



The University of Iowa UIChoice Active POS HMO



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.wellmark.com or call 1-800-643-9724. 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 1-800-643-9724 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u>?	Level 1: UIHC and other Affiliated Partners: \$400 person . Level 2: WHPI Providers: \$600 person . Level 3: Out-of-Network (OON) Providers: \$800 person .	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>?	<u>Deductible</u> applies to inpatient facility services only and taken once per admission.	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?	Yes. \$400 person for Level 2 inpatient facility services for mental health/ substance abuse. 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 limit</u> for this <u>plan</u>?	Level 1: UIHC and other Affiliated Partners: \$1,700 person/ \$3,400 family . Level 2: WHPI Providers: \$1,700 person/ \$3,400 family . Level 3: Out-of-Network (OON) Providers: \$2,000 person/ \$4,000 family . Drug Card: \$1,100 person/ \$2,200 family . The In-Network health and drug card <u>out-of-pocket</u> maximum amounts accumulate separately.	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>?	Premiums, <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> .

Important Questions	Answers	Why this Matters:
Will you pay less if you use a <u>network provider</u>?	Yes. See www.wellmark.com or call 1-800-643-9724 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 <u>out-of-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 <u>out-of-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.

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-643-9724.

Common Medical Event	Services You May Need	What You Will Pay Level 1: UIHC and other Affiliated Partners (You will pay the least)	What You Will Pay Level 2: WHPI Providers (You will pay more)	What You Will Pay Level 3: Out-of-Network (OON) Providers (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	\$10 exam <u>copay</u> per <u>provider</u> per date of service Other services: 10% <u>coinsurance</u>	\$25 exam <u>copay</u> per <u>provider</u> per date of service Other services: 10% <u>coinsurance</u>	50% <u>coinsurance</u>	Level 1: All UI Health Care locations including UIHC, The Iowa Clinic & Washington Co Hospital & Clinics; Level 2: All other Wellmark Health Plan providers. <u>Primary Care Provider (PCP)</u> or OB/GYN selection is not required. \$5 exam <u>copay</u> per <u>provider</u> per date of service applies to UI QuickCare.
	<u>Specialist visit</u>	\$10 exam <u>copay</u> per <u>provider</u> per date of service Other services: 10% <u>coinsurance</u>	\$25 exam <u>copay</u> per <u>provider</u> per date of service Other services: 10% <u>coinsurance</u>	50% <u>coinsurance</u>	-----None-----
	<u>Preventive care/ screening/ immunization</u>	No charge	No charge	0% <u>coinsurance</u> for participating <u>providers</u> 50% <u>coinsurance</u> for non-participating <u>providers</u>	Preventive exams, gynecological exams, immunizations, mammograms, hearing exams and well-child care are unlimited. Preventive medical examinations performed for administrative purposes are covered in addition to a preventive exam. Waive <u>coinsurance</u> for participating <u>providers</u> <u>preventive care</u> . 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>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	In- <u>network</u> independent labs for mental health/ substance abuse services are not subject to <u>coinsurance</u> .
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----

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Common Medical Event	Services You May Need	What You Will Pay Level 1: UIHC and other Affiliated Partners (You will pay the least)	What You Will Pay Level 2: WHPI Providers (You will pay more)	What You Will Pay Level 3: Out-of-Network (OON) Providers (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.wellmark.com/prescriptions .	Tier 1	0% <u>coinsurance</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	Drugs listed on Wellmark's Blue Rx Complete Drug List are covered. Drugs not on this Drug List are not covered. For OON <u>prescription drugs</u> , you may be balance billed. 30-day supply for <u>specialty drugs</u> . 34-day supply for <u>prescription drugs</u> . 100-day supply prescription maximum (Maintenance). <u>Specialty drugs</u> are covered only when obtained through the UIHC Specialty Pharmacy. See wellmark.com/prescriptions for information about drugs and drug quantities that require prior authorization by Wellmark to be covered by your plan.
	Tier 2	30% <u>coinsurance</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	
	Tier 3	50% <u>coinsurance</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Tier 4	50% <u>coinsurance</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Specialty drugs	Same as cost-share above depending on drug category	Not covered	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----
	Physician/surgeon fees	10% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----
If you need immediate medical attention	<u>Emergency room care</u>	\$100 <u>copay</u> and 10% <u>coinsurance</u>	\$100 <u>copay</u> and 10% <u>coinsurance</u>	\$100 <u>copay</u> and 10% <u>coinsurance</u>	For <u>emergency medical conditions</u> treated OON, it is likely you may not be balance billed pursuant to the federal rules developed for implementation of the No Surprises Act. Emergency room <u>copay</u> applies per visit for facility and physician(s) services combined.
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	For covered non-emergent situations, OON ambulance services are NOT reimbursed at the IN level. The member may be balance billed for any OON service as established under the rules developed for implementation of the No Surprises Act.
	<u>Urgent care</u>	\$10 <u>copay</u> per provider per date of service	\$25 <u>copay</u> per provider per date of service	50% <u>coinsurance</u>	Waive cost-share on in- <u>network</u> outpatient services for mental health/substance abuse.

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-643-9724.

Common Medical Event	Services You May Need	What You Will Pay Level 1: UIHC and other Affiliated Partners (You will pay the least)	What You Will Pay Level 2: WHPI Providers (You will pay more)	What You Will Pay Level 3: Out-of-Network (OON) Providers (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Transplants must be done at UIHC or Blue Distinction Centers.
	Physician/surgeon fees	10% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: \$0 <u>copay</u> Facility: 10% coin.	Office: \$0 <u>copay</u> Facility: 10% coin.	Office: 50% coin. Facility: 40% coin.	-----None-----
	Inpatient services	10% <u>coinsurance</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Residential treatment is covered with no 24 hour nursing supervision requirement.
If you are pregnant	Office visits	No charge	No charge	50% <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	No charge	No charge	40% <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>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Newborn's initial <u>hospitalization</u> is not subject to <u>deductible</u> .

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Common Medical Event	Services You May Need	What You Will Pay Level 1: UIHC and other Affiliated Partners (You will pay the least)	What You Will Pay Level 2: WHPI Providers (You will pay more)	What You Will Pay Level 3: Out-of-Network (OON) Providers (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	Home health care	10% coinsurance	10% coinsurance	40% coinsurance	-----None-----
	Rehabilitation services	10% coinsurance	10% coinsurance	Office: 50% coin. Facility: 40% coin.	Level 1 and 2 copay applies to office billed physical therapy.
	Habilitation services	10% coinsurance	10% coinsurance	Office: 50% coin. Facility: 40% coin.	Level 1 and 2 copay applies to office billed physical therapy.
	Skilled nursing care	10% coinsurance	10% coinsurance	40% coinsurance	-----None-----
	Durable medical equipment	20% coinsurance	20% coinsurance	20% coinsurance	Wigs are covered following chemotherapy up to \$1,000 annual max and are calculated using billed charge. Orthotics, including shoes, are covered.
	Hospice services	10% coinsurance	10% coinsurance	40% coinsurance	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	\$10 exam copay per provider per date of service Other: services: 10% coinsurance	\$25 exam copay per provider per date of service Other services: 10% coinsurance	50% coinsurance	Routine vision exams are unlimited.
	Children's glasses	Not covered	Not covered	Not covered	-----None-----
	Children's dental check-up	Not covered	Not covered	Not covered	-----None-----

For more information about limitations and exceptions, see your [plan](#) document or call Wellmark at 1-800-643-9724.

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
- Glasses
- Long-term care
- 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
- Hearing aids (\$1,500 limit every 36 months)
- Infertility treatment (\$25,000 LTM, Level 2: 30% coins)
- Most coverage provided outside the U.S.
- Private-duty nursing - short term intermittent home skilled nursing
- Routine eye care - Adult (unlimited exams)

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, you can contact: Wellmark at 1-800-643-9724.

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

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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 \$400
- PCP exam copay services coinsurance\$10 and 10%
- Hospital(facility) coinsurance 10%
- Other no charge No Charge

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$400
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$800
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,260

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

- The plan's overall deductible \$400
- Specialist exam copay services coinsurance\$10 and 10%
- Hospital(facility) coinsurance 10%
- Other coinsurance 20%

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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$80
<u>Coinsurance</u>	\$1,100
<i>What isn't covered</i>	
Limits or exclusions	\$200
The total Joe would pay is	\$1,380

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

- The plan's overall deductible \$400
- Specialist exam copay services coinsurance\$10 and 10%
- Hospital(facility) copay and coinsurance\$100 and 10%
- Other coinsurance 20%

This EXAMPLE event includes services like:

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

Total Example Cost	\$2,800
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$400

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.

