



### **North Cedar Community School PPO**



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?	\$5,000 person/\$10,000 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 deductible?	Yes. Well-child care, <u>preventive care</u> , in- network outpatient/office services for mental health/substance abuse, colonoscopies, in- <u>network</u> prosthetic limbs 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 <u>www.healthcare.gov/coverage/preventive-care-benefits/</u> .	
Are there other <u>deductibles</u> for specific services?	Yes. <b>\$100</b> person/ <b>\$200</b> family per calendar year for drug card. There are no other specific <u>deductibles</u> .	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> ?	Health: \$6,350 person/\$12,700 family per calendar year. Drug Card: \$6,350 person/\$12,700 family per calendar year. The In-Network health and drug card out-of-pocket maximum amounts accumulate together.	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 <a href="https://www.wellmark.com">www.wellmark.com</a> or call 1-800-524-9242 for a list of <a href="https://www.methodologies.network">network</a> <a href="https://www.methodologies.network">providers</a> .	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 Medical Event Services You May Need		What You Will Pay In- <u>Network</u> (IN) <u>Provider</u> (You will pay the least)	What You Will Pay Out-of- <u>Network</u> (OON) <u>Provider</u> (You will pay the most)	Limitations, Exceptions, & Other Important Information	
	Primary care visit to treat an injury or illness	\$30 <u>copay</u> per <u>provider</u> per date of service	40% coinsurance	Primary Care Practitioners (PCP) are defined as General and Family Practice, Internal Medicine, OB/GYN, Pediatricians, Nurse Practitioners, and PAs. \$30 copay per provider per date of service applies to Doctor on Demand contracted telehealth services.	
If you visit a health care provider's office or clinic	Specialist visit	\$60 <u>copay</u> per <u>provider</u> per date of service	40% coinsurance	Applies to Non-PCP <u>providers</u> . \$30 <u>copay</u> per <u>provider</u> per date of service for in- <u>network</u> chiropractic services.	
	Preventive care/screening/ immunization	No charge	40% coinsurance	One preventive exam and one gynecological exam per calendar year. 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 you need 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)	Independent labs: \$60 copay per provider per date of service Facility: 20% coinsurance	40% coinsurance	For a test in a <u>provider</u> 's office or clinic, your cost is included in the cost-share listed above. Waive cost-share on in- <u>network</u> outpatient services for mental health/ substance abuse.	
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	For a test in a <u>provider</u> 's office or clinic, your cost is included in the cost-share listed above.	

For more information about limitations and exceptions, see your <u>plan</u> document or call Wellmark at 1-800-524-9242. To find your Coverage Manual visit <u>www.wellmark.com/coveragemanual</u>, click on "Large Group Plans" and enter the following number, including dashes, into the search field. **142841-26-170841-18** 

Common Medical Event	Services You May Need	What You Will Pay In- <u>Network</u> (IN) <u>Provider</u> (You will pay the least)	What You Will Pay Out-of- <u>Network</u> (OON) <u>Provider</u> (You will pay the most)	Limitations, Exceptions, & Other Important Information	
If you need drugs to	Tier 1	\$4 <u>copay</u> per prescription	\$4 <u>copay</u> per prescription	Drugs listed on Wellmark's Blue Rx Complete Drug List are covered. Drugs not on this Drug List are not covered.	
treat your illness or condition	Tier 2	\$35 <u>copay</u> per prescription	\$35 <u>copay</u> per prescription	For out-of- <u>network</u> prescription drugs, you may be balance billed.  1 <u>copay</u> for 30-day supply.	
More information about <b>prescription</b>	Tier 3	\$50 <u>copay</u> per prescription	\$50 <u>copay</u> per prescription	3 <u>copays</u> for 90-day supply (Retail maintenance). 2 <u>copays</u> for 90-day supply (Mail order maintenance).	
drug coverage is available at	Tier 4	\$50 <u>copay</u> per prescription	\$50 <u>copay</u> per prescription	Specialty drugs are covered only when obtained through the Specialty Pharmacy Program.	
www.wellmark.com/ prescriptions.	Specialty drugs	\$85 <u>copay</u> per prescription	Not covered	See wellmark.com/prescriptions for information about drugs and drug quantities that require prior authorization by Wellmark to be covered by your <u>plan</u> .	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Waive cost-share on in- <u>network</u> outpatient services for mental health/substance abuse.	
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Waive cost-share on in- <u>network</u> outpatient services for mental health/substance abuse.	
	Emergency room care	20% coinsurance	20% coinsurance	For <u>emergency medical conditions</u> treated out-of- <u>network</u> , you may be balance billed.	
If you need immediate medical attention	Emergency medical transportation	20% coinsurance	20% coinsurance	For <u>emergency medical conditions</u> treated out-of- <u>network</u> , you may be balance billed. Waive cost-share on in- <u>network</u> outpatient services for mental health/substance abuse.	
	Urgent care	\$30 <u>copay</u> per <u>provider</u> per date of service	40% coinsurance	None	
If you have a hospital	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Reduction for failure to precertify out-of-network services is 50%.	
stay	Physician/surgeon fees	20% coinsurance	40% coinsurance	None	

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Common Medical Event	Services You May Need	What You Will Pay In- <u>Network</u> (IN) <u>Provider</u> (You will pay the least)	What You Will Pay Out-of- <u>Network</u> (OON) <u>Provider</u> (You will pay the most)	Limitations, Exceptions, & Other Important Information	
If you need mental health, behavioral health, or substance	Outpatient services	Office: \$30 copay per provider per date of service Facility: No charge	40% coinsurance	None	
abuse services	Inpatient services	20% coinsurance	40% coinsurance	Reduction for failure to precertify out-of-network services is 50%.	
	Office visits	20% coinsurance	40% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Cost sharing does not apply to certain <u>preventive services</u> . For any innetwork services that fall outside of routine obstetric care, the office visit benefits shown above may apply.	
If you are pregnant	Childbirth/delivery professional services	20% coinsurance	40% 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	20% coinsurance	40% coinsurance	None	

For more information about limitations and exceptions, see your <u>plan</u> document or call Wellmark at 1-800-524-9242. To find your Coverage Manual visit <u>www.wellmark.com/coveragemanual</u>, click on "Large Group Plans" and enter the following number, including dashes, into the search field. **142841-26-170841-18** 

Common Medical Event	Services You May Need	What You Will Pay In- <u>Network</u> (IN) <u>Provider</u> (You will pay the least)	What You Will Pay Out-of- <u>Network</u> (OON) <u>Provider</u> (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Home health care	20% coinsurance	40% coinsurance	Waive cost-share on in-network outpatient services for mental health/substance abuse. Reduction for failure to precertify is 50% per covered service.
	Rehabilitation services	Office: \$30 PCP/\$60 Non-PCP <u>copay</u> per <u>provider</u> per date of service Facility: 20% <u>coinsurance</u>	40% coinsurance	\$30 <u>copay</u> per <u>provider</u> per date of service applies to in- <u>network</u> Physical and Occupational Therapists and Speech Language Pathologists. Waive cost-share on in- <u>network</u> outpatient services for mental health/substance abuse.
If you need help recovering or have other special health needs	Habilitation services	Office: \$30 PCP/\$60 Non-PCP <u>copay</u> per <u>provider</u> per date of service Facility: 20% <u>coinsurance</u>	40% coinsurance	\$30 <u>copay</u> per <u>provider</u> per date of service applies to in- <u>network</u> Physical and Occupational Therapists and Speech Language Pathologists. Waive cost-share on in- <u>network</u> outpatient services for mental health/substance abuse.
	Skilled nursing care	20% coinsurance	40% coinsurance	Reduction for failure to precertify out-of-network services is 50%.
	Durable medical equipment	20% coinsurance	40% coinsurance	None
	Hospice services	20% coinsurance	40% coinsurance	Waive cost-share on in-network outpatient services for mental health/substance abuse. Hospice respite care is limited to 15 inpatient and 15 outpatient days per lifetime.
16 1211	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
actual of oyo care	Children's dental check-up	Not covered	Not covered	None

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### **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-covered subject to state mandate through age 18 subject to Private-duty nursing annual limits
- Bariatric surgery
- Chiropractic care
- Infertility treatment (\$15,000 LTM)

- Most coverage provided outside the U.S.
- 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.

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, vou can contact: Wellmark at 1-800-524-9242 or the lowa Insurance Division at 515-281-5705.

### Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

## 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 plan 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-network pre-natal care and a hospital
delivery)

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The plan's overall deductible	\$5,000
■ PCP <u>copayment</u>	\$30
<ul><li>Hospital(facility) <u>coinsurance</u></li></ul>	20%
<ul><li>Other <u>coinsurance</u></li></ul>	20%

### 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	\$12,800
Total Example 303t	Ψ12,000

# In this example, Peg would pay:

Cost Sharing			
<u>Deductibles</u>	\$5,000		
<u>Copayments</u>	\$100		
Coinsurance	\$1,200		
What isn't covered			
Limits or exclusions	\$60		
The total Peg would pay is	\$6,360		

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

The plan's overall deductible	\$5,000
Specialist copayment	\$60
Hospital(facility) coinsurance	20%
Other coinsurance	20%

### This EXAMPLE event includes services like:

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

Diagnostic tests (blood work)

Prescription drugs

Durable medical equipment (glucose meter)

### In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$200
<u>Copayments</u>	\$1,700
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$200
The total Joe would pay is	\$2,100

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

■ The plan's overall deductible	\$5,000
<ul> <li>Specialist copayment</li> </ul>	\$60
<ul><li>Hospital(facility) coinsurance</li></ul>	20%
<ul> <li>Other coinsurance</li> </ul>	20%

### 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	\$1,900
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### In this example, Mia would pay:

Cost Sharing	
\$1,300	
\$300	
\$0	
What isn't covered	
\$0	
\$1,600	

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>plan</u>s may actually apply a two-person or family deductible to maternity services for the mother and newborn baby.

The <u>plan</u> would be responsible for the other costs of these EXAMPLE covered services.

# Required Federal Accessibility and Nondiscrimination Notice



### 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. Wellmark does not exclude people or treat them differently because of their race, color, national origin, age, disability or sex.

#### 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

If you need these 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 5W189, Des Moines, IA 50309-2901, 515-376-4500, TTY 888-781-4262, Fax 515-376-9073, Email CRC@Wellmark.com. You can file a grievance in person, 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 <a href="https://ocrportal.hhs.gov/ocr/portal/lobby.jsf">https://ocrportal.hhs.gov/ocr/portal/lobby.jsf</a>, or by mail, phone or fax at: U.S. Department of Health and Human Services, 200 Independence Avenue S.W., Room 509F, HHH Building, Washington DC 20201, 800-368-1019, 800-537-7697 (TDD).

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

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).

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

โปรดุทราบ: 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).

တာ်ခူးသွဉ်ညါ–နမ္နာကတီးကညီကျိန်-ကျိန်တာ်မးစားတာ်ဖုံးတာမ်းတာဖန်-လာတာာန်လာဘာ့လေးဆိုန်လာနဂိၢိလီး.ဆဲးကျိုးဆူ ၈၀၀–၅၂၄–၉၂၄၂မှတမှ $\gamma$ (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 तपाईं नेपाली बोल्नुहुन्छ भने, तपाईंका लागि नि:शुल्क रूपमा भाषा सहायता सेवाहरू उपलब्ध गराइन्छ । 800-524-9242 वा (TTY: 888-781-4262) मा सम्पर्क गर्नुहोस् ।

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.

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