



### IAED Copay Select \$1,500 PPO



The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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 <u>www.wellmark.com</u> or call 1-866-807-9430. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms see the Glossary. You can view the Glossary at <u>www.healthcare.gov/sbc-glossary</u> or call 1-866-807-9430 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$1,500 person/\$3,000 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> .
Are there services covered before you meet your deductible?	Yes. Well-child care, in-network preventive care, in-network independent labs, in-network routine vision exams, in-network prosthetic limbs, mammograms and services subject to copayments are covered before you meet your deductible.	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 <u>www.healthcare.gov/coverage/preventive-care-benefits/</u> .
Are there other <u>deductibles</u> for specific services?	Yes. <b>\$50</b> person/ <b>\$100</b> family per calendar year for drug card, which does not apply to Tier 1 Rx. There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	Health: \$3,000 person/\$6,000 family per calendar year. Drug Card: \$1,500 person/\$3,000 family per calendar year. The In-Network 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.
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 <u>network provider</u> ?	Yes. See <a href="https://www.wellmark.com">www.wellmark.com</a> or call 1-866-807-9430 for a list of <a href="https://www.mellmark.com">network</a> <a href="https://www.mellmark.com">providers</a> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan</u> 's <u>network</u> . You will pay the most if you use an out-of- <u>network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider</u> 's charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an out-of- <u>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 <u>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> applies.

	Common Medical Event	Services You May Need	What You Will Pay In- <u>Network</u> (IN) <u>Provider</u> (You will pay the least)	What You Will Pay Out-of- <u>Network</u> (OON) <u>Provider</u> (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	\$15 <u>copay</u> per date of service	30% coinsurance	Primary Care Practitioners (PCP) are defined as General and Family Practice, Internal Medicine, OB/GYN, Pediatricians, Nurse Practitioners and PAs.	
	Specialist visit	\$30 <u>copay</u> per date of service	30% coinsurance	Applies to Non-PCP <u>providers</u> . \$15 <u>copay</u> per date of service for in- <u>network</u> chiropractic services.	
	Preventive care/screening/ immunization	No charge	30% coinsurance	One preventive exam and one gynecological exam per calendar year. One mammogram per calendar year. Well-child care is covered to age 7. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need 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)	20% coinsurance	30% coinsurance	For a test in a <u>provider</u> 's office or clinic, your cost is included in the cost-share listed above. In- <u>network</u> independent labs for mental health/substance abuse services are not subject to <u>coinsurance</u> .
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance	For a test in a <u>provider</u> 's office or clinic, your cost is included in the cost-share listed above.	

For more information about limitations and exceptions, see your <u>plan</u> document or call Wellmark at 1-866-807-9430. You can find your Coverage Manual at <u>sbccmfinder.wellmark.com</u>.

Common Medical Event	Services You May Need	What You Will Pay In- <u>Network</u> (IN) <u>Provider</u> (You will pay the least)	What You Will Pay Out-of- <u>Network</u> (OON) <u>Provider</u> (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need drugs to	Tier 1	\$10 copay per prescription	\$10 copay per prescription	Drugs listed on Wellmark's Blue Rx Value Plus Drug List are covered. Drugs not on this Drug List are not covered.
treat your illness or condition	Tier 2	\$25 <u>copay</u> per prescription	\$25 <u>copay</u> per prescription	For out-of- <u>network prescription drugs</u> , you may be balance billed.  1 <u>copay</u> for 30-day supply.
More information	Tier 3	\$40 <u>copay</u> per prescription	\$40 <u>copay</u> per prescription	3 <u>copays</u> for 90-day supply (Retail maintenance). 2 <u>copays</u> for 90-day supply (Mail order maintenance).
about <u>prescription</u> <u>drug coverage</u> is at <u>www.wellmark.com/</u> <u>prescriptions</u> .	Specialty drugs	\$85 <u>copay</u> per prescription	Not covered	Specialty drugs are covered only when obtained through the CVS Specialty Pharmacy Program. See wellmark.com/prescriptions for information about drugs and drug quantities that require prior authorization by Wellmark to be covered by your plan.
If you have	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance	None
outpatient surgery	Physician/surgeon fees	20% coinsurance	30% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	For <u>emergency medical conditions</u> treated out-of- <u>network</u> , you may be balance billed.
	Emergency medical transportation	20% coinsurance	20% 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	\$15 <u>copay</u> per date of service	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance	Reduction for failure to precertify out-of-network services is 50% and will not exceed \$500 per admission.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	None

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Common Medical Event	Services You May Need	What You Will Pay In- <u>Network</u> (IN) <u>Provider</u> (You will pay the least)	What You Will Pay Out-of- <u>Network</u> (OON) <u>Provider</u> (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance	Outpatient services	Office: \$15 copay per date of service Facility: 20% coinsurance	30% coinsurance	None
abuse services	Inpatient services	20% coinsurance	30% coinsurance	Reduction for failure to precertify out-of-network services is 50% and will not exceed \$500 per admission.
If you are pregnant	Office visits	20% coinsurance	30% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Cost sharing does not apply to certain <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	20% 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	20% coinsurance	30% coinsurance	None

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Common Medical Event	Services You May Need	What You Will Pay In- <u>Network</u> (IN) <u>Provider</u> (You will pay the least)	What You Will Pay Out-of- <u>Network</u> (OON) <u>Provider</u> (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Home health care	20% coinsurance	30% coinsurance	Reduction for failure to precertify is 50% per covered service.
	Rehabilitation services	Office: \$15 PCP/\$30 Non-PCP <u>copay</u> per date of service Facility: 20% <u>coinsurance</u>	30% coinsurance	\$15 <u>copay</u> per date of service applies to in- <u>network</u> Physical and Occupational Therapists and Speech Language Pathologists.
If you need help recovering or have other special health needs	Habilitation services	Office: \$15 PCP/\$30 Non-PCP <u>copay</u> per date of service Facility: 20% <u>coinsurance</u>	30% coinsurance	\$15 <u>copay</u> per date of service applies to in- <u>network</u> Physical and Occupational Therapists and Speech Language Pathologists.
	Skilled nursing care	20% coinsurance	30% coinsurance	Reduction for failure to precertify out-of-network services is 50% and will not exceed \$500 per admission.
	Durable medical equipment	20% coinsurance	30% coinsurance	Orthopedic devices are covered including application of orthotic, impression, casting, fitting, training, shoes and trusses.
	Hospice services	20% coinsurance	30% coinsurance	Hospice respite care is limited to 15 inpatient and 15 outpatient days per lifetime.
	Children's eye exam	No charge	30% coinsurance	One routine vision exam per calendar year.
If your child needs dental or eye care	Children's glasses	Not covered	Not covered	None
dental of eye care	Children's dental check-up	Not covered	Not covered	None

For more information about limitations and exceptions, see your <u>plan</u> document or call Wellmark at 1-866-807-9430. You can find your Coverage Manual at <u>sbccmfinder.wellmark.com</u>.

### **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
- Some pharmacy drugs are not covered
- 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 subject to state mandate through age 18 subject to Private-duty nursing annual limits
- Bariatric surgery
- Chiropractic care
- Infertility treatment (\$25,000 LTM)

- Most coverage provided outside the U.S.
- 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, vou can contact: Wellmark at 1-866-807-9430, lowa 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 <u>plan</u> might cover costs for a sample medical situation, see the next page.

### Wellmark Blue Cross and Blue Shield of Iowa is an Independent Licensee of the Blue Cross and Blue Shield Association.

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 <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. 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 <u>deductible</u>	\$1,500
■ PCP copayment	\$15
<ul> <li>Hospital(facility) <u>coinsurance</u></li> </ul>	20%
<ul><li>Other <u>coinsurance</u></li></ul>	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	\$12,800
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# In this example, Peg would pay:

Cost Sharing			
<u>Deductibles</u>	\$1,500		
<u>Copayments</u>	\$100		
<u>Coinsurance</u>	\$1,400		
What isn't covered			
Limits or exclusions \$60			
The total Peg would pay is	\$3,060		

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

3311414311)	
■ The plan's overall deductible	\$1,500
<ul><li>Specialist copayment</li></ul>	\$30
<ul><li>Hospital(facility) <u>coinsurance</u></li></ul>	20%
<ul><li>Other <u>coinsurance</u></li></ul>	20%

### This EXAMPLE event includes services like:

<u>Primary care physician</u> 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		
<u>Deductibles</u>	\$100	
Copayments	\$1,400	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$200	
The total Joe would pay is	\$1,700	

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

■ The plan's overall deductible	\$1,500
<ul><li>Specialist copayment</li></ul>	\$30
<ul><li>Hospital(facility) coinsurance</li></ul>	20%
<ul> <li>Other coinsurance</li> </ul>	20%

### This EXAMPLE event includes services like:

<u>Emergency room care</u> (including medical supplies)

Diagnostic test (x-ray)

Durable medical equipment (*crutches*)

Rehabilitation services (physical therapy)

Total Example Cost \$1,900
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# In this example, Mia would pay:

Copayments \$200 Coinsurance \$0  What isn't covered			
Copayments \$200 Coinsurance \$0  What isn't covered	Cost Sharing		
Coinsurance \$0  What isn't covered	<u>Deductibles</u>	\$1,300	
What isn't covered	<u>Copayments</u>	\$200	
	<u>Coinsurance</u>	\$0	
Limits or exclusions \$0	What isn't covered		
·	Limits or exclusions	\$0	
The total Mia would pay is \$1,500	The total Mia would pay is	\$1,500	

The amounts shown in the maternity <u>claim</u> example above are based on amounts using a single per person <u>deductible</u>. Some <u>plan</u>s may actually apply a two-person or family deductible to maternity services for the mother and newborn baby.

The <u>plan</u> would be responsible for the other costs of these EXAMPLE covered services.

# Required Federal Accessibility and Nondiscrimination Notice



### Discrimination is against the law

Wellmark complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Wellmark does not exclude people or treat them differently because of their race, color, national origin, age, disability or sex.

#### Wellmark provides:

- Free aids and services to people with disabilities so they may communicate effectively with us. such as:
  - · Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - · Qualified interpreters
  - · Information written in other languages

If you need these services, call 800-524-9242.

If you believe that Wellmark has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Wellmark Civil Rights Coordinator, 1331 Grand Avenue, Station 5W189, Des Moines, IA 50309-2901, 515-376-4500, TTY 888-781-4262, Fax 515-376-9073, Email CRC@Wellmark.com. You can file a grievance in person, by mail, fax or email. If you need help filing a grievance, the Wellmark Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at <a href="https://ocrportal.hhs.gov/ocr/portal/lobby.jsf">https://ocrportal.hhs.gov/ocr/portal/lobby.jsf</a>, or by mail, phone or fax at: U.S. Department of Health and Human Services, 200 Independence Avenue S.W., Room 509F, HHH Building, Washington DC 20201, 800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at <a href="http://www.hhs.gov/ocr/office/file/index.html">http://www.hhs.gov/ocr/office/file/index.html</a>.

ATENCIÓN: Si habla español, los servicios de asistencia de idiomas se encuentran disponibles gratuitamente para usted. Comuníquese al 800-524-9242 o al (TTY: 888-781-4262).

注意:如果您说普通话,我们可免费为您提供语言协助服务。请拨打800-524-9242或(听障专线:888-781-4262)。

CHÚ Ý: Nếu quý vị nói tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho quý vị. Xin hãy liên hệ 800-524-9242 hoặc (TTY: 888-781-4262).

NAPOMENA: Ako govorite hrvatski, dostupna Vam je besplatna podrška na Vašem jeziku. Kontaktirajte 800-524-9242 ili (tekstualni telefon za osobe oštećena sluha: 888-781-4262).

ACHTUNG: Wenn Sie deutsch sprechen, stehen Ihnen kostenlose sprachliche Assistenzdienste zur Verfügung. Rufnummer: 800-524-9242 oder (TTY: 888-781-4262).

تنبيه: إذا كنت تتحدث اللغة العربية, فإننا نوفر لك خدمات المساعدة اللغوية، المجانية. اتصل بالرقم 802-924-808).

ສິ່ງຄວນເອົາໃຈໃສ່, ພາສາລາວ ຖ້າທ່ານເວົ້າ: ພວກເຮົາມີບໍລິການຄວາມຊ່ວຍເຫຼືອດ້ານພາສາ ໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ ຫຼື 800-524-9242 ຕິດຕໍ່ທີ່. (TTY: 888-781-4262.)

주의: 한국어 를 사용하시는 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 800-524-9242번 또는 (TTY: 888-781-4262)번으로 연락해 주십시오.

ध्यान रखें : अगर आपकी भाषा हिन्दी है, तो आपके लिए भाषा सहायता सेवाएँ, निःशुल्क उपलब्ध हैं। 800-524-9242 पर संपर्क करें या (TTY: 888-781-4262)।

ATTENTION: si vous parlez français, des services d'assistance dans votre langue sont à votre disposition gratuitement. Appelez le 800 524 9242 (ou la ligne ATS au 888 781 4262).

Geb Acht: Wann du Deitsch schwetze duscht, kannscht du Hilf in dei eegni Schprooch koschdefrei griege. Ruf 800-524-9242 odder (TTY: 888-781-4262) uff.

โปรดุทราบ: หากคุณพูด ไทย เรามีบริการช่วยเหลือด้านภาษาสำหรับคุณโดยไม่คิด ค่าใช้จ่าย ติดต่อ 800-524-9242 หรือ (TTY: 888-781-4262)

PAG-UKULAN NG PANSIN: Kung Tagalog ang wikang ginagamit mo, may makukuha kang mga serbisyong tulong sa wika na walang bayad. Makipag-ugnayan sa 800-524-9242 o (TTY: 888-781-4262).

တာ်ခူးသွဉ်ညါ–နမ္နာကတီးကညီကျိန်-ကျိန်တာ်မးစားတာ်ဖုံးတာမ်းတာဖန်-လာတာာန်လာဘာ့လေးဆိုန်လာနဂိၢိလီး.ဆဲးကျိုးဆူ ၈၀၀–၅၂၄–၉၂၄၂မှတမှ $\gamma$ (TTY:၈၈၈–၇၈၁–၄၂၆၂)တက္၊.

ВНИМАНИЕ! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. Обращайтесь 800-524-9242 (телетайп: 888-781-4262).

सावधान: यदि तपाईं नेपाली बोल्नुहुन्छ भने, तपाईंका लागि नि:शुल्क रूपमा भाषा सहायता सेवाहरू उपलब्ध गराइन्छ । 800-524-9242 वा (TTY: 888-781-4262) मा सम्पर्क गर्नुहोस् ।

HEETINA To a wolwa Fulfulde laabi walliinde dow wolde, naa e njobdi, ene ngoodi ngam maaɗa. Heɓir 800-524-9242 malla (TTY: 888-781-4262).

FUULEFFANNAA: Yo isin Oromiffaa, kan dubbattan taatan, tajaajiloonni gargaarsa afaanii, kaffaltii malee, isiniif ni jiru. 800-524-9242 yookin (TTY: 888-781-4262) guunnamaa.

УВАГА! Якщо ви розмовляєте українською мовою, для вас доступні безкоштовні послуги мовної підтримки. Зателефонуйте за номером 800-524-9242 або (телетайп: 888-781-4262).

Ge': Diné k'ehjí yáníłti'go níká bizaad bee áká' adoowoł, t'áá jiik'é, náhóló. Kojj' hólne' 800-524-9242 doodaii' (TTY: 888-781-4262)