Iowa State University Retiree 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 https://hr.iastate.edu/retiree-benefits or call 515-294-4800. 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 1-800-318-2596 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$250** person/**$500** family per calendar year.	Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Well-child care, in-network preventive care, in-network independent labs, in-network physician maternity care, in-network prosthetic limbs, your drug costs and services subject to copayments are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No. There are no other deductibles.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Health: **$1,500** person/**$3,000** family per calendar year. Express Scripts: **$2,000** per person/**$4,000** family per calendar year. Humana: **$2,000** per member. The In-Network health and drug card out-of-pocket maximum amounts accumulate separately.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit 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 out-of-pocket limit.

Will you pay less if you use a network provider?	Yes. See www.wellmark.com or call 1-800-524-9242 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Important Questions	Answers	Why this Matters:
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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	$15 copay per provider per date of service	Not covered	For this plan you must select a designated Primary Care Provider. PCP provider types can be found in the What You Pay section of your plan document. $15 copay per provider per date of service applies to telehealth services delivered by in-network primary care providers. $15 copay per provider per date of service applies to telehealth services contracting through Doctor on Demand. If covered by Medicare Part A, benefits will be coordinated with benefits available under Medicare Part A and Part B, even if not enrolled in Part B. Payment will be calculated by reducing allowed charges by 80% for benefits attributable to Part B eligibility.
	Specialist visit	$15 copay per provider per date of service	Not covered	Applies to Non-PCP providers. $15 copay per provider per date of service for in-network chiropractic services. One routine hearing exam per calendar year. $15 copay per provider per date of service applies to covered telehealth services delivered by in-network specialists.

	Preventive care/screening/ immunization	No charge	Not covered	Must be provided by or coordinated through your designated personal doctor or OB/GYN. One preventive exam and 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 provider if the services needed are preventive. Then check what your plan will pay for.

For more information about limitations and exceptions, see your plan document or call Iowa State University at 515-294-4800.

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 have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	Not covered	For a test in a provider's office or clinic, your costs is included in the cost-share listed above.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	Not covered	For a test in a provider's 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 **prescription drug coverage** is available at https://hr.iastate.edu/prescriptiondrug-plan-0.	Tier 1 – Generics	Co-pay $15 / zero for 90-day retail or mail order	For OON pharmacies, you may be required to pay 100% to pharmacy and file a claim; reimbursement will be determined by the Express Scripts plan.	Retirees and family members have prescription coverage from either Express Scripts or Humana Medicare Part D PDP. The Humana plan is a Medicare Part D group plan subject to Center for Medicare (CMS) regulations. The maximum out-of-pocket on Express Scripts is $2,000.00 for single, $4,000.00 for family. The maximum out-of-pocket on Humana is $2,500.00 per person. Participants should contact the customer service number found on the applicable drug card. More information about prescription drug coverage is available at https://hr.iastate.edu/prescriptiondrug-plan-0.
	Tier 2 – Preferred brand	Coinsurance 30% / 25% for 90-day retail or mail order		
	Tier 3 – Non-preferred brand	Coinsurance 50% / 33% for 90-day retail or mail order		
	Specialty Drugs	May be preferred or non-preferred category and Specialty pharmacy may be required		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	Not covered	------None------
	Physician/surgeon fees	10% coinsurance	Not covered	------None------

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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 immediate medical attention	Emergency room care	$125 copay and 10% coinsurance per visit for facility and physician(s) combined	$125 copay and 10% coinsurance per visit for facility and physician(s) combined	For emergency medical conditions 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. Waive cost-share on emergency room services for mental health/substance abuse.
	Emergency medical transportation	10% coinsurance	10% coinsurance	Benefits for non-participating ambulance providers are based on actual billed charges. For covered non-emergent situations, out-of-network 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.
	Urgent care	$15 copay per provider per date of service for facility and physician(s) combined	Not covered	------None------
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	Not covered	------None------
	Physician/surgeon fees	10% coinsurance	Not covered	------None------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	Not covered	Contracted telehealth services are covered.
	Inpatient services	10% coinsurance	Not covered	------None------

For more information about limitations and exceptions, see your plan document or call Iowa State University at 515-294-4800.

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 are pregnant	Office visits	10% coinsurance	Not covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). For any in-network services that fall outside of routine obstetric care, the office visit benefits shown above may apply.
	Childbirth/delivery professional services	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	10% coinsurance	Not covered	------None------
If you need help recovering or have other special health needs	Home health care	10% coinsurance	Not covered	------None------
	Rehabilitation services	10% coinsurance	Not covered	------None------
	Habilitation services	10% coinsurance	Not covered	------None------
	Skilled nursing care	10% coinsurance	Not covered	------None------
	Durable medical equipment	10% coinsurance	Not covered	Orthotics are covered as follows: orthotic foot devices such as arch supports or in-shoe supports, elastic supports or examinations to prescribe or fit such devices and orthotics training.
	Hospice services	10% coinsurance	Not covered	------None------
If your child needs dental or eye care	Children's eye exam	$15 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	------None------
	Children's dental check-up	Not covered	Not covered	------None------

For more information about limitations and exceptions, see your plan document or call Iowa State University at 515-294-4800.

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.)

- Cosmetic surgery
- Custodial care - in home or facility
- Dental care - Adult
- Dental check-up
- Extended home skilled nursing
- Glasses
- Hearing aids
- 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.)

- Acupuncture ($15 copay per pv, $500 per calendar year)
- Applied Behavior Analysis therapy
- Bariatric surgery
- Chiropractic care
- 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. 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: Iowa State University at 515-294-4800.

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.

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	$250
PCP copayment	$15
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*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$250
Copayments	$0
Coinsurance	$800
What isn't covered	
Limits or exclusions	**$70**
The total Peg would pay is	**$1,120**

Managing Joe's type 2 Dia etes
(a years of routine in-network care of a well-

The plan's overall deductible	$250
Specialist copayment	$15
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
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$50
Copayments	$150
Coinsurance	$0
What isn't covered	
Limits or exclusions	**$1,350**
The total Joe would pay is	**$1,550**

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

The plan's overall deductible	$250
Specialist copayment	$15
Hospital(facility) copay and coinsurance	$125 and 10%
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	
Deductibles	$250
Copayments	$200
Coinsurance	$200
What isn't covered	
Limits or exclusions	**$10**
The total Mia would pay is	**$660**

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.