

## City of Ames Advantage 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 medical coverage, or to get a copy of the complete terms of medical coverage, visit and log into [www.mywellmark.com](http://www.mywellmark.com) or call 1-800-355-2031. For Rx coverage, contact Carelon Rx at 1-833-320-1156. 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](http://www.healthcare.gov/sbc-glossary).

| Important Questions  | Answers   | Why this Matters:   |
|--|---|---|
| <b>What is the overall deductible?</b>                             | \$0 person per calendar year.   | Generally, you must pay all the costs from providers up to the deductible 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 individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.  |
| <b>Are there services covered before you meet your deductible?</b> | No. This <u>plan</u> has no deductibles.  | This <u>plan</u> 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 <u>plan</u> covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> .                     |
| <b>Are there other deductibles for specific services?</b>          | No. There are no deductibles.   | You don't have to meet deductibles for specific services.   |
| <b>What is the out-of-pocket limit for this <u>plan</u>?</b>       | Health: \$1,000 person/\$2,000 family per calendar year. Drug card: \$1,000 person/\$2,000 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 <u>plan</u> , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.  |
| <b>What is not included in the out-of-pocket limit?</b>            | Premiums, balance-billed charges, and health care this <u>plan</u> doesn't cover.   | Even though you pay these expenses, they don't count toward the out-of-pocket limit.  |
| <b>Will you pay less if you use a network provider?</b>            | Yes. See <a href="http://www.mywellmark.com">www.mywellmark.com</a> or call 1-800-355-2031 for a list of network providers.   | This <u>plan</u> 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. |
| <b>Do you need a referral to see a specialist?</b>                 | 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 | \$10 <u>copay</u> per <u>provider</u> per date of service  | Not covered   | Primary Care Practitioners (PCP) are defined as General and Family Practice, Internal Medicine, OB/GYN, Pediatricians, Nurse Practitioners and PAs. For this <u>plan</u> you must designate a personal doctor from the above <u>provider</u> types.  |
|  | <u>Specialist</u> visit                          | \$10 <u>copay</u> per <u>provider</u> per date of service  | Not covered   | Applies to Non-PCP <u>providers</u> . Hearing exams are covered according to ACA guidelines.   |
|  | <u>Preventive care/screening/immunization</u>    | No charge  | Not covered   | Must be provided by or coordinated through your designated personal doctor or OB/GYN. One preventive exam and one gynecological exam with Pap smear per calendar year. One mammogram per calendar year, waive cost-share for mammograms. Well- child care is covered to age 7. 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)       | Independent Lab: \$10 <u>copay</u> per <u>provider</u> per date of service<br>Facility: 10% <u>coinsurance</u> | Not covered   | For a test in a <u>provider's</u> office or clinic, your cost is included in the cost-share listed above. Waive cost-share for in- <u>network</u> outpatient services for mental health/substance abuse.   |
|  | Imaging (CT/PET scans, MRIs)                     | 10% <u>coinsurance</u>   | Not covered   | For a test in a <u>provider's</u> office or clinic, your cost is included in the cost-share listed above.  |

For more information about limitations and exceptions on **medical coverage**, see your plan document or **call Wellmark** at 1-800-355-2031.

For more information about limitations and exceptions on **pharmacy coverage**, see your plan document or **call Carelon Rx** at 1-833-320-1156.

| Common Medical Event  | Services You May Need                                 | What You Will Pay In- <u>Network</u> (IN) <u>Provider</u> (You pay the least)             | What You Will Pay Out-of- <u>Network</u> (OON) <u>Provider</u> (You pay the most)         | Limitations, Exceptions, & Other Important Information  |
|---|---|---|---|---|
| <b>If you need drugs to treat your illness or condition</b><br><br>More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://www.carelonrx.com">www.carelonrx.com</a> |   | <b><u>Retail</u></b>  | <b><u>Mail Order</u></b>  | Drugs listed on the Carelon Rx drug list are covered. Drugs not on this drug list are not covered. For out-of-network prescription drugs, you may be balance billed.<br>1 copay for 30-day supply.<br>1 copay for 90-day supply (Retail Tier 1 maintenance drugs).<br>3 copays for 90-day supply (Retail Tier 2, 3 and 4 maintenance drugs).<br>Specialty drugs are covered only when obtained through Carelon Rx.<br>\$5 copay per prescription applies to smoking cessation drugs.<br>See <a href="http://www.carelonrx.com">www.carelonrx.com</a> for information about drugs and drug quantities that require prior authorization to be covered by your plan. |
|   | Tier 1  | \$5 copay per prescription  | \$5 copay per prescription  |   |
|   | Tier 2  | \$20 copay per prescription   | \$60 copay per prescription   |   |
|   | Tier 3  | \$35 copay per prescription   | \$105 copay per prescription  |   |
|   | Tier 4  | \$85 copay per prescription   | Up to \$255 maximum copay per prescription  |   |
| <b>If you have outpatient surgery</b>   | <b>Facility fee (e.g., ambulatory surgery center)</b> | <b>10% <u>coinsurance</u></b>   | <b>Not covered</b>  | Waive cost-share for in- <u>network</u> outpatient services for mental health/substance abuse.  |
|   | <u>Physician/surgeon fees</u>                         | 10% <u>coinsurance</u>  | Not covered   | Waive cost-share for in- <u>network</u> outpatient services for mental health/substance abuse.  |
| <b>If you need immediate medical attention</b>  | <u>Emergency room care</u>                            | \$50 <u>copay</u> per facility per date of service for facility and physician(s) combined | \$50 <u>copay</u> per facility per date of service for facility and physician(s) combined | For <u>emergency medical conditions</u> treated <u>out-of-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> outpatient services for mental health/substance abuse. For covered non-emergent situations, <u>out-of-network</u> ambulance services are NOT reimbursed at the in- <u>network</u> level. The member may be balance billed for any <u>out-of-network</u> service as established under the rules developed for implementation of the No Surprises Act.  |
|   | <u>Urgent care</u>                                    | \$10 <u>copay</u> per provider per date of service for facility and physician(s) combined | Not covered   | -----None-----  |

| 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 hospital stay   | Facility fee (e.g., hospital room)        | \$100 <u>copay</u> and 10% <u>coinsurance</u> per admission         | Not covered   | Inpatient <u>copay</u> limited to 3 per person per calendar year.   |
|   | Physician/surgeon fees                    | 10% <u>coinsurance</u>  | Not covered   | -----None-----  |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | No charge   | Not covered   | -----None-----  |
|   | Inpatient services                        | Practitioner: No charge<br>Facility: 10% <u>coinsurance</u>         | Not covered   | -----None-----  |
| If you are pregnant   | Office visits                             | No charge   | 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> . For any <u>in-network</u> 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     | No charge   | Not covered   | -----None-----  |

For more information about limitations and exceptions on **medical coverage**, see your plan document or **call Wellmark** at 1-800-355-2031.

For more information about limitations and exceptions on **pharmacy coverage**, see your plan document or **call Carelon Rx** at 1-833-320-1156.

| 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   |
|---|----------------------------------|---|---|--|
| <b>If you need help recovering or have other special health needs</b> | <u>Home health care</u>          | 10% <u>coinsurance</u>  | Not covered   | Waive cost-share for <u>in-network</u> outpatient services for mental health/substance abuse.  |
|   | <u>Rehabilitation services</u>   | Office: \$10 <u>copay</u> per <u>provider</u> per date of service<br>Outpatient: 10% <u>coinsurance</u> | Not covered   | Waive cost-share for <u>in-network</u> outpatient services for mental health/substance abuse. Massage therapy is limited to 12 visits per calendar year.                           |
|   | <u>Habilitation services</u>     | Office: \$10 <u>copay</u> per <u>provider</u> per date of service<br>Outpatient: 10% <u>coinsurance</u> | Not covered   | Waive cost-share for <u>in-network</u> outpatient services for mental health/substance abuse. Massage therapy is limited to 12 visits per calendar year.                           |
|   | <u>Skilled nursing care</u>      | 10% <u>coinsurance</u>  | Not covered   | -----None-----   |
|   | <u>Durable medical equipment</u> | 10% <u>coinsurance</u>  | Not covered   | -----None-----   |
|   | <u>Hospice services</u>          | 10% <u>coinsurance</u>  | Not covered   | Waive cost-share for <u>in-network</u> outpatient services for mental health/substance abuse. Hospice respite care is limited to 15 inpatient and 15 outpatient days per lifetime. |
| <b>If your child needs dental or eye care</b>                         | Children's eye exam              | \$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   | -----None-----   |
|   | Children's dental check-up       | Not covered   | Not covered   | -----None-----   |

For more information about limitations and exceptions on **medical coverage**, see your plan document or **call Wellmark** at 1-800-355-2031.

For more information about limitations and exceptions on **pharmacy coverage**, see your plan document or **call Carelon Rx** at 1-833-320-1156.

## 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 (limited to 12 visits 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](http://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](http://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 **medical plan** rights, this notice, or assistance, you can **contact Wellmark** at 1-800-355-2031. For more information about your **pharmacy plan** rights, this notice, or assistance, you can **contact Carelon Rx** at 1-833-320-1156.

### 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 \$0
- PCP copayment \$10
- Hospital(facility) 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               |      |
|----------------------------|------|
| <u>Deductibles</u>         | \$0  |
| <u>Copayments</u>          | \$10 |
| <u>Coinsurance</u>         | \$0  |
| What isn't covered         |      |
| Limits or exclusions       | \$60 |
| The total Peg would pay is | \$70 |

### 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 copayment \$10
- Hospital(facility) 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               |       |
|----------------------------|-------|
| <u>Deductibles</u>         | \$0   |
| <u>Copayments</u>          | \$420 |
| <u>Coinsurance</u>         | \$0   |
| What isn't covered         |       |
| Limits or exclusions       | \$20  |
| The total Joe would pay is | \$440 |

### Mia's Simple Fracture

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

- The plan's overall deductible \$0
- Specialist copayment \$10
- Hospital(facility) copayment \$50

#### 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 | \$2,800 |
|--------------------|---------|

In this example, Mia would pay:

| Cost Sharing               |       |
|----------------------------|-------|
| <u>Deductibles</u>         | \$0   |
| <u>Copayments</u>          | \$60  |
| <u>Coinsurance</u>         | \$100 |
| What isn't covered         |       |
| Limits or exclusions       | \$0   |
| The total Mia would pay is | \$200 |

Note: Immunizations in office are covered under medical as preventive. All amounts rounded to nearest \$10. The above diabetes example is based on 12 month, 30-day supply, at a preferred tier 3 copayment. This situation can vary based on prescriptions and other services your provider recommends.

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.

