

The University of Iowa UISelect Retiree Access 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](http://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](http://www.healthcare.gov/sbc-glossary) or call 1-800-643-9724 to request a copy.

Important Questions	Answers	Why this Matters:
<b>What is the overall <u>deductible</u>?</b>	Level 1: UIHC and other Affiliated Partners: <b>\$400</b> person/ <b>\$800</b> family per calendar year. Level 2: WHPI <u>Providers</u> : <b>\$800</b> person/ <b>\$1,600</b> 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> .
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Well-child care, <u>prescription drugs</u> , <u>preventive care</u> , 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 <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <u>deductibles</u> for specific services?</b>	No. There are no other <u>deductibles</u> .	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	Level 1: UIHC and other Affiliated Partners: <b>\$2,000</b> person/ <b>\$3,400</b> family per calendar year. Level 2: WHPI <u>Providers</u> : <b>\$3,000</b> person/ <b>\$6,000</b> family per calendar year. Drug Card: <b>\$1,100</b> person/ <b>\$2,200</b> family per calendar year. The In- <u>Network</u> 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.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	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 <a href="http://www.wellmark.com">www.wellmark.com</a> 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.

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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$10 <u>copay</u> per <u>provider</u> per date of service	\$35 <u>copay</u> per <u>provider</u> per date of service	Not covered	Primary Care Practitioners (PCP) are defined as Gen and Family Prac, Int. Med, OB/GYN, Pediatricians, Nurse Pract, Cert. Nurse Midwives and PAs. Level 1: All UI Health Care locations incl. UIHC, The Iowa Clinic & Wash. Co Hosp & Clinics; Level 2: All other Wellmark Health <u>Plan</u> prov.
	<u>Specialist</u> visit	\$20 <u>copay</u> per <u>provider</u> per date of service	\$50 <u>copay</u> per <u>provider</u> per date of service	Not covered	Applies to Non-PCP prov. \$10 Level 1/\$35 Level 2 <u>copay</u> per prov. per date of svc for in- <u>network</u> chiro.
	<u>Preventive care</u> / <u>screening</u> / immunization	No charge	No charge	Not covered	One prev. exam, one gyn. exam w/ Pap smear, and one mammo. per cal year. Well-child care is cov to age 7. Prev. med exams perf. for admin. purposes are cov. in add. to a prev. exam. You may have to pay for svcs that aren't prev. Ask your prov. if the svcs needed are prev. Then check what your <u>plan</u> will pay for. Prev. care must be prov. by a PCP.

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 test	Diagnostic test (x-ray, blood work)	15% <u>coinsurance</u>	25% <u>coinsurance</u>	Not covered	For a test in a <u>provider's</u> office or clinic, your cost is included in the cost-share listed above.
	Imaging (CT/PET scans, MRIs)	15% <u>coinsurance</u>	25% <u>coinsurance</u>	Not covered	For a test in a <u>provider's</u> office or clinic, your cost is included in the cost-share listed above.
If you need drugs to treat your illness or condition  More information about <u>prescription drug coverage</u> is at <a href="http://www.wellmark.com/prescriptions">www.wellmark.com/prescriptions</a> .	Tier 1	0% <u>coinsurance</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	Drugs listed on Wellmark's Blue Rx Value Plus 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 <u>prescription maximum</u> (Maintenance). <u>Specialty drugs</u> are covered only when obtained through the UIHC Specialty Pharmacy. See <a href="http://wellmark.com/prescriptions">wellmark.com/prescriptions</a> 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>	
	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)	15% <u>coinsurance</u>	25% <u>coinsurance</u>	Not covered	-----None-----
	Physician/surgeon fees	15% <u>coinsurance</u>	25% <u>coinsurance</u>	Not covered	-----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 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>	15% <u>coinsurance</u>	15% <u>coinsurance</u>	15% <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 <u>provider</u> per date of service	\$35 <u>copay</u> per <u>provider</u> per date of service	Not covered	\$10 <u>copay</u> per <u>provider</u> per date of service for mental health/substance abuse services.
If you have a hospital stay	Facility fee (e.g., hospital room)	15% <u>coinsurance</u>	25% <u>coinsurance</u>	Not covered	Transplants must be done at UIHC or Blue Distinction Centers.
	<u>Physician/surgeon fees</u>	15% <u>coinsurance</u>	25% <u>coinsurance</u>	Not covered	-----None-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: \$10 <u>copay</u> Facility: 15% coin.	Office: \$10 <u>copay</u> Facility: 15% coin.	Not covered	<u>Copay</u> is per <u>provider</u> per date of service.
	Inpatient services	15% <u>coinsurance</u>	15% <u>coinsurance</u>	Not covered	Residential treatment is covered with no 24 hour nursing supervision requirement.

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 are pregnant	Office visits	No charge	No charge	Not covered	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 in- <u>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	Not covered	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	15% <u>coinsurance</u>	25% <u>coinsurance</u>	Not covered	Newborn's initial <u>hospitalization</u> is not subject to <u>deductible</u> .
If you need help recovering or have other special health needs	<u>Home health care</u>	15% <u>coinsurance</u>	25% <u>coinsurance</u>	Not covered	-----None-----
	<u>Rehabilitation services</u>	Office: \$10 PCP/ \$20 Non-PCP <u>copay per provider</u> per date of service Facility: 15% coin.	Office: \$35 PCP/ \$50 Non-PCP <u>copay per provider</u> per date of service Facility: 25% coin.	Not covered	\$10 Level 1/\$35 Level 2 <u>copay per provider</u> per date of service applies to in- <u>network</u> Physical and Occupational Therapists and Speech Language Pathologists.
	<u>Habilitation services</u>	Office: \$10 PCP/ \$20 Non-PCP <u>copay per provider</u> per date of service Facility: 15% coin.	Office: \$35 PCP/ \$50 Non-PCP <u>copay per provider</u> per date of service Facility: 25% coin.	Not covered	\$10 Level 1/\$35 Level 2 <u>copay per provider</u> per date of service applies to in- <u>network</u> Physical and Occupational Therapists and Speech Language Pathologists.
	<u>Skilled nursing care</u>	15% <u>coinsurance</u>	25% <u>coinsurance</u>	Not covered	-----None-----
	<u>Durable medical equipment</u>	15% <u>coinsurance</u>	25% <u>coinsurance</u>	Not covered	-----None-----
	<u>Hospice services</u>	15% <u>coinsurance</u>	25% <u>coinsurance</u>	Not covered	Hospice respite care is limited to 15 inpatient and 15 outpatient days per lifetime.

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 your child needs dental or eye care	Children's eye exam	\$20 copay per provider per date of service	\$50 copay per provider per date of service	Not covered	One routine vision exam per calendar year. Must be performed by an in-network provider.
	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
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Some pharmacy drugs are not covered
- 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 (\$15,000 LTM)
- Private-duty nursing - short term intermittent home skilled nursing
- Routine eye care - Adult (one vision exam per calendar year)

**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](http://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 copayment \$10
- Hospital(facility) coinsurance 15%
- 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*)  
Specialist visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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**In this example, Peg would pay:**

Cost Sharing	
<u>Deductibles</u>	\$400
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,200
What isn't covered	
<b>Limits or exclusions</b>	<b>\$60</b>
<b>The total Peg would pay is</b>	<b>\$1,660</b>

### 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 copayment \$20
- Hospital(facility) coinsurance 15%
- Other coinsurance 15%

**This EXAMPLE event includes services like:**

Primary care physician office visits (*including disease education*)  
Diagnostic tests (*blood work*)  
Prescription drugs  
Durable medical equipment (*glucose meter*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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**In this example, Joe would pay:**

Cost Sharing	
<u>Deductibles</u>	\$50
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$1,100
What isn't covered	
<b>Limits or exclusions</b>	<b>\$20</b>
<b>The total Joe would pay is</b>	<b>\$1,270</b>

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

- The plan's overall deductible \$400
- Specialist copayment \$20
- Hospital(facility) copay and coinsurance \$100 and 10%
- Other coinsurance 15%

**This EXAMPLE event includes services like:**

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

<b>Total Example Cost</b>	<b>\$2,800</b>
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**In this example, Mia would pay:**

Cost Sharing	
<u>Deductibles</u>	\$400
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$200
What isn't covered	
<b>Limits or exclusions</b>	<b>\$0</b>
<b>The total Mia would pay is</b>	<b>\$800</b>

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.



