

# City of Iowa City CMM



The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit <u>www.wellmark.com</u> or call 1-800-524-9242. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms see the Glossary. You can view the Glossary at <u>www.healthcare.gov/sbc-glossary</u> or call 1-800-524-9242 to request a copy.

| Important Questions  | Answers  | Why this Matters:  |
|--|--|--|
| What is the overall deductible?                                      | \$0 person per calendar year.  | Generally, you must pay all the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .   |
| Are there services covered before you meet your deductible?          | Other services <u>deductible</u> (below) applies to ambulance services, prescriptions drugs, durable medical equipment, oxygen, private duty nursing and physical therapy. Other services <u>deductible</u> is waived for in- <u>network</u> prosthetic limbs and mental health/ substance abuse services. | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <u>www.healthcare.gov/coverage/preventive-care-benefits/</u> .  |
| Are there other <u>deductibles</u> for specific services?            | Yes. <b>\$800</b> person/ <b>\$1,600</b> family per calendar year for other services; and 2-day inpatient <u>deductible</u> . The inpatient <u>deductible</u> consists of the first 2 days of billed charges.  | You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.   |
| What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ? | \$1,300 person/\$2,600 family per calendar year.   | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.  |
| What is not included in the out-of-pocket limit?                     | Premiums, balance-billed charges, and health care this plan doesn't cover.   | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .   |
| Will you pay less if you use a network provider?                     | Yes. See <u>www.wellmark.com</u> or call 1-800-524-9242 for a list of <u>network</u> <u>providers</u> .  | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan</u> 's <u>network</u> . You will pay the most if you use an out-of- <u>network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider</u> 's charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an out-of- <u>network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |

| Important Questions  | Answers | Why this Matters:  |
|--|---------|--|
| Do you need a <u>referral</u> to see a <u>specialist</u> ? | No.     | You can see the <u>specialist</u> you choose without a <u>referral</u> . |



All <u>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> applies.

| Common<br>Medical Event   | Services You May Need                            | What You Will Pay<br>In- <u>Network</u> (IN)<br><u>Provider</u><br>(You will pay the<br>least) | What You Will Pay<br>Out-of- <u>Network</u><br>(OON) <u>Provider</u><br>(You will pay the<br>most) | Limitations, Exceptions, & Other Important<br>Information   |
|---|--|--|--|---|
|   | Primary care visit to treat an injury or illness | 10% coinsurance  | 10% coinsurance  | None  |
| If you visit a health   | Specialist visit                                 | 10% coinsurance  | 10% coinsurance  | None  |
| care <u>provider's</u> office or clinic   | Preventive care/screening/<br>immunization       | No charge  | 10% coinsurance  | One preventive exam and one mammogram per calendar year. Well-child care is covered to age 7. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.   |
| If you have a test  | Diagnostic test (x-ray, blood work)              | 10% coinsurance  | 10% coinsurance  | None  |
| If you have a test  | Imaging (CT/PET scans, MRIs)                     | 10% coinsurance  | 10% coinsurance  | None  |
| If you need drugs to treat your illness or condition  More information about prescription drug coverage is available at www.wellmark.com/prescriptions. | Pharmacy Drugs                                   | 10% coinsurance  | 10% coinsurance  | Prescription drugs are covered under the medical plan subject to the other services deductible and out-of-pocket maximum level. You pay the discounted cost of your prescription drugs until your deductible is met. For out-of-network prescription drugs, you may be balance billed. Other services deductible is waived for generic contraceptives and generic contraceptive delivery devices. |

For more information about limitations and exceptions, see your <u>plan</u> document or call Wellmark at 1-800-524-9242.

| Common<br>Medical Event                                      | Services You May Need                          | What You Will Pay<br>In- <u>Network</u> (IN)<br><u>Provider</u><br>(You will pay the<br>least) | What You Will Pay Out-of- <u>Network</u> (OON) <u>Provider</u> (You will pay the most) | Limitations, Exceptions, & Other Important<br>Information  |
|--|--|--|--|--|
| If you have outpatient surgery                               | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance  | 10% coinsurance  | None   |
| outpatient Surgery   | Physician/surgeon fees                         | 10% coinsurance  | 10% coinsurance  | None   |
|  | Emergency room care                            | 10% coinsurance  | 10% coinsurance  | For <u>emergency medical conditions</u> treated out-of- <u>network</u> , it is likely you may not be balance billed pursuant to the federal rules developed for implementation of the No Surprises Act.  |
| If you need immediate medical attention                      | Emergency medical transportation               | 10% <u>coinsurance</u>   | 10% coinsurance  | Subject to other services <u>deductible</u> . For covered non-<br>emergent situations, out-of- <u>network</u> ground ambulance<br>services are NOT reimbursed at the in- <u>network</u> level.<br>Benefits for non-participating ambulance <u>providers</u> are<br>based on actual billed charges. The member may be<br>balance billed for any out-of- <u>network</u> service as<br>established under the rules developed for implementation<br>of the No Surprises Act. |
|  | <u>Urgent care</u>                             | 10% coinsurance  | 10% coinsurance  | None   |
| If you have a hospital                                       | Facility fee (e.g., hospital room)             | 10% coinsurance  | 10% coinsurance  | Subject to 2-day inpatient <u>deductible</u> . Reduction for failure to precertify is 50%.   |
| stay   | Physician/surgeon fees                         | 10% coinsurance  | 10% coinsurance  | None   |
| If you need mental   | Outpatient services                            | 10% coinsurance  | 10% coinsurance  | None   |
| health, behavioral<br>health, or substance<br>abuse services | Inpatient services                             | 10% coinsurance  | 10% coinsurance  | Subject to 2-day inpatient <u>deductible</u> . Reduction for failure to precertify out-of- <u>network</u> services is 50%.   |
|  | Office visits                                  | 10% coinsurance  | 10% coinsurance  | Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Cost sharing does not apply for preventive services.   |
| If you are pregnant  | Childbirth/delivery professional services      | 10% coinsurance  | 10% coinsurance  | Benefits shown reflect OB/GYN practitioner services which are typically globally billed at time of delivery for pre-natal, post-natal and delivery services.   |
|  | Childbirth/delivery facility services          | 10% coinsurance  | 10% coinsurance  | Subject to 2-day inpatient <u>deductible</u> .   |

For more information about limitations and exceptions, see your <u>plan</u> document or call Wellmark at 1-800-524-9242.

| Common<br>Medical Event                                  | Services You May Need      | What You Will Pay<br>In- <u>Network</u> (IN)<br><u>Provider</u><br>(You will pay the<br>least) | What You Will Pay<br>Out-of- <u>Network</u><br>(OON) <u>Provider</u><br>(You will pay the<br>most) | Limitations, Exceptions, & Other Important<br>Information   |
|--|----------------------------|--|--|---|
|  | Home health care           | 10% coinsurance  | 10% coinsurance  | Reduction for failure to precertify out-of-network services is 50%.   |
|  | Rehabilitation services    | 10% coinsurance  | 10% coinsurance  | Subject to 2-day inpatient <u>deductible</u> . Physical therapy services from a licensed physical therapist are subject to the other services <u>deductible</u> . |
| If you need help recovering or have other special health | Habilitation services      | 10% coinsurance  | 10% coinsurance  | Subject to 2-day inpatient <u>deductible</u> . Physical therapy services from a licensed physical therapist are subject to the other services <u>deductible</u> . |
| needs  | Skilled nursing care       | 10% coinsurance  | 10% coinsurance  | Subject to a 2-day inpatient <u>deductible</u> . Reduction for failure to precertify out-of- <u>network</u> services is 50%.                                      |
|  | Durable medical equipment  | 10% coinsurance  | 10% coinsurance  | All durable medical equipment is subject to the other services <u>deductible</u> except in- <u>network</u> prosthetic limbs.                                      |
|  | Hospice services           | 10% coinsurance  | 10% coinsurance  | Hospice respite care is limited to 15 inpatient and 15 outpatient days per lifetime.  |
| 17.  | Children's eye exam        | Not covered  | Not covered  | None  |
| If your child needs dental or eye care                   | Children's glasses         | Not covered  | Not covered  | None  |
| dental of eye care                                       | Children's dental check-up | Not covered  | Not covered  | None  |

For more information about limitations and exceptions, see your <u>plan</u> document or call Wellmark at 1-800-524-9242.

### **Excluded Services & Other Covered Services:**

# Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Custodial care in home or facility
- Dental care Adult
- Dental check-up
- Eye exam
- Glasses

- Hearing aids
- Long-term care
- Routine eye care Adult
- Routine foot care
- · Weight loss programs

# Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Applied Behavior Analysis therapy
- Bariatric surgery
- Chiropractic care
- Extended home skilled nursing
- Infertility treatment (excludes some services)
- Most coverage provided outside the U.S.

 Private-duty nursing short term intermittent home skilled nursing (subject to other services <u>deductible</u>)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or <a href="https://www.cciio.cms.gov">www.cciio.cms.gov</a>. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance <a href="https://www.dealthcare.gov">Marketplace</a>. For more information about the <a href="https://www.dealthcare.gov">Marketplace</a>, visit <a href="https://www.dealthcare.gov">www.dealthcare.gov</a> or call 1-800-318-2596.

Your <u>Grievance</u> and <u>Appeals</u> <u>Rights</u>: There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, you can contact: Wellmark at 1-800-524-9242.

# Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

# Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

\_\_\_\_\_\_To see examples of how this <u>plan</u> might cover costs for a sample medical situation, see the next page. \_\_\_\_\_

# Wellmark Blue Cross and Blue Shield of Iowa is an independent licensee of the Blue Cross and Blue Shield Association.

This contains only a partial description of the benefits, limitations, exclusions and other provisions of the health care plan. It is not a contract or policy. It is a general overview only. It does not provide all the details of coverage, including benefits, exclusions, and policy limitations. In the event there are discrepancies between this document and the Coverage Manual, Certificate, or Policy, the terms and conditions of the Coverage Manual, Certificate, or Policy will govern.

# **About These Coverage Examples:**



**This is not a cost estimator.** Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plan</u>s. Please note these coverage examples are based on self-only coverage.

| Peg is Having a Baby (9 months of in- <u>network</u> pre-natal care and a hospital |
|--|
| delivery)  |
| TI   |

| ■ The plan's overall deductible                         | \$0 |
|---|-----|
| ■ PCP <u>coinsurance</u>                                | 10% |
| <ul><li>Hospital(facility) <u>coinsurance</u></li></ul> | 10% |
| <ul><li>Other <u>coinsurance</u></li></ul>              | 10% |

# This EXAMPLE event includes services like:

Specialist office visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (ultrasounds and blood work)
Specialist visit (anesthesia)

| Total Example Cost | \$12,700 |
|--------------------|----------|
|--------------------|----------|

# In this example, Peg would pay:

| Cost Sharing               |         |  |
|----------------------------|---------|--|
| <u>Deductibles</u>         | \$800   |  |
| <u>Copayments</u>          | \$0     |  |
| Coinsurance                | \$500   |  |
| What isn't covered         |         |  |
| Limits or exclusions \$60  |         |  |
| The total Peg would pay is | \$1,360 |  |

# Managing Joe's type 2 Diabetes (a years of routine in-<u>network</u> care of a well-controlled condition)

| The plan's overall deductible  | \$0 |
|--------------------------------|-----|
| Specialist coinsurance         | 10% |
| Hospital(facility) coinsurance | 10% |
| Other coinsurance              | 10% |

#### This EXAMPLE event includes services like:

<u>Primary care physician</u> office visits (*including disease education*)

<u>Diagnostic tests</u> (blood work)

Prescription drugs

<u>Durable medical equipment</u> (glucose meter)

| Total Example Cost | \$5,600 |
|--------------------|---------|
|--------------------|---------|

# In this example, Joe would pay:

| Cost Sharing |  |  |
|--------------|--|--|
| \$800        |  |  |
| \$0          |  |  |
| \$500        |  |  |
|              |  |  |
| \$20         |  |  |
| \$1,320      |  |  |
|              |  |  |

# Mia's Simple Fracture (in-network emergency room visit and follow up care)

| ■ The plan's overall <u>deductible</u>                    | \$0 |
|---|-----|
| <ul> <li>Specialist coinsurance</li> </ul>                | 10% |
| <ul> <li>Hospital(facility) <u>coinsurance</u></li> </ul> | 10% |
| <ul> <li>Other coinsurance</li> </ul>                     | 10% |

## This EXAMPLE event includes services like:

<u>Emergency room care</u> (including medical supplies)

Diagnostic test (x-ray)

<u>Durable medical equipment</u> (crutches)

Rehabilitation services (physical therapy)

| Total Example Cost | \$2,800 |
|--------------------|---------|
|--------------------|---------|

# In this example, Mia would pay:

| \$800              |  |  |
|--------------------|--|--|
| \$0                |  |  |
| \$200              |  |  |
| What isn't covered |  |  |
| \$0                |  |  |
| \$1,000            |  |  |
|                    |  |  |

The amounts shown in the maternity <u>claim</u> example above are based on amounts using a single per person <u>deductible</u>. Some <u>plans</u> may actually apply a two-person or family deductible to maternity services for the mother and newborn baby.

The plan would be responsible for the other costs of these EXAMPLE covered services.



# **Wellmark Language Assistance**

# Discrimination is against the law

Wellmark Blue Cross and Blue Shield complies with applicable state and federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

### Wellmark provides:

- Free aids and services to people with disabilities so they may communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

You have the right to get this information and help in your language for free. If you need these services, call 800-524-9242.

ATENCIÓN: Si habla español, los servicios de asistencia de idiomas se encuentran disponibles gratuitamente para usted. Comuníquese al 800-524-9242 o al (TTY: 888-781-4262).

注意:如果您说普通话,我们可免费为您提供语言协助服务。请拨打800-524-9242或(听障专线:888-781-4262)。

CHÚ Ý: Nếu quý vị nói tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho quý vị. Xin hãy liên hê 800-524-9242 hoặc (TTY: 888-781-4262).

NAPOMENA: Ako govorite hrvatski, dostupna Vam je besplatna podrška na Vašem jeziku. Kontaktirajte 800-524-9242 ili (tekstualni telefon za osobe oštećena sluha: 888-781-4262).

ACHTUNG: Wenn Sie deutsch sprechen, stehen Ihnen kostenlose sprachliche Assistenzdienste zur Verfügung. Rufnummer: 800-524-9242 oder (TTY: 888-781-4262).

تنبيه: إذا كنت تتحدث اللغة العربية, فإننا نوفر لك خدمات المساعدة اللغوية، المجانية. اتصل بالرقم 800-524-9242 أو (خدمة الهاتف النصى: 882-781-888).

ສິ່ງຄວນເອົາໃຈໃສ່, ພາສາລາວ ຖ້າທ່ານເວົ້າ: ພວກເຮົາມີບໍລິການຄວາມຊ່ວຍເຫຼືອດ້ານພາສາ ໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ ຫຼື 800-524-9242 ຕິດຕໍ່ທີ່. (TTY: 888-781-4262.)

주의: 한국어 를 사용하시는 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 800-524-9242번 또는 (TTY: 888-781-4262)번으로 연락해 주십시오.

ध्यान रखें : अगर आपकी भाषा हिन्दी है, तो आपके लिए भाषा सहायता सेवाएँ, निःशुल्क उपलब्ध हैं। 800-524-9242 पर संपर्क करें या (TTY: 888-781-4262)।

ATTENTION: si vous parlez français, des services d'assistance dans votre langue sont à votre disposition gratuitement. Appelez le 800 524 9242 (ou la ligne ATS au 888 781 4262).

Geb Acht: Wann du Deitsch schwetze duscht, kannscht du Hilf in dei eegni Schprooch koschdefrei griege. Ruf 800-524-9242 odder (TTY: 888-781-4262) uff.

โปรดทราบ: หากคุณพูด ไทย เรามีบริการช่วยเหลือด้านภาษาสำหรับคุณโดยไม่คิด ค่าใช้จ่าย ติดต่อ 800-524-9242 หรือ (TTY: 888-781-4262)

PAG-UKULAN NG PANSIN: Kung Tagalog ang wikang ginagamit mo, may makukuha kang mga serbisyong tulong sa wika na walang bayad. Makipag-ugnayan sa 800-524-9242 o (TTY: 888-781-4262).

တာ်နားသည်သြ-နမ္မာ်ကတီးကညီကိုြိန္ကကိုြိတ်မေးစားတာ်မီးတာမေးတဖြန္နလာတာာဉ်လာဘာ့လနာဆိုင်လာနဂိၢိလီး.ဆဲးကျိုးဆူ ၈၀၀–၅၂၄–၉၂၄၂မှတမွ $\Gamma(TTY)$ -၈၈၈–၇၈၁–၄၂၆၂)တက္၊

ВНИМАНИЕ! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. Обращайтесь 800-524-9242 (телетайп: 888-781-4262).

सावधान: यदि तपाईँ नेपाली बोल्नुहुन्छ भने, तपाईँका लागि नि:शुल्क रूपमा भाषा सहायता सेवाहरू उपलब्ध गराइन्छ । 800-524-9242 वा (TTY: 888-781-4262) मा सम्पर्क गर्नहोस् ।

HEETINA To a wolwa Fulfulde laabi walliinde dow wolde, naa e njobdi, ene ngoodi ngam maaɗa. Heɓir 800-524-9242 malla (TTY: 888-781-4262).

FUULEFFANNAA: Yo isin Oromiffaa, kan dubbattan taatan, tajaajiloonni gargaarsa afaanii, kaffaltii malee, isiniif ni jiru. 800-524-9242 yookin (TTY: 888-781-4262) guunnamaa.

УВАГА! Якщо ви розмовляєте українською мовою, для вас доступні безкоштовні послуги мовної підтримки. Зателефонуйте за номером 800-524-9242 або (телетайп: 888-781-4262).

Ge': Diné k'ehjí yáníłti'go níká bizaad bee áká' adoowoł, t'áá jiik'é, náhóló. Koji' hólne' 800-524-9242 doodaii' (TTY: 888-781-4262)