

City of Cedar Rapids Airport Safety Choice 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 medical coverage, or to get a copy of the complete terms of coverage, visit www.wellmark.com or call 1-800-381-0214. For more information about your prescription drug coverage, visit www.cap-rx.com or call 1-833-599-0984. 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 1-319-286-5000 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$500 person/\$1,000 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. Contracted telehealth services, in-network preventive care/prosthetic limbs/colonoscopies, in-network office/independent lab services, outpatient services for mental health/chemical dependency and your drug card costs 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: \$2,000 person/\$4,000 family per calendar year. Drug Card: \$1,500 person/\$4,500 family per calendar year. 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.

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> .
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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	10% <u>coinsurance</u>	20% <u>coinsurance</u>	-----None-----
	<u>Specialist</u> visit	10% <u>coinsurance</u>	20% <u>coinsurance</u>	Hearing exams are covered according to ACA guidelines.
	<u>Preventive care/screening/immunization</u>	No charge	20% <u>coinsurance</u>	One preventive exam and one mammogram per calendar year. Well-child care is covered to age 7. In addition to a preventive physical exam, administrative type physicals performed for driver licensing are covered for the employee only. <u>Copay</u> , <u>deductible</u> and <u>coinsurance</u> are waived. 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>	-----None-----
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	20% <u>coinsurance</u>	-----None-----

For more information about limitations and exceptions, see your plan document or call the City of Cedar Rapids at 319-286-5000

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 drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.cap-rx.com .	Tier 1 (Generic)	10% coinsurance	Not covered	Drugs listed on Capital Rx's drug list are covered. Drugs not listed on this drug list are not covered. 30-day supply for prescription drugs. 90-day prescription maximum (maintenance). Maintenance medications can be filled at retail pharmacies or through mail service. Specialty drugs are covered only when obtained through Costco Specialty Pharmacy. Visit www.cap-rx.com for more information about drugs and drug quantities which require prior authorization by Capital Rx in order to be covered by your plan.
	Tier 2 (Preferred Brands)	25% coinsurance	Not covered	
	Tier 3 (Non-Preferred Brands)	40% coinsurance	Not covered	
	Specialty Drugs	Generic: 10% coinsurance Preferred: 25% coinsurance Non-preferred: 40% coinsurance	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	20% <u>coinsurance</u>	Waive cost-share for in- <u>network</u> colonoscopies.
	Physician/surgeon fees	10% <u>coinsurance</u>	20% <u>coinsurance</u>	-----None-----
If you need immediate medical attention	<u>Emergency room care</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	For <u>emergency medical conditions</u> treated out-of- <u>network</u> , 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>	Waive cost-share for in- <u>network</u> colonoscopies.
	<u>Urgent care</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	20% <u>coinsurance</u>	-----None-----
	Physician/surgeon fees	10% <u>coinsurance</u>	20% <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 mental health, behavioral health, or substance abuse services	Outpatient services	10% <u>coinsurance</u>	20% <u>coinsurance</u>	-----None-----
	Inpatient services	10% <u>coinsurance</u>	20% <u>coinsurance</u>	-----None-----
If you are pregnant	Office visits	10% <u>coinsurance</u>	20% <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> .
	Childbirth/delivery professional services	10% <u>coinsurance</u>	20% <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>	20% <u>coinsurance</u>	-----None-----
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	-----None-----
	<u>Rehabilitation services</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	-----None-----
	<u>Habilitation services</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	-----None-----
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	-----None-----
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	-----None-----
	<u>Hospice services</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	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	Not covered	Not covered	-----None-----
	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 the City of Cedar Rapids at 319-286-5000

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
- Eye exam
- Glasses
- Hearing aids
- Long-term care
- Routine eye care - Adult
- 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 (\$10,000 LTM)
- Most coverage provided outside the U.S.
- Private-duty nursing - Short term intermittent home skilled nursing

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: the City of Cedar Rapids at 1-319-286-5000 or the Iowa Insurance Division at 515-654-6600

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 hospital delivery)

■ The plan's overall <u>deductible</u>	\$500
■ PCP <u>coinsurance</u>	10%
■ Hospital(facility) <u>coinsurance</u>	10%
■ Rx (tier 1) <u>coinsurance</u>	10%

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*)

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall <u>deductible</u>	\$500
■ <u>Specialist</u> <u>coinsurance</u>	10%
■ Hospital(facility) <u>coinsurance</u>	10%
■ Rx (tiers 1&2) <u>coinsurance</u>	10% & 25%

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*)

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall <u>deductible</u>	\$500
■ <u>Specialist</u> <u>coinsurance</u>	10%
■ Hospital(facility) <u>coinsurance</u>	10%
■ Rx (tier 1) <u>coinsurance</u>	10%

This EXAMPLE event includes services like:

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

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

Total Example Cost	\$5,600
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In this example, Joe would pay:

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

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 service

Cost Sharing	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,200
What isn't covered	
Limits or exclusions	\$110
The total Peg would pay is	\$1,810

Cost Sharing	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,000
What isn't covered	
Limits or exclusions	\$30
The total Mia would pay is	\$1,530

Cost Sharing	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$100
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$670