

Iowa State University Retiree PPO



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? | In-Network: \$400 person/ \$800 family per calendar year. Out-of-Network: \$800 person/ \$1,600 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 <u>individual 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, in-network independent labs, in-network 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 www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other deductibles 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 out-of-pocket limit for this plan? | Health In-Network: \$2,000 person/ \$4,000 family per calendar year. Health Out-Of-Network: \$4,000 person/ \$8,000 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 <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 out-of-pocket limit? | <u>Premiums</u> , your drug card costs, <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 1-800-524-9242 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 charge</u> 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. |
|--|---|---|

| 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 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- <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 visit a health care <u>provider's</u> office or clinic | Primary care visit to treat an injury or illness | \$25 <u>copay</u> per <u>provider</u> per date of service | 40% <u>coinsurance</u> | \$25 <u>copay</u> per <u>provider</u> per date of service applies to telehealth services delivered by in- <u>network</u> <u>primary care providers</u> . \$25 <u>copay</u> per <u>provider</u> per date of service applies to telehealth services delivered by <u>providers</u> 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. |
| | <u>Specialist</u> visit | \$25 <u>copay</u> per <u>provider</u> per date of service | 40% <u>coinsurance</u> | One routine hearing exam per calendar year. \$25 <u>copay</u> per <u>provider</u> per date of service applies to covered telehealth services provided by in- <u>network</u> <u>specialists</u> . |
| | <u>Preventive care/screening/immunization</u> | No charge | 40% <u>coinsurance</u> | 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. |

| | | | | |
|---------------------------|--|------------------------|------------------------|--|
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | For a test in a provider's office or clinic, your cost is included in the cost-share listed above. |
| | Imaging (CT/PET scans, MRIs) | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | For a test in a provider's office or clinic, your cost is included in the cost-share listed above. |

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- <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 |
|---|--|--|--|--|
| <p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at https://hr.iastate.edu/prescription-drug-plan-0.</p> | Tier 1 – Generics | Co-pay \$15 / zero for 90-day retail or mail order | <p>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.</p> | <p>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.</p> |
| | 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 | | |
| <p>If you have outpatient surgery</p> | Facility fee (e.g., ambulatory surgery center) | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | -----None----- |
| | <u>Physician/surgeon fees</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 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 | <u>Emergency room care</u> | \$125 <u>copay</u> and 20% <u>coinsurance</u> per visit for facility and physician(s) combined | \$125 <u>copay</u> and 20% <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> | 20% <u>coinsurance</u> | 20% <u>coinsurance</u> | Benefits for non-participating ambulance <u>providers</u> 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. |
| | <u>Urgent care</u> | \$25 <u>copay</u> per <u>provider</u> per date of service for facility and physician(s) combined | 40% <u>coinsurance</u> | -----None----- |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | -----None----- |
| | <u>Physician/surgeon fees</u> | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | -----None----- |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | Contracted telehealth services are covered. |
| | Inpatient services | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | -----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 | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | 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 | 20% <u>coinsurance</u> | 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 | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | -----None----- |
| If you need help recovering or have other special health needs | <u>Home health care</u> | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | -----None----- |
| | <u>Rehabilitation services</u> | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | -----None----- |
| | <u>Habilitation services</u> | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | -----None----- |
| | <u>Skilled nursing care</u> | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | -----None----- |
| | <u>Durable medical equipment</u> | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | -----None----- |
| | <u>Hospice services</u> | 20% <u>coinsurance</u> | 40% <u>coinsurance</u> | -----None----- |
| If your child needs dental or eye care | Children's eye exam | \$25 <u>copay</u> per <u>provider</u> per date of service | 40% <u>coinsurance</u> | One routine vision exam per calendar year. |
| | 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.)

- Acupuncture
- Cosmetic surgery
- Custodial care - in home or facility
- Dental care - Adult
- Dental check-up
- Extended home skilled nursing
- Glasses
- Hearing aids
- 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
- Infertility treatment (\$15,000 LTM)
- Most coverage provided outside the U.S.
- 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 <u>deductible</u> | \$400 |
| ■ PCP <u>copayment</u> | \$25 |
| ■ Hospital(facility) <u>coinsurance</u> | 20% |
| ■ Other <u>coinsurance</u> | 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 | \$12,700 |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing | |
|--|----------------|
| <u>Deductibles</u> | \$400 |
| <u>Copayments</u> | \$100 |
| <u>Coinsurance</u> <i>What isn't covered</i> | \$1,500 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$70 |
| The total Peg would pay is | \$2,070 |

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

| | |
|---|-------|
| ■ The plan's overall <u>deductible</u> | \$400 |
| ■ <u>Specialist</u> <u>copayment</u> | \$25 |
| ■ Hospital(facility) <u>coinsurance</u> | 20% |
| ■ Other <u>coinsurance</u> | 20% |

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 | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$50 |
| <u>Copayments</u> | \$200 |
| <u>Coinsurance</u> | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$1,350 |
| The total Joe would pay is | \$1,650 |

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

| | |
|--|---------------|
| ■ The plan's overall <u>deductible</u> | \$400 |
| ■ <u>Specialist</u> <u>copayment</u> | \$25 |
| ■ Hospital(facility) <u>copay</u> and <u>coinsurance</u> | \$125 and 20% |
| ■ Other <u>coinsurance</u> | 20% |

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 | |
|-----------------------------------|--------------|
| <u>Deductibles</u> | \$400 |
| <u>Copayments</u> | \$200 |
| <u>Coinsurance</u> | \$300 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$10 |
| The total Mia would pay is | \$910 |

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.

