

Iowa City Community School District PPO



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) 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 www.webaddress.com or call 1-000-000-0000. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-000-000-0000 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u>?	In- <u>Network</u> : \$1,000 person/ \$2,000 family per calendar year. Out-of- <u>Network</u> : \$3,000 person/ \$6,000 family 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 <u>deductible</u>?	Yes. Your drug card costs, ambulance services, in- <u>network</u> <u>preventive care</u> , in- <u>network</u> <u>prosthetic limbs</u> and services subject to <u>copayments</u> are covered before you meet your <u>deductible</u> .	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 www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?		
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	In- <u>Network</u> : \$2,500 person/ \$5,000 family per calendar year. Out-Of- <u>Network</u> : \$3,000 person/ \$6,000 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 <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>balance-billed charges</u> , and health care this <u>plan</u> 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 <u>network provider</u>?	Yes. See www.wellmark.com or call 1-800-524-9242 for a list of <u>network 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's 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's</u> 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.
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 copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Exams: \$20 <u>copay</u> per <u>provider</u> per date of service Other services: 10% <u>coinsurance</u>	30% <u>coinsurance</u>	Primary Care Provider (PCP) types can be found in the What You Pay section of your <u>plan</u> document. Cost-share is waived for office surgeries.
	<u>Specialist</u> visit	Exams: \$20 <u>copay</u> per <u>provider</u> per date of service Other services: 10% <u>coinsurance</u>	30% <u>coinsurance</u>	Applies to Non-PCP <u>providers</u> . \$20 <u>copay</u> per <u>provider</u> per date of service for in- <u>network</u> chiropractic services. Cost-share is waived for office surgeries.
	<u>Preventive care/screening/immunization</u>	No charge	Not covered	One preventive exam and one mammogram per calendar year. Well-child care is covered to age 7. Non-par <u>preventive care</u> is not covered, except for well-child care. 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	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Pathologists and radiologists are covered at the in- <u>network</u> level.
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Radiologists are covered at the in- <u>network</u> level.

For more information about limitations and exceptions, see your plan document or call Group name at 1-000-000-0000.

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
<p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at https://nativus.com or call 866-333-2757.</p>	Tier 1	\$5 copay (30-day supply) \$12 copay (31 – 90-day supply Retail or Mail Order)	Not covered	<p>\$750 per individual out-of-pocket maximum \$2,000 per family out-of-pocket maximum</p> <p>Once you have met this amount with prescription drug costs you will pay \$0 until the end of the benefit year, December 31st.</p> <p>Prior authorizations may be required for certain drugs. Members choosing a brand when a generic is available may experience additional co-payment costs.</p> <p>The Plan works with Navitus to provide access guidance services to assist you in obtaining copay assistance for certain drugs that have manufacturer-funded copay assistance programs.</p> <p>If the drug has copay assistance available, the amount you pay for that drug may vary. It may be set to the maximum of the current benefit design, \$0, or the amount determined by the manufacturer-funded copay assistance programs. To take advantage of this pricing, you will be required to remain enrolled in the manufacturer copay assistance program. Amounts paid by manufacturers on your behalf or directly reimbursed to you (including manufacturer coupons) will not count toward your annual out-of-pocket maximum or deductible. Instead, only those payments made directly by you, and not reimbursed by the manufacturer, will count toward your out-of-pocket maximum or deductible. Once manufacturer-funded copay assistance is exhausted, the amount you pay will be no more than your benefit design. Your copay will default to the formulary's current tiered coinsurance/copay if you are not eligible for manufacturer copay assistance or if the drug is removed from or does not qualify for these services.</p> <p>The plan's preferred mail order vendor is Costco.</p> <p>For more information, please register online at www.nativus.com or call 866-333-2757.</p>
	Tier 2	\$25 copay (30-day supply) \$60 copay (31 – 90-day supply Retail or Mail Order)		
	Tier 3	\$50 copay (30-day supply) \$120 copay (31 – 90-day supply retail or Mail Order)		
	Specialty Drugs	10% up to \$75 max (30-day supply)		

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	-----None-----
	Inpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	-----None-----
If you are pregnant	Office visits	Exams: \$20 <u>copay</u> per provider per date of service Other services: 10% <u>coinsurance</u>	30% <u>coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Cost sharing does not apply for <u>preventive services</u> . For any <u>in-network</u> services that fall outside of routine obstetric care, the office visit benefits shown above may apply.
	Childbirth/delivery professional services	Exams: \$20 <u>copay</u> per provider per date of service Other services: 10% <u>coinsurance</u>	30% <u>coinsurance</u>	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% <u>coinsurance</u>	30% <u>coinsurance</u>	Anesthesiologists are covered at the <u>in-network</u> level.
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	Not covered	-----None-----
	<u>Rehabilitation services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Massage therapy is covered.
	<u>Habilitation services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Massage therapy is covered.
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	-----None-----
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	Not covered	One pair of custom molded shoe inserts are covered every 24 months.
	<u>Hospice services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Hospice respite care is limited to 5 days per calendar year. Hospice respite care is limited to 15 inpatient and 15 outpatient days per lifetime.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	-----None-----
	Children's glasses	Not covered	Not covered	-----None-----
	Children's dental check-up	Not covered	Not covered	-----None-----

For more information about limitations and exceptions, see your plan document or call Group name at 1-000-000-0000.

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
- Extended home skilled nursing
- 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
- Infertility treatment (Out-of-network not covered)
- Most coverage provided outside the U.S.
- Private-duty nursing -
- short term intermittent home skilled nursing

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 www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, you can contact: Group name at 1-000-000-0000.

Does this plan provide Minimum Essential Coverage? Yes/No

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/No

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 plan might cover costs for a sample medical situation, see the next page. _____

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 plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$1,000
- PCP exam copay services coinsurance\$20 and 10%
- Hospital(facility) coinsurance 10%
- Other copayment \$250

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*)

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

In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,000
<u>Copayments</u>	\$250
<u>Coinsurance</u> <i>What isn't covered</i>	\$1,100
<i>What isn't covered</i>	
Limits or exclusions	\$70
The total Peg would pay is	\$2,420

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

- The plan's overall deductible \$1,000
- Specialist exam copay services coinsurance\$20 and 10%
- Hospital(facility) coinsurance 10%
- Other coinsurance 10%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs

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

In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$300
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$4,300
The total Joe would pay is	\$4,800

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

- The plan's overall deductible \$1,000
- Specialist exam copay services coinsurance\$20 and 10%
- Hospital(facility) copayment \$100
- Other coinsurance 10%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)

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

In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$900
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$90
<i>What isn't covered</i>	
Limits or exclusions	\$10
The total Mia would pay is	\$1,100

The amounts shown in the maternity claim example above are based on amounts using a single per person deductible. Some plans 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 complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes. Wellmark does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Wellmark

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
 - Qualified interpreters
 - Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, call 800-524-9242.

If you believe that Wellmark has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Wellmark Civil Rights Coordinator, 1331 Grand Avenue, Station 3E417, Des Moines, IA 50309-2901, 515-376-6500, TTY 888-781-4262, Fax 515-376-9055, Email CRC@Wellmark.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Wellmark Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

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 hệ 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).

تنبیه: إذا كنت تتحدث اللغة العربية، فلننا نوفر لك خدمات المساعدة اللغوية، المجانية، اتصل بالرقم 2429-425-008 أو خدمة الهاتف النصي: 2624-187-888.)

ສົ່ງຄວນເອົາໃຈໃສ່, ພາສາລາວ ຖ້າທ່ານເວົ້າ:

ພວກເຮົາມີບໍລິການຄວາມຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານ ໂດຍບໍ່ເສັຍຄ່າ ຫຼື 800-524-9242 ຕົວຕໍ່ໜ້າ. (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 हिंदी है, तो आपकी हिंदी भाषा सेवाएँ, हमेशा मुफ्त में उपलब्ध हैं। 800-524-9242 पर संपर्क करे 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 Deutsch schwetze duscht, kannscht du Hilf in dei eegni Schprooch koschdefrei griege. Ruf 800-524-9242 odder (TTY: 888-781-4262) uff.

โปรดทราบ: หากคุณพูด ไทย 泰语，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).

w>'k;oh.ng= erh>uwdR unDusdm< usdmw>rRpXRw>H;w>rRwz.< vXwb.vXmbl;vJ< td.vXe*D>vDRI qJ;us 800=524=9242 rhwh> (T88T8Y=7:81=4262) wuh>|

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

सावाधान: याददी तोपाई नेपा बोल्नुहुन्छ भने, तोपाईकी भाषा हन्शुल्की भाषा सहायता सेवाहरू उपलब्ध गराइन्छ। 800-524-9242 वा (TTY: 888-781-4262) मा सम्पर्क गर्नुहोस्।

ማሳሰቢያ:- አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ እገዛ አገልግሎቶቻችን፣ ከክፍያ ነፃ፣ ያገኛሉ። በ 800-524-9242 ወይም በ(TTY: 888-781-4262) ደውለው ያነጋግሩን።

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

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

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'ehj7 y1n7[ti'go n7k1 bizaad bee 1k1' adoowo[, t'11 jiik'4, n1h0l= . Koj8' h0lne' 800-524-9242 doodaii' (TTY: 888-781-4262)

Wellmark Blue Cross and Blue Shield of Iowa, Wellmark Health Plan of Iowa, Inc. and Wellmark Blue Cross and Blue Shield of South Dakota are independent licensees of the Blue Cross and Blue Shield Association.

M-2318376 10/24 A