North Cedar Community School District
Summary of Benefits and Coverage (SBC)
Wrap Document
2016 – 2017 School Year

Federal law requires that annually North Cedar CSD provide you with a "Summary of Benefits and Coverage" (hereafter referred to as the SBC.) The SBC gives you the basic Wellmark benefits and definitions of certain insurance terms.

Because your group health benefits are provided by a combination of (1) an underlying Wellmark Blue Cross Alliance Select group health plan, plus (2) an integrated Medical Expense Reimbursement Plan sponsored by the District, confusion is possible on account of the Wellmark SBC being limited to describing only the Wellmark portion of your benefits. This Wrap Document (hereafter referred to as the Wrap) summarizes the integrated benefits from the Medical Expense Reimbursement portion. The Wrap does not in any way, change, alter, or replace the contents of the Wellmark SBC, except when specifically noted.

Page 2 of the Wrap restates your actual benefits (deductible / annual out of pocket maximum) when combining both the underlying Wellmark Blue Cross coverage along with the benefits provided by our Medical Reimbursement Plan. On page 9 of the SBC, Wellmark has had to comply with the law by providing two examples how their plan might cover medical care in given situations (having a baby and managing type 2 diabetes.) Page 2 of the Wrap also restates the amount you might pay taking into consideration that benefits are provided by both Wellmark and the Medical Expense Reimbursement plan.

If you have any questions regarding the Wrap document, please call Bob Hanna at P.R.I.M.E. Benefit Systems (direct 319-294-4044) or e-mail him at Bhanna@primebenefitsystems.com.

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SBC page 1 of 10, "What is the overall **deductible**?" is restated to be "$500 per person/$1,000 aggregate family per calendar year." Both in-network eligible charges as well as out-of-network charges are applied to satisfying the deductible. The term "aggregate" means that no one person in a family needs to incur a $500 deductible, but rather any combination of deductibles met by all family members are limited to $1,000.

SBC page 1 of 10, "Is there an **out-of-pocket limit** on my expenses?" is restated to be "Yes, $750 person/$1,500 aggregate family per calendar year. Once you have met your single or family deductible, you will be responsible for paying 20% coinsurance of the allowed in-network charge, or 40% if the allowed charge was incurred out-of-network.
Once the sum of deductibles and coinsurance (for eligible charges subject to the deductible) has reached $750 for single coverage and $1,500 (in the aggregate) for family coverage, then Wellmark Blue Cross and/or your Medical Expense Reimbursement Plan will pay 100% of the remaining charges that are subject to the deductible or coinsurance. Again, eligible charges include those from in-network as well as out-of-network.

All other medical charges other than those above are correctly stated in the Wellmark Blue Cross SBC.

SBC page 9 of 10, the column noted as "Having a baby" is restated, in part, to be: (no change in the cost of type 2 diabetes)
O Amount owed to providers: $7,540
O Wellmark Alliance Select pays $1,960
O Medical Reimbursement Plan pays $3,864
O Patient pays $1,716

Patient pays:

Deductibles	$500
Copays	$100
Coinsurance	$966
Limits or exclusions	$150
Total	$1,716

Wellmark

Alliance Select℠

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

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 at www.wellmark.com or by calling 1-800-524-9242. To find your Coverage Manual visit www.wellmark.com/coveragemanual, click on "Large Group Plans" and enter the following number, including dashes, into the search field. **142841-18-170841-10**

Important Questions	Answers	Why this Matters:
What is the overall **deductible**?	**$5,000** person/**$10,000** family per calendar year Does not apply to well-child care, preventive care, in-network prosthetic limbs, colonoscopies, in-network outpatient/office services for mental health/substance abuse 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. **$100** person/**$200** family per calendar year for drug card. There are no other specific **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. Health: **$6,350** person/**$12,700** family per calendar year Drug Card: **$6,350** person/**$12,700** family per calendar year The In-Network health and drug card out-of-pocket maximum amounts accumulate together.	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, pre-service review penalties, 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.

Questions: Call 1-800-524-9242 or visit us at www.wellmark.com. 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.

06/18/2015;07/01/2016;9KI;3U1;142841-18;170841-10;00034384;N;NGF

Important Questions	Answers	Why this Matters:
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**.
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	$20 copay	40% coinsurance	------None------
	Specialist visit	$20 copay	40% coinsurance	------None------
	Other practitioner office visit	$20 copay for Chiropractors	40% coinsurance for Chiropractors	------None------
	Preventive care/screening/ immunization	No charge	40% 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)	Independent Lab: $20 copay Facility: 20% coinsurance	40% coinsurance	For a test in a provider's office or clinic, your cost is included in the cost-share listed above. Waive cost-share on in-network outpatient services for mental/ health substance abuse. Failure to obtain prior approval for services listed on Wellmark.com will result in denial with review rights.
	Imaging (CT /PET scans, MRIs)	20% coinsurance	40% 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	$8 copay	$8 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. 3 copays for 90-day supply (Retail maintenance). 2 copays for 90-day supply (Mail order maintenance). Specialty drugs are covered only when obtained through the Specialty Pharmacy Program. Failure to obtain prior authorization or prior approval for drugs listed on Wellmark.com will result in denial with review rights.
	Preferred brand drugs	$35 copay	$35 copay	
	Non-preferred brand drugs	$50 copay	$50 copay	
	Select non-preferred brand drugs	$50 copay	$50 copay	
	Specialty drugs	$85 copay	Not covered	

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 outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Waive cost-share on in-network outpatient services for mental health/substance abuse. Failure to obtain prior approval for services listed on Wellmark.com will result in denial with review rights.
	Physician / surgeon fees	20% coinsurance	40% coinsurance	Waive cost-share on in-network outpatient services for mental health/substance abuse. Failure to obtain prior approval for services listed on Wellmark.com will result in denial with review rights.
If you need immediate medical attention	Emergency room services	20% coinsurance	20% coinsurance	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	20% coinsurance	40% coinsurance	Waive cost-share on in-network outpatient services for mental health/substance abuse.
	Urgent care	$20 copay	40% coinsurance	------None------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Reduction for failure to precertify is 50%.
	Physician / surgeon fee	20% coinsurance	40% 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	0% coinsurance	40% coinsurance	------None------
	Mental/Behavioral health inpatient services	20% coinsurance	40% coinsurance	Reduction for failure to precertify is 50%.
	Substance use disorder outpatient services	0% coinsurance	40% coinsurance	------None------
	Substance use disorder inpatient services	20% coinsurance	40% coinsurance	Reduction for failure to precertify is 50%.
If you are pregnant	Prenatal and postnatal care	20% coinsurance	40% coinsurance	------None------
	Delivery and all inpatient services	20% coinsurance	40% 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	20% coinsurance	40% coinsurance	Waive cost-share on in-network outpatient services for mental health/substance abuse. Reduction for failure to precertify is 50% per approved service.
	Rehabilitation services	Office: $20 copay Facility: 20% coinsurance	40% coinsurance	Waive cost-share on in-network outpatient services for mental health/substance abuse. Reduction for failure to precertify is 50%.
	Habilitative services	Office: $20 copay Facility: 20% coinsurance	40% coinsurance	Waive cost-share on in-network outpatient services for mental health/substance abuse. Reduction for failure to precertify is 50%.
	Skilled nursing care	20% coinsurance	40% coinsurance	Limit of 90 days per calendar year. Reduction for failure to precertify is 50%.
	Durable medical equipment	20% coinsurance	40% coinsurance	Failure to obtain prior approval for services listed on Wellmark.com will result in denial with review rights.
	Hospice service	20% coinsurance	40% coinsurance	Waive cost-share on in-network outpatient services for mental health/substance abuse. Hospice respite care is limited to 15 inpatient and 15 outpatient days per lifetime.
If your child needs dental or eye care	Eye exam	Not covered	Not covered	------None------
	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
- Eye exam
- Glasses
- Hearing aids
- Long-term care
- Routine eye care - Adult
- 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 ($15,000 LTM, excludes some services)
- Most coverage provided outside the U.S.
- Private-duty nursing - short term intermittent home skilled nursing

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** $1,960
- **Patient pays** $5,580

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	$5,020
Copays	$100
Coinsurance	$310
Limits or exclusions	$150
Total	**$5,580**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,790
- **Patient pays** $1,610

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	$120
Copays	$1,330
Coinsurance	$0
Limits or exclusions	$160
Total	**$1,610**

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.

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