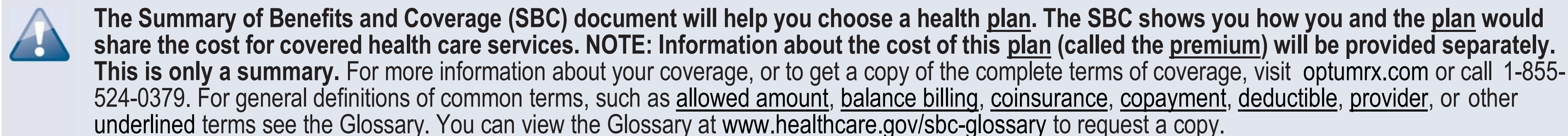
Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage Period: 07/01/2021 – 12/31/2021
Coverage for: Single, Two-person & Family | Plan Type: PPO

City of Sioux City Plan C 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 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 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-Network: **$667** person/**$934** two-person/**$1,200** family per calendar year. Out-of-Network: **$1,000** person/**$1,500** two-person/**$2,000** 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. Well-child care, in-network preventive care, in-network independent labs, preadmission testing, your drug card costs and services subject to office visit and urgent care copayments.	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?	Yes. **$140** person per calendar year for prosthetic limbs. Applies to overall deductible. There are no other specific deductibles.	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.
What is the out-of-pocket limit for this plan?	Health In-Network: **$1,067** person/**$1,600** two-person/**$2,134** family per calendar year. Health Out-Of-Network: **$2,000** person/**$3,000** two-person/**$4,000** family per calendar year. Drug Card: **$6,050** person/**$9,075** two-person/**$12,100** 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.

Important Questions	Answers	Why this Matters:
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 health 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 referral to see a specialist?	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	$25 copay per date of service	30% coinsurance	Waive cost-share for preadmission testing.
	Specialist visit	$25 copay per date of service	30% coinsurance	Waive cost-share for preadmission testing. Hearing exams are covered according to ACA guidelines.
	Preventive care/screening/ immunization	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-network routine care. Waive cost-share for out-of-network well-child care. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	For a test in a provider's 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% coinsurance	30% coinsurance	For a test in a provider's 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 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		
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com.	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 BriovaRx.com 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 www.optumrx.com, 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	
		600 Day	$100		
		90 Day	$100		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance		30% coinsurance	------None------
	Physician/surgeon fees	10% coinsurance		30% coinsurance	------None------
If you need immediate medical attention	Emergency room care	$100 copay and 10% coinsurance per date of service for facility and physician(s) combined		$100 copay and 10% coinsurance per date of service for facility and physician(s) combined	For emergency medical conditions treated out-of-network, you may be balance billed.
	Emergency medical transportation	10% coinsurance		10% coinsurance	For covered non-emergent situations, out-of-network ambulance services are NOT reimbursed at the in-network level. The member may be balance billed for any out-of-network service.
	Urgent care	$25 copay per date of service		30% coinsurance	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 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% coinsurance	30% coinsurance	Reduction for failure to precertify out-of-network services is 50% and will not exceed $850 per admission.
	Physician/surgeon fees	Physician visit: 0% coinsurance Surgeon: 10% coinsurance	Physician visit: 0% coinsurance Surgeon: 10% coinsurance	------None------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	30% coinsurance	------None------
	Inpatient services	10% coinsurance	30% coinsurance	Residential treatment is covered with no 24 hour nursing supervision requirement. Reduction for failure to precertify out-of-network services is 50% and will not exceed $850 per admission.
If you are pregnant	Office visits	10% coinsurance	30% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Cost sharing does not apply for preventive services. For any in-network services that fall outside of routine obstetric care, the office visit benefits shown above may apply.
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	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% coinsurance	30% coinsurance	------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 need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	Reduction for failure to precertify is 50% and will not exceed $850 per admission. Waive cost-share for preadmission testing.
	Rehabilitation services	Office: $25 copay per date of service Facility: 10% coinsurance	30% coinsurance	Massage therapy is covered.
	Habilitation services	Office: $25 copay per date of service Facility: 10% coinsurance	30% coinsurance	Massage therapy is covered.
	Skilled nursing care	10% coinsurance	30% coinsurance	Reduction for failure to precertify out-of-network services is 50% and will not exceed $850 per admission.
	Durable medical equipment	10% coinsurance	30% coinsurance	Orthotics are covered. Wigs are covered for hair loss due to a medical condition.
	Hospice services	10% coinsurance	30% coinsurance	Hospice care is limited to 30 days inpatient days per calendar year. Hospice respite is not covered.
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------

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.

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.

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.

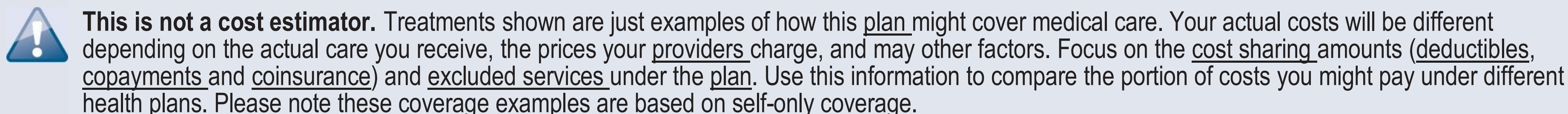
Does this plan meet the Minimum Value Standards? Yes

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 $667
- 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*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$667
Copayments	$100
Coinsurance	$300
What isn't covered	
Limits or exclusions	**$70**
The total Peg would pay is	**$1,137**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible $667
- 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*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$50
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	**$4,300**
The total Joe would pay is	**$4,550**

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

- The plan's overall deductible $667
- 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*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$667
Copayments	$200
Coinsurance	$100
What isn't covered	
Limits or exclusions	**$10**
The total Mia would pay is	**$977**

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.