levels *Separate OOP for prescription
Lifetime maximum	Unlimited	Unlimited	Unlimited
PREVENTIVE SERVICES			
Member pays:			
Routine annual physicals	$0 (100% coverage)	40% coinsurance, after deductible	$0 (100% coverage)
Labs, colonoscopies, sigmoidoscopies	$0 (100% coverage)	40% coinsurance, after deductible	$0 (100% coverage)
Routine pap smears, routine mammography	$0 (100% coverage)	40% coinsurance, after deductible	$0 (100% coverage)

PLAN PROVISIONS	BluePPO		BlueHMO
	In-Network	Out-of-Network	*Primary Care Physician designation required
PHYSICIAN SERVICES			
	Member pays:		
Office exams, includes mental health services	$25 copay	40% coinsurance, after deductible	$15 copay
Telehealth (visual **&** audio required)	$25 copay	40% coinsurance, after deductible	$15 copay
X-ray, lab, and outpatient surgery	20% coinsurance, after deductible	40% coinsurance, after deductible	10% coinsurance, after deductible
Routine eye exam (eyeglasses not covered)	$25 copay	40% coinsurance, after deductible	$15 copay
Routine hearing exam (hearing aids not covered)	$25 copay	40% coinsurance, after deductible	$15 copay
INPATIENT SERVICES			
	Member pays:		
Inpatient surgery	20% coinsurance, after deductible; prior approval required for certain procedures	40% coinsurance, after deductible; prior approval required for certain procedures	10% coinsurance, after deductible; prior approval required for certain procedures
Physician services, room and board, other inpatient care	20% coinsurance, after deductible	40% coinsurance, after deductible	10% coinsurance, after deductible
MISCELLANEOUS SERVICES			
	Member pays:		
Acupuncture	Not covered	Not covered	$15 copay $500 benefit maximum per benefit year/member
Allergy treatment	$25 copay	40% coinsurance, after deductible	$15 copay
Emergency room care	$125 copay, plus 20% coinsurance *Copay is waived if admitted	$125 copay, plus 20% coinsurance *Copay is waived if admitted	$125 copay, plus 10% coinsurance *Copay is waived if admitted
Chiropractic care	$25 copay	40% coinsurance, after deductible	$15 copay
Outpatient chemotherapy	20% coinsurance, after deductible	40% coinsurance, after deductible	10% coinsurance, after deductible
Speech, physical, occupational, and respiratory therapy	$25 copay *Non-office setting, coinsurance may apply.	40% coinsurance, after deductible	$15 copay *Non-office setting, coinsurance may apply.