Black Hawk College Health Benefit Plan

Coverage for: Individual, Family | **Plan Type:** 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, contact your Human Resources Department. 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.consociatehealth.com or call 1-800-798-2422 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0** Network and **$400** person/**$1200** family Non-network. Doesn't apply to preventative care or drug card.	Generally, you must pay all of 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. Preventive care services 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. 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 https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductible for specific services.
What is the out-of-pocket limit for this plan?	**$2,100** person / **$6,300** for family for Network and **$2,500** person / **$6,600** family for Non-Network.	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, penalties for failure to complete Preauthorization, balanced-billed charges, amounts over Usual and Customary fees and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See **www.aetna.com/asa** for a list of Network (AETNA) 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 **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		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copayment / visit	30% coinsurance	None
	Specialist visit	$20 copayment / visit	30% coinsurance	Chiropractic Services limited to 12 visits per calendar year.
	Preventive care/screening/ immunization	No charge	No charge	Covered at 100% according to the guidelines under Healthcare Reform. You may have to pay for services that are not preventative. Ask your provider if the services needed are preventative, then check what your plan will pay for. Two Wellness visits covered for Women per calendar year: Well Woman Exam and Wellness Visit with physician.
If you have a test	Diagnostic test (x-ray, blood work)	0% to max basic benefit, then $20 copayment per separate provider.	30% coinsurance	Different Benefits if not Hospital Outpatient
	Imaging (CT/PET scans, MRIs)	0% to max basic benefit, then $20 copayment per separate provider.	30% coinsurance	Preauthorization required. Different benefits if not Hospital Outpatient.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.serve-you-rx.com or call 1-800-759-3203.	Generic drugs	$10/prescription (retail) and $20/prescription (mail order)	$10 copay, then 25% coinsurance	Covers up to a 34-day supply (retail); 90- day supply (mail order).
	Preferred brand drugs	$30/prescription (retail) and $60/prescription (mail order)	$30 copay, then 25% coinsurance	
	Non-preferred brand drugs	$30/prescription (retail) and $60/prescription (mail order)	$30 copay, then 25% coinsurance	
	Specialty drugs	$100/prescription	Not Covered	Available through mail order only
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 copayment then 0% to max basic benefit, then 20% coinsurance	$100 copayment, then 30% coinsurance	Procedures requiring anesthesia require Preauthorization.
	Physician/surgeon fees	$100 copayment then 0% to max basic benefit, then 20% coinsurance	$100 copayment, then 30% coinsurance	Procedures requiring anesthesia require Preauthorization.
If you need immediate medical attention	Emergency room care	$150 copayment then covered 100%	$150 copayment, then covered 100% for true emergency, **or** $150 copayment, then covered 30% for non-emergency.	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency medical transportation	No Charge	No Charge	None
	Urgent care	$20 copayment / visit	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 copayment then 0% to max basic benefit, then 20% coinsurance	$100 copayment, then 30% coinsurance	All inpatient stays require Preauthorization.
	Physician/surgeon fees	$100 copayment then 0% to max basic benefit, then 20% coinsurance	30% coinsurance	All inpatient stays require Preauthorization.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copayment / visit	30% coinsurance	None
	Inpatient services	$100 copayment then 0% to max basic benefit, then 20% coinsurance	$100 copayment, then 30% coinsurance	All inpatient stays require Preauthorization.
If you are pregnant	Office visits	$20 copayment	30% coinsurance	Some maternity inpatient stays require Preauthorization.
	Childbirth/delivery professional services	$100 copayment then 0% to max basic benefit, then 20% coinsurance	$100 copayment, then 30% coinsurance	
	Childbirth/delivery facility services	$100 copayment then 0% to max basic benefit, then 20% coinsurance	$100 copayment, then 30% coinsurance	
If you need help recovering or have other special health needs	Home health care	$20 copayment / day	30% coinsurance	Limited to 120 visits per calendar year
	Rehabilitation services	$100 copayment then 0% to max basic benefit, then 20% coinsurance	30% coinsurance	Inpatient Care paid as hospital benefit. All inpatient stays require Preauthorization.
	Habilitation services	$20 copayment / day	30% coinsurance	None
	Skilled nursing care	$40 copayment / day	25% coinsurance	Limited to 60 days per calendar year
	Durable medical equipment	$20 copayment / fitting visit. Appliance or device covered 100%	30% coinsurance	None
	Hospice services	No Charge	30% coinsurance	All inpatient stays require Preauthorization.
If your child needs dental or eye care	Children's eye exam	No Charge	Limited to one exam per year	None
	Children's glasses	See Plan Document for Coverage Limits	Limited to one pair of glasses per year	None
	Children's dental check-up	No Charge	Limited to two per year	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 (if prescribed for rehabilitation purposes) • Bariatric surgery • Cosmetic surgery	• Hearing aids • Infertility Treatment • Long Term Care	• Massage Therapy • 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.)		
• Chiropractic care (limited to 12 visits per calendar year.) • Dental care	• Non-emergency care when traveling outside the USA	• Private-duty 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: Consociate Health: 1-800-798-2422. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa or the U.S. Department of Health and Human Services at 1-877-267-2323 x 61565 or 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 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 on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Consociate Health: 1-800-798-2422

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.

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-800-798-2422.

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-798-2422.

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-798-2422.

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-798-2422.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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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**
- **Specialist copayment** **$20**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

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	$0
Copayments	$200
Coinsurance	$1,900
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$2,100**

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 copayment** **$20**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

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	$0
Copayments	$180
Coinsurance	$1,084
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,264**

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

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$20**
- **Hospital (facility) copayment** **$150**
- **Other coinsurance** **20%**

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	$0
Copayments	$270
Coinsurance	$
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$376**

The plan would be responsible for the other costs of these EXAMPLE covered services.