

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.

Important Questions	Answers	Why this Matters:
What is the overall deductible ?	\$250 person/ \$500 family per calendar year Does not apply to well-child/maternity care, in-network preventive/prosthetic limbs/inpatient, in and out-of-network practitioner, outpatient/home health/ambulance/office/independent labs for mental health/substance abuse services 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. There are no other 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: \$1,000 person/ \$2,000 family per calendar year Drug Card: \$5,600 person/ \$11,200 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 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 <i>specific</i> 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.

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	\$15 copay	20% coinsurance	Primary Care Practitioners (PCP) are defined as General and Family Practice, Internal Medicine, OB/GYN, Pediatricians, Nurse Practitioners, and PAs. You must designate a PCP or OB/GYN.
	Specialist visit	\$30 copay	20% coinsurance	Applies to Non-PCP providers.
	Other practitioner office visit	\$15 copay for Chiropractors \$15 Level 1/\$30 Level 2 copay for hearing exams	20% coinsurance for Chiropractors, hearing and vision exams	No charge for routine vision exam. One routine hearing and vision exam per calendar year.
	Preventive care/screening/immunization	No charge	Not covered	One preventive exam, one gynecological exam with Pap smear and one mammogram per calendar year. Well-child care is covered to age 7. Must be provided by or coordinated through your designated PCP or OB/GYN.
If you have a test	Diagnostic test (x-ray, blood work)	Independent Lab: No charge Facility: \$25 copay	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 on 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)	Practitioner: 10% coinsurance Facility: \$25 copay	30% 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.

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 drugs to treat your illness or condition More information about prescription drug coverage is available at www.wellmark.com .	Generic drugs	\$5 copay	\$5 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 34-day supply. 2 copays for 93-day supply (Retail and Mail order maintenance). Injectable specialty drugs are covered under health and oral specialty drugs are covered under the drug card plan and your cost share is determined by their placement on Wellmark's Drug List. Failure to obtain prior authorization or prior approval for drugs listed on Wellmark.com will result in denial with review rights.
	Preferred brand drugs	\$20 copay	\$20 copay	
	Non-preferred brand drugs	\$35 copay	\$35 copay	
	Select non-preferred brand drugs	\$35 copay	\$35 copay	
	Specialty drugs	Same as cost-share above depending on drug category.	Same as cost-share above depending on drug category.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$25 copay	30% coinsurance	Waive cost-share on 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	10% coinsurance	30% coinsurance	Waive cost-share on 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.

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 immediate medical attention	Emergency room services	10% coinsurance	10% coinsurance	For emergency medical conditions treated out-of-network, you may be balance billed. Dental treatment for accidental injury is limited to care initiated within 72 hours and completed within 30 days of the injury.
	Emergency medical transportation	\$50 copay	30% coinsurance	Waive cost-share on outpatient services for mental health/substance abuse.
	Urgent care	\$15 Level 1/\$30 Level 2 copay	30% coinsurance	Waive cost-share on outpatient services for mental health/substance abuse. Benefits shown apply to office/clinic practitioners. The cost you will pay for facility services will depend on how the facility bills the services.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	\$300 copay and 30% coinsurance	Reduction for failure to precertify is 20%.
	Physician / surgeon fee	10% coinsurance	30% 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	0% coinsurance	-----None-----
	Mental/Behavioral health inpatient services	10% coinsurance	\$300 copay and 30% coinsurance	Reduction for failure to precertify is 20%.
	Substance use disorder outpatient services	0% coinsurance	0% coinsurance	-----None-----
	Substance use disorder inpatient services	10% coinsurance	\$300 copay and 30% coinsurance	Reduction for failure to precertify is 20%.
If you are pregnant	Prenatal and postnatal care	No Charge	30% coinsurance	-----None-----
	Delivery and all inpatient services	Practitioner: No Charge Facility: 10% coinsurance	Practitioner: 30% coinsurance Facility: \$300 copay and 30% 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	10% coinsurance	30% coinsurance	Limit of 60 visits per calendar year. Waive cost-share on outpatient services for mental health/substance abuse. Reduction for failure to precertify is 20%.
	Rehabilitation services	Office: \$15 Level 1 / \$30 Level 2 copay \$10 copay for PT / ST / OT Outpatient: \$25 copay Inpatient: 10% coinsurance	30% coinsurance	Physical Therapists, Occupational Therapists and Speech Language Pathologists are covered at the PCP benefit level. Physical, speech and occupational therapies are limited to 60 visits each per calendar year. Waive cost-share on outpatient services for mental health/substance abuse. Reduction for failure to precertify is 20%.
	Habilitative services	Office: \$15 Level 1 / \$30 Level 2 copay \$10 copay for PT / ST / OT Outpatient: \$25 copay Inpatient: 10% coinsurance	30% coinsurance	Physical Therapists, Occupational Therapists and Speech Language Pathologists are covered at the PCP benefit level. Physical, speech and occupational therapies are limited to 60 visits each per calendar year. Waive cost-share on outpatient services for mental health/substance abuse. Reduction for failure to precertify is 20%.
	Skilled nursing care	\$50 per day copay	\$300 copay and 30% coinsurance	Reduction for failure to precertify is 20%.
	Durable medical equipment	\$50 copay	30% coinsurance	Wigs are a covered benefit.
	Hospice service	20% coinsurance	30% coinsurance	Waive cost-share on outpatient services for mental health/substance abuse.
	If your child needs dental or eye care	Eye exam	No charge	20% coinsurance
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
- Dental care - Adult
- Dental check-up
- Glasses
- Hearing aids
- Long-term care
- 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 (limited to Blue Distinction Centers)
- Chiropractic care
- Infertility treatment (excludes some services)
- Most coverage provided outside the U.S.
- Private-duty nursing
- Routine eye care - Adult (one vision exam per calendar year)

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.

Language Access Services:

Para recibir asistencia en español, por favor comuníquese al servicio de cliente, al número que aparece 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 \$6,710
- Patient pays \$830

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	\$250
Copays	\$10
Coinsurance	\$420
Limits or exclusions	\$150
Total	\$830

Claim example applies Level 1 benefits.

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.

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

- Amount owed to providers: \$5,400
- Plan pays \$4,260
- Patient pays \$1,140

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	\$0
Copays	\$980
Coinsurance	\$0
Limits or exclusions	\$160
Total	\$1,140

Claim example applies Level 1 benefits.

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?

- X 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?

- X 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.

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.

Wellmark Health Plan of Iowa, Inc. is an Independent Licensee of the Blue Cross and Blue Shield Association.

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.