


City of Sioux City Plan A Active 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 [optumrx.com](http://optumrx.com) or call 1-855-524-0379. 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) to request a copy.

Important Questions	Answers	Why this Matters:
<b>What is the overall <u>deductible</u>?</b>	In- <u>Network</u> : <b>\$1,000</b> person/ <b>\$1,400</b> two-person/ <b>\$1,800</b> family per calendar year. Out-of- <u>Network</u> : <b>\$1,500</b> person/ <b>\$2,250</b> two-person/ <b>\$3,000</b> 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 individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Yes. Well-child care, in- <u>network</u> <u>preventive care</u> , in-network independent labs, preadmission testing, your drug card costs and services subject to office visit and <u>urgent care copayments</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 <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <u>deductibles</u> for specific services?</b>	Yes. <b>\$140</b> person per calendar year for prosthetic limbs. Applies to overall <u>deductible</u> . There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	Health In- <u>Network</u> : <b>\$1,600</b> person/ <b>\$2,400</b> two-person/ <b>\$3,200</b> family per calendar year. Health Out-Of- <u>Network</u> : <b>\$3,000</b> person/ <b>\$4,500</b> two-person/ <b>\$6,000</b> family per calendar year. Drug card: <b>\$6,050</b> person/ <b>\$9,075</b> two-person/ <b>\$12,100</b> family per calendar year. The In- <u>Network</u> health and drug card out-of-pocket 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.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	Premiums, <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> .

Important Questions	Answers	Why this Matters:
Will you pay less if you use a <u>network provider</u> ?	Yes. See <a href="http://www.wellmark.com">www.wellmark.com</a> or call 1-800-524-9242 for a list of health <u>network providers</u> .	This plan uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>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 provider's charge 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.
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-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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$25 <u>copay</u> per date of service	30% <u>coinsurance</u>	Waive cost-share for preadmission testing.
	<u>Specialist</u> visit	\$25 <u>copay</u> per date of service	30% <u>coinsurance</u>	Waive cost-share for preadmission testing. Hearing exams are covered according to ACA guidelines.
	<u>Preventive care/screening/immunization</u>	No charge	Not covered	One preventive exam and one gynecological exam per calendar year. One mammogram per calendar year. Well-child care is covered to age 15. Waive cost-share up to \$500 for employee/spouse and \$250 for children per calendar year for out-of- <u>network</u> routine care. Waive cost-share for out-of- <u>network</u> well-child care. 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>	30% <u>coinsurance</u>	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 preadmission testing.
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	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, see your plan document or call City of Sioux City at 1-712-279-6200.

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
		Retail 30	Mail 90		
<b>If you need drugs to treat your illness or condition</b>  More information about <b>prescription drug coverage</b> is available at <a href="http://www.optum.com">www.optum.com</a>	Tier 1	\$5	\$10	N/A	Retail prescriptions are limited to a 30 day supply. Mail Order prescriptions can be filled for 30, 60, or 90 day supply.  Specialty medications must be filled using the BrioVaRx Specialty Pharmacy. Visit <a href="http://BrioVaRx.com">BrioVaRx.com</a> or call 1-855-427-4682.  Certain medications are excluded from coverage, and others require Prior Authorization. Additionally, certain preventative medications are covered without cost sharing in accordance with the Affordable Care Act. For more information about prescription drug coverage, please visit <a href="http://www.optumrx.com">www.optumrx.com</a> , or call 1-855-524-0379.
	Tier 2	\$25	\$50	N/A	
	Tier 3	\$35	\$70	N/A	
	Specialty drugs	30 Day	\$50	N/A	
	60 Day	\$100			
	90 Day	\$100			
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>		30% <u>coinsurance</u>	-----None-----
	Physician/surgeon fees	10% <u>coinsurance</u>		30% <u>coinsurance</u>	-----None-----
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	\$100 <u>copay</u> and 10% <u>coinsurance</u> per date of service for facility and physician(s) combined		\$100 <u>copay</u> and 10% <u>coinsurance</u> per date of service for facility and physician(s) combined	For <u>emergency medical conditions</u> treated out-of- <u>network</u> , you may be balance billed.
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>		10% <u>coinsurance</u>	For covered non-emergent situations, out-of- <u>network</u> ambulance services are NOT reimbursed at the in- <u>network</u> level. The member may be balance billed for any out-of- <u>network</u> service.
	<u>Urgent care</u>	\$25 <u>copay</u> per date of service		30% <u>coinsurance</u>	Waive in-network copay on services for mental health/substance abuse.

For more information about limitations and exceptions, see your plan document or call City of Sioux City at 1-712-279-6200.

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)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Reduction for failure to precertify out-of- <u>network</u> services is 50% and will not exceed \$850 per admission.
	<u>Physician</u> /surgeon fees	Physician visit: 0% <u>coinsurance</u> Surgeon: 10% <u>coinsurance</u>	Physician visit: 0% <u>coinsurance</u> Surgeon: 30% <u>coinsurance</u>	-----None-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	-----None-----
	Inpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Residential treatment is covered with no 24 hour nursing supervision requirement. Reduction for failure to precertify out-of- <u>network</u> services is 50% and will not exceed \$850 per admission.
If you are pregnant	Office visits	10% <u>coinsurance</u>	30% <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> . For any in- <u>network</u> services that fall outside of routine obstetric care, the office visit benefits shown above may apply.
	Childbirth/delivery professional services	10% <u>coinsurance</u>	30% <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>	30% <u>coinsurance</u>	-----None-----

For more information about limitations and exceptions, see your plan document or call City of Sioux City at 1-712-279-6200.

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>	30% <u>coinsurance</u>	Reduction for failure to precertify is 50% per covered service. Waive cost-share for preadmission testing.
	<u>Rehabilitation services</u>	Office: \$25 <u>copay</u> per date of service Facility: 10% <u>coinsurance</u>	30% <u>coinsurance</u>	Massage therapy is covered.
	<u>Habilitation services</u>	Office: \$25 <u>copay</u> per date of service Facility: 10% <u>coinsurance</u>	30% <u>coinsurance</u>	Massage therapy is covered.
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Reduction for failure to precertify out-of-network services is 50% and will not exceed \$850 per admission.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Orthotics are covered. Wigs are covered for hair loss due to a medical condition.
	<u>Hospice services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Hospice care is limited to 30 inpatient days per calendar year. Hospice respite is not covered.
<b>If your child needs dental or eye care</b>	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 City of Sioux City at 1-712-279-6200.

## 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-covered through age 18 subject to annual limits
- Bariatric surgery
- Chiropractic care (26 visits per calendar year)
- Infertility treatment (excludes some services)
- 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 Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

**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: City of Sioux City at 1-712-279-6200, Iowa Insurance Division at 515-281-5705, or Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

### **Does this plan provide Minimum Essential Coverage? Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.


### **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 may 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 \$1,000
- PCP copayment \$25
- Hospital(facility) coinsurance 10%
- Other coinsurance 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 deductible \$1,000
- Specialist copayment \$25
- Hospital(facility) coinsurance 10%
- Other 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)

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

- The plan's overall deductible \$1,000
- Specialist copayment \$25
- Hospital(facility) copay and coin. \$100 and 10%
- Other coinsurance 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)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,000
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$500
What isn't covered	
<b>Limits or exclusions</b>	<b>\$70</b>
<b>The total Peg would pay is</b>	<b>\$1,670</b>

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$50
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$0
What isn't covered	
<b>Limits or exclusions</b>	<b>\$4,300</b>
<b>The total Joe would pay is</b>	<b>\$4,550</b>

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,000
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$80
What isn't covered	
<b>Limits or exclusions</b>	<b>\$10</b>
<b>The total Mia would pay is</b>	<b>\$1,290</b>

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.