Coverage Period: 01/01/2022 – 12/31/2022
Coverage for: Single & Family | Plan Type: PPO

Iowa State University Employee 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 https://www.hr.iastate.edu/benefits/insurance/isu-plan#medical or call 1-515-294-4800. 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 or call 1-800-318-2596 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-Network: **$0** person per calendar year. Out-of-Network: **$400** person/**$800** 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 independent labs, in-network providers, your drug card costs and services subject to copayments are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	No. There are no other deductibles. Drug card deductible?	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: **$2,000** person/**$4,000** family per calendar year. Out-Of-Network: **$4,000** person/**$8,000** family per calendar year.	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, copayments, 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.

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 for exams, 10% coinsurance other services per provider per date of service	20% coinsurance	$25 copay for exams, 10% coinsurance other services per provider per date of service applies to telehealth services delivered by in-network primary care providers. $25 copay per provider per date of service applies to telehealth services delivered by providers contracting through Doctor on Demand.
	Specialist visit	$25 copay for exams, 10% coinsurance other services per provider per date of service	20% coinsurance	$25 copay per provider per date of service for in-network chiropractic services. This copay is waived for mental health/substance abuse. One routine hearing exam per calendar year. Out-of-network hearing exam is not covered. $25 copay for exams, 10% coinsurance other services per provider per date of service applies to covered telehealth services provided by in-network specialists.
	Preventive care/screening/ immunization	$25 copay for exams, 10% coinsurance other services per provider per	20% coinsurance	One preventive exam and one gynecological exam with Pap smear per calendar year. One mammogram per calendar year. Well-child care is covered to age 7. Out-of-network preventive services are not covered, except for immunizations, mammograms and well-child care.

For more information about limitations and exceptions, see your plan document or call Iowa State University at 1-515-294-4800

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
		date of service		
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	20% coinsurance	In-network independent labs services for mental health/ substance abuse are not subject to coinsurance.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	20% coinsurance	------None------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.hr.iastate.edu/benefits/insurance/isu-plan#prescription	Tier 1 – Generics	Co-pay $15.00 /zero for 90 days mail order	For OON pharmacies, you may be required to pay 100% to pharmacy and file a claim; reimbursement will be determined by the Express Scripts plan.	The PPO plan has limited drug coverage and the certificate should be reviewed for the specifics. ISU has a stand-alone prescription plan. The drugs listed on the ISU/ Express Scripts plan drug formulary are covered per the Express Script contract ISU maintains. Drugs not on the plan formulary are not covered. The plan has clinical programs including step therapy and prior authorization requirements for some drugs or the drug may not be covered. For Specialty drugs, participants should contact the customer service on the prescription drug ID card. **For brand name drugs the co-insurance has a maximum cost limit dependent on drug tier.**
	Tier 2 - Preferred brand	Coinsurance 30% 25% for mail order		
	Tier 3 – Non-preferred brand	Coinsurance 50% 33% for mail order		
	Specialty drugs	May be preferred or non-preferred category and Specialty pharmacy may be required		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	20% coinsurance	------None------
	Physician/surgeon fees	10% coinsurance	20% coinsurance	------None------
If you need immediate medical attention	Emergency room care	$125 copay and 10% coinsurance per visit for facility and physician(s) combined	$125 copay and 10% coinsurance per visit for facility and physician(s) combined	For emergency medical conditions treated out-of-network, you may be balance billed. Waive cost-share on emergency room services for mental health/substance abuse.
	Emergency medical transportation	10% coinsurance	10% coinsurance	Benefits for non-participating ambulance providers are based on actual billed charges. For covered non-emergent situations, out-of-network ambulance services are NOT reimbursed at the in-network level.
	Urgent care	$25 copay for exams, 10% coinsurance	20% coinsurance	Waive cost-share on urgent care services for mental health/substance abuse.

For more information about limitations and exceptions, see your plan document or call Iowa State University at 1-515-294-4800

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
		other services per provider per date of service		
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	20% coinsurance	Reduction for failure to precertify out-of-network services is 30% and will not exceed $2,000 per calendar year.
	Physician/surgeon fees	10% coinsurance	20% coinsurance	------None------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: 0% coinsurance Facility: 10% coinsurance	20% coinsurance	------None------
	Inpatient services	10% coinsurance	20% coinsurance	Reduction for failure to precertify out-of-network services is 30% and will not exceed $2,000 per calendar year.
If you are pregnant	Office visits	10% coinsurance	20% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). 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	20% 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	20% coinsurance	------None------

For more information about limitations and exceptions, see your plan document or call Iowa State University at 1-515-294-4800

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	20% coinsurance	Reduction for failure to precertify is 30% and will not exceed $2,000 per calendar year.
	Rehabilitation services	10% coinsurance	20% coinsurance	------None------
	Habilitation services	10% coinsurance	20% coinsurance	------None------
	Skilled nursing care	10% coinsurance	20% coinsurance	Reduction for failure to precertify out-of-network services is 30% and will not exceed $2,000 per calendar year.
	Durable medical equipment	10% coinsurance	20% coinsurance	------None------
	Hospice services	10% coinsurance	20% coinsurance	Hospice respite care is limited to 15 inpatient and 15 outpatient days per lifetime.
If your child needs dental or eye care	Children's eye exam	$25 copay for exams, 10% coinsurance other services per provider per date of service	Not covered	One routine vision exam per calendar year.
	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 Iowa State University at 1-515-294-4800

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
- Glasses
- Hearing aids
- Long-term care
- 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
- Bariatric surgery
- Chiropractic care
- Infertility treatment ($15,000 LTM)
- 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: 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: Iowa State University at 1-515-294-4800, 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 $0
- PCP exam copay services coinsurance $25 and 10%
- 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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$1,300
What isn't covered	
Limits or exclusions	**$100**
The total Peg would pay is	**$1,400**

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

- The plan's overall deductible $0
- Specialist exam copay services coinsurance $25 and 10%
- 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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$200
Coinsurance	$30
What isn't covered	
Limits or exclusions	**$4,400**
The total Joe would pay is	**$4,630**

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

- The plan's overall deductible $0
- Specialist exam copay services coinsurance $25 and 10%
- Hospital(facility) copay and coinsurance $125 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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$200
Coinsurance	$200
What isn't covered	
Limits or exclusions	**$10**
The total Mia would pay is	**$410**

RX Admin Note: Excluded charges include all pharmacy drugs. Immunizations in office are covered under medical as preventive. All amounts rounded to nearest $10.