

The University of Iowa UIGradCare Blue 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>?	UIHC <u>Providers</u> : \$0 person/ \$0 family . person	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers. 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>Deductibles</u> do not 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?	No. There are no other <u>deductibles</u> .	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	UIHC <u>Providers</u> : \$1,000 person/ \$1,700 family . Drug Card: \$1,000 person/ \$1,700 family . 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.
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> .
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 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 UIHC <u>Providers</u> (You will pay the least)	What You Will Pay Wellmark Health <u>Plan of Iowa (IN) Providers</u> (You will pay more)	What You Will Pay <u>Out-of-Network (OON) Providers</u> (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	Exam: \$10 <u>copay</u> per <u>provider</u> per date of service Other services: 10% <u>coinsurance</u>	Not covered	Not covered	Level 1: UIHC <u>providers</u> ; Level 2: All other Wellmark Health <u>Plan of Iowa</u> and Allied <u>providers</u> .
	<u>Specialist</u> visit	Exam: \$10 <u>copay</u> per <u>provider</u> per date of service Other services: 10% <u>coinsurance</u>	Not covered	Not covered	-----None-----
	<u>Preventive care/ screening/ immunization</u>	No charge	Not covered	Not covered	One routine hearing exam per calendar year. Preventive medical examinations performed for administrative purposes are covered in addition to a preventive exam. 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>	Not covered	Not covered	UIHC independent labs for mental health/chemical dependency services are not subject to <u>coinsurance</u> .
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	Not covered	Not covered	-----None-----

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 UIHC Providers (You will pay the least)	What You Will Pay Wellmark Health Plan of Iowa (IN) Providers (You will pay more)	What You Will Pay 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	Greater of \$7 <u>copay</u> or 25% <u>coinsurance</u> per prescription	Greater of \$7 <u>copay</u> or 25% <u>coinsurance</u> per prescription	Greater of \$7 <u>copay</u> or 25% <u>coinsurance</u> per prescription	Refer to your Blue Rx Complete Drug List to determine the tier that applies to a covered drug. 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. 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	Greater of \$7 <u>copay</u> or 25% <u>coinsurance</u> per prescription	Greater of \$7 <u>copay</u> or 25% <u>coinsurance</u> per prescription	Greater of \$7 <u>copay</u> or 25% <u>coinsurance</u> per prescription	
	Tier 3	Greater of \$7 <u>copay</u> or 25% <u>coinsurance</u> per prescription	Greater of \$7 <u>copay</u> or 25% <u>coinsurance</u> per prescription	Greater of \$7 <u>copay</u> or 25% <u>coinsurance</u> per prescription	
	Tier 4	Greater of \$7 <u>copay</u> or 25% <u>coinsurance</u> per prescription	Greater of \$7 <u>copay</u> or 25% <u>coinsurance</u> per prescription	Greater of \$7 <u>copay</u> or 25% <u>coinsurance</u> per prescription	
	Specialty drugs	Same as cost-share above depending on drug category.	Same as cost-share above depending on drug category.	Same as cost-share above depending on drug category.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	Not covered	Not covered	-----None-----
	Physician/surgeon fees	10% <u>coinsurance</u>	Not covered	Not covered	-----None-----

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Common Medical Event	Services You May Need	What You Will Pay UIHC <u>Providers</u> (You will pay the least)	What You Will Pay Wellmark Health <u>Plan of Iowa (IN) Providers</u> (You will pay more)	What You Will Pay <u>Out-of-Network (OON) Providers</u> (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need immediate medical attention	<u>Emergency room care</u>	\$50 <u>copay</u> and 10% <u>coinsurance</u> per visit for facility and physician(s) combined	\$50 <u>copay</u> and 10% <u>coinsurance</u> per visit for facility and physician(s) combined	\$50 <u>copay</u> and 10% <u>coinsurance</u> per visit for facility and physician(s) combined	For <u>emergency medical conditions</u> treated out-of-network, it is likely you may not be balance billed pursuant to the federal rules developed for implementation of the No Surprises Act.
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	For covered non-emergent situations, OON ground ambulance services are NOT reimbursed at the in-network level. You may be balance billed for any out-of-network service as established under the rules developed for implementation of the No Surprises Act.
	<u>Urgent care</u>	\$10 <u>copay</u> for exam per provider per date of service for facility and physician(s) combined Other services: 10% <u>coinsurance</u>	Not covered	Not covered	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	\$125 per day <u>copay</u> and 10% <u>coinsurance</u>	Not covered	Not covered	Transplants must be done at UIHC or Blue Distinction Centers for Transplant.
	<u>Physician/surgeon fees</u>	10% <u>coinsurance</u>	Not covered	Not covered	Transplants must be done at UIHC or Blue Distinction Centers for Transplant.

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Common Medical Event	Services You May Need	What You Will Pay UIHC Providers (You will pay the least)	What You Will Pay Wellmark Health Plan of Iowa (IN) Providers (You will pay more)	What You Will Pay Out-of-Network (OON) Providers (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: 0% <u>coinsurance</u> Facility: 10% <u>coinsurance</u>	Office: 0% <u>coinsurance</u> Facility: 10% <u>coinsurance</u>	50% <u>coinsurance</u>	OON mental health and chemical dependency is limited to 50 visits per calendar year.
	Inpatient services	Facility: \$125 per day <u>copay</u> and 10% <u>coinsurance</u> Practitioner: 10% <u>coinsurance</u>	Facility: \$125 per day <u>copay</u> and 10% <u>coinsurance</u> Practitioner: 10% <u>coinsurance</u>	Facility: \$125 per day <u>copay</u> and 50% <u>coinsurance</u> Practitioner: 50% <u>coinsurance</u>	Residential treatment is covered with no 24 hour nursing supervision requirement. The member may be balance billed for any out-of-network service.
If you are pregnant	Office visits	Exam: \$10 <u>copay</u> per provider per date of service Other services: 10% <u>coinsurance</u>	Not covered	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> .
	Childbirth/delivery professional services	Exam: \$10 <u>copay</u> per provider per date of service Other services: 10% <u>coinsurance</u>	Not covered	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	Facility: \$125 per day <u>copay</u> and 10% <u>coinsurance</u>	Not covered	Not covered	<u>Copay</u> is waived for newborn's initial <u>hospitalization</u> .

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If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	Not covered	-----None-----
	<u>Rehabilitation services</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	Not covered	-----None-----
	<u>Habilitation services</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	Not covered	-----None-----
	<u>Skilled nursing care</u>	\$125 per day <u>copay</u> and 10% <u>coinsurance</u>	Not covered	Not covered	-----None-----
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	Not covered	Manual and electric breast pumps covered no charge. Orthotics, including shoes, are covered. Hospital grade breast pumps subject to <u>coinsurance</u> .
	<u>Hospice services</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	Not covered	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	No charge	\$10 <u>copay</u> per <u>provider</u> per date of service	Not covered	One routine vision exam per calendar year. Must be performed by an <u>in-network provider</u> .
	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
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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 (calendar year)
- Bariatric surgery
- Chiropractic care
- Private-duty nursing - short term intermittent home skilled nursing
- Routine eye care - Adult (one vision exam per

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: 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.

Wellmark Health Plan of Iowa, Inc. 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 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 \$0
- PCP exam copay services coinsurance\$10 and 10%
- Hospital(facility) copayment \$125
- Other exam copay services coinsurance\$10 and 10%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services

Total Example Cost	\$12,700
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$250
<u>Coinsurance</u>	\$750
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,060

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

- The plan's overall deductible \$0
- Specialist exam copay services coinsurance\$10 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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$800
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,120

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

- The plan's overall deductible \$0
- Specialist exam copay services coinsurance\$10 and 10%
- Hospital(facility) copay and coinsurance\$50 and 10%
- Other coinsurance 10%

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>	\$80
<u>Coinsurance</u>	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$380

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.

