Grinnell-Newburg Community School District – Partial Self-Funded Health Plan

Plan B **Coverage Period: 07-01-2016 to 06-30-2017**

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individuals & Families **Plan Type:** PSF

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document by calling **1-800-373-1327**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	The insurance plan starts at: **$3,000** Per Individual for a Calendar Year/ **$6,000** For Family per Calendar Year. The employer then "buys down" the deductible, so your actual deductible becomes **$750** per individual for a calendar year, and **$1,500** for a family per calendar year.	This benefit is in addition to the Wellmark Blue Cross Blue Shield plan already in place. Refer to the Wellmark Blue Cross Blue Shield of Iowa Summary of Benefits and Coverage for covered services for your particular plan. You must pay all the costs up to the ***deductible*** amount before this plan begins to pay for covered services you use. This buy down benefit will then be paid as reimbursement to the covered service provider. Check your policy or plan document to see when the ***deductible*** starts over.
Is there an out–of–pocket limit on my expenses?	The insurance plan starts at: Individual **$4,000** for Calendar Year/ Family **$8,000** for Calendar Year. The employer then "buys down" the out-of-pocket, so your actual out-of-pocket becomes **$1,500** per individual for a calendar year, and **$3,000** for a family per calendar year.	The ***out-of-pocket limit*** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. The deductible is included in the ***out-of-pocket limit***.
What is not included in the out–of–pocket limit?	Benefits not covered under the Wellmark Blue Cross and Blue Shield Plan.	See your Wellmark Blue Cross Blue Shield Plan for covered benefits and limitations or exclusions.

Questions: Call **1-800-373-1327**

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at **www.cciio.cms.gov** or call **1-800-524-9242** to request a copy.

What is the Office services co-pay?	See the SBC of the insured group health plan.	**Co-payments** are fixed dollar amounts (for example, $40) you pay for covered health care, usually when you receive the service. Member is responsible for full **co-payment** at time of service.
What is the services co-pay benefit for an Emergency Room Visit?	See the SBC of the insured group health plan.	
What are the Prescription co-pay amounts?	**Generic:** See the SBC of the insured group health plan.	Refer to the insured group health plan for information on drugs covered by your plan.
	Preferred drugs: See the SBC of the insured group health plan.	
	Non-preferred drugs: See the SBC of the insured group health plan.	
	Select non-preferred drugs: See the SBC of the insured group health plan.	
	Specialty drugs: See the SBC of the insured group health plan.	

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Coverage Period: 07/01/2016 – 06/30/2017
Coverage for: Single & Family | **Plan Type:** PPO

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

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Important Questions	Answers	Why this Matters:
What is the overall **deductible**?	**$3,000** person/**$6,000** family per calendar year Does not apply to well-child care, preventive care, in-network independent labs, in-network routine vision exams, in-network prosthetic limbs, ambulance and services subject to copayments.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the Common Medical Event chart on the following pages for how much you pay for covered services after you meet the **deductible**.
Are there other **deductibles** for specific services?	No. There are no other deductibles.	You don't have to meet **deductibles** for specific services, but see the Common Medical Event chart on the following pages for other costs for services this plan covers.
Is there an **out–of–pocket limit** on my expenses?	Yes. **$4,000** person/**$8,000** family per calendar year	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the **out–of–pocket limit**?	Premiums, copayments, infertility, pre-service review penalties, your drug card costs, 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**.
Is there an overall annual limit on what the plan pays?	No.	See the Common Medical Event chart on the following pages which describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a **network** of **providers**?	Yes. See www.wellmark.com for a list of in-network providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the Common Medical Event chart on the following pages for how this plan pays different kinds of **providers**.

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Important Questions	Answers	Why this Matters:
Do I need a referral to see a **specialist**?	No. You do not need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments**, and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an		Limitations & Exceptions
		In-Network (IN) Provider	Out-of-Network (OON) Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 copay	20% coinsurance	------None------
	Specialist visit	$10 copay	20% coinsurance	------None------
	Other practitioner office visit	$10 copay for Chiropractors and vision exams	20% coinsurance for Chiropractors and vision exams	One routine vision exam per calendar year.
	Preventive care/screening/ immunization	$10 copay	20% coinsurance	One preventive exam and one gynecological exam per calendar year. One mammogram per calendar year. Well-child care is covered to age 7.

Common Medical Event	Services You May Need	Your Cost If You Use an		Limitations & Exceptions
		In-Network (IN) Provider	Out-of-Network (OON) Provider	
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	20% coinsurance	For a test in a provider's office or clinic, your cost is included in the cost-share listed above. In-network independent labs for mental health/substance abuse services are not subject to coinsurance. Failure to obtain prior approval for services listed on Wellmark.com will result in denial with review rights.
	Imaging (CT /PET scans, MRIs)	10% coinsurance	20% coinsurance	For a test in a provider's office or clinic, your cost is included in the cost-share listed above. Failure to obtain prior approval for imaging services listed on Wellmark.com will result in denial.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.wellmark.com.	Generic drugs	$5 copay	$5 copay	Drugs listed on Wellmark's Drug List are covered. Drugs not on the Drug List are not covered. For out-of-network prescription drugs, you may be balance billed. 1 copay for 30-day supply. 2 copays for 90-day supply (Retail and Mail order maintenance). $5 copay applies to insulin syringes. Failure to obtain prior authorization or prior approval for drugs listed on Wellmark.com will result in denial with review rights.
	Preferred brand drugs	$25 copay	$25 copay	
	Non-preferred brand drugs	$40 copay	$40 copay	
	Select non-preferred brand drugs	$40 copay	$40 copay	
	Specialty drugs	$85 copay	$85 copay	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	20% coinsurance	Failure to obtain prior approval for services listed on Wellmark.com will result in denial with review rights.
	Physician / surgeon fees	10% coinsurance	20% coinsurance	Failure to obtain prior approval for services listed on Wellmark.com will result in denial with review rights.

Common Medical Event	Services You May Need	Your Cost If You Use an		Limitations & Exceptions
		In-Network (IN) Provider	Out-of-Network (OON) Provider	
If you need immediate medical attention	Emergency room services	$100 copay	$100 copay	For emergency medical conditions treated out-of-network, you may be balance billed. Dental treatment for accidental injury is limited to care completed within 12 months of the injury.
	Emergency medical transportation	0% coinsurance	0% coinsurance	------None------
	Urgent care	$10 copay	20% coinsurance	------None------
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	20% coinsurance	Reduction for failure to precertify is 50% and will not exceed $500 per admission.
	Physician / surgeon fee	10% coinsurance	20% coinsurance	Failure to obtain prior approval for services listed on Wellmark.com will result in denial with review rights.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Office: $10 copay Facility: 10% coinsurance	20% coinsurance	------None------
	Mental/Behavioral health inpatient services	10% coinsurance	20% coinsurance	Reduction for failure to precertify is 50% and will not exceed $500 per admission.
	Substance use disorder outpatient services	Office: $10 copay Facility: 10% coinsurance	20% coinsurance	------None------
	Substance use disorder inpatient services	10% coinsurance	20% coinsurance	Reduction for failure to precertify is 50% and will not exceed $500 per admission.
If you are pregnant	Prenatal and postnatal care	$200 copay	20% coinsurance	------None------
	Delivery and all inpatient services	Practitioner: $200 copay Facility: 10% coinsurance	20% coinsurance	------None------

Common Medical Event	Services You May Need	Your Cost If You Use an		Limitations & Exceptions
		In-Network (IN) Provider	Out-of-Network (OON) Provider	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	Not covered	20% coinsurance on out-of-network mental health/ substance abuse services. Reduction for failure to precertify is 50% per approved service.
	Rehabilitation services	Office: $10 copay Facility: 10% coinsurance	20% coinsurance	Physical, speech and occupational therapies are limited to 60 combined visits per calendar year. Reduction for failure to precertify is 50% and will not exceed $500 per admission.
	Habilitative services	Office: $10 copay Facility: 10% coinsurance	20% coinsurance	Physical, speech and occupational therapies are limited to 60 combined visits per calendar year. Reduction for failure to precertify is 50% and will not exceed $500 per admission.
	Skilled nursing care	10% coinsurance	20% coinsurance	Limit of 90 days per calendar year. Reduction for failure to precertify is 50% and will not exceed $500 per admission.
	Durable medical equipment	10% coinsurance	20% coinsurance	Failure to obtain prior approval for services listed on Wellmark.com will result in denial with review rights.
	Hospice service	10% coinsurance	Not covered	Hospice respite care is limited to 15 inpatient and 15 outpatient days per lifetime. 20% coinsurance on out-of-network mental health/substance abuse services.
If your child needs dental or eye care	Eye exam	$10 copay	20% coinsurance	One routine vision exam per calendar year.
	Glasses	Not covered	Not covered	------None------
	Dental check-up	Not covered	Not covered	------None------

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for 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 (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care
- Infertility treatment ($25,000 LTM; no coverage out-of-network)
- 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:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact your employer or group sponsor.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Wellmark at 1-800-524-9242 or the Iowa Insurance Division at 515-281-5705.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Para recibir asistencia en espanõl, por favor comuníquense al servicio de cliente, al número que aparence en su tarjeta de identificación.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,420
- **Patient pays** $3,120

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$2,710
Copays	$260
Coinsurance	$0
Limits or exclusions	$150
Total	**$3,120**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,170
- **Patient pays** $1,230

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$20
Copays	$1,010
Coinsurance	$0
Limits or exclusions	$200
Total	**$1,230**

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.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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.

Wellmark Blue Cross and Blue Shield of Iowa is an Independent Licensee of the Blue Cross and Blue Shield Association.

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