



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 www.wellmark.com or call 1-800-524-9242. 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 1-800-524-9242 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u>?	\$2,000 person/ \$4,000 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 <u>deductible</u>?	Yes. Well-child care, <u>preventive care</u> from your DPD, physician maternity care, mammograms, <u>in-network</u> prosthetic limbs, telehealth services, one colonoscopy/sigmoidoscopy per calendar year and services subject to health and drug card <u>copayments</u> are covered before you meet your <u>deductible</u> .	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 www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No. There are no other <u>deductibles</u> .	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	Health: \$4,000 person/ \$8,000 family per calendar year. Drug Card: \$2,600 person/ \$5,200 family per calendar year. The <u>In-Network</u> health and drug card <u>out-of-pocket</u> 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 <u>out-of-pocket limit</u>?	Premiums, pre-service review penalties, <u>balance-billed charges</u> , and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

Important Questions	Answers	Why this Matters:
Will you pay less if you use a <u>network provider</u>?	Yes. See www.wellmark.com or call 1-800-524-9242 for a list of <u>network providers</u> .	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's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-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 copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-524-9242.

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	\$35 <u>copay</u> per <u>provider</u> per date of service	Not covered	Designated Personal Doctors (DPD) are defined as General and Family Practice, Internal Medicine, OB/GYN, Pediatricians, Nurse Practitioners and PAs. You must use a DPD or OB/GYN to coordinate your care. Waive cost-share for office billed preventive x-ray and labs and their interpretations. Waive cost-share for Doctor on Demand contracted telehealth services.
	<u>Specialist</u> visit	\$35 <u>copay</u> per <u>provider</u> per date of service	Not covered	Applies to Non-DPD <u>providers</u> . Waive cost-share for office billed preventive x-ray and labs and their interpretations.
	<u>Preventive care/screening/immunization</u>	No charge	Not covered	Must be provided by or coordinated through your DPD or OB/GYN. One preventive exam, one gynecological exam with Pap smear, and one mammogram per calendar year. Well-child care is covered to age 7. Preventive medical examinations performed for administrative purposes are covered in lieu of a preventive exam. Waive cost-share for one colonoscopy/sigmoidoscopy per calendar year. Any additional colonoscopies/sigmoidoscopies in a calendar year are subject to <u>deductible</u> and <u>coinsurance</u> . 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)	Independent Lab: \$35 <u>copay</u> per <u>provider</u> per date of service Facility: 25% <u>coinsurance</u>	Not covered	For a test in a <u>provider's</u> office or clinic, your cost is included in the cost-share listed above. Waive cost-share for billed preventive x-ray and labs and their interpretations.
	Imaging (CT/PET scans, MRIs)	25% <u>coinsurance</u>	Not covered	For a test in a <u>provider's</u> office or clinic, your cost is included in the cost-share listed above.

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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 drugs to treat your illness or condition More information about prescription drug coverage is available at www.wellmark.com/prescriptions .	Tier 1	\$10 <u>copay</u> per prescription	\$10 <u>copay</u> per prescription	Drugs listed on Wellmark's Blue Rx Complete Drug List are covered. Drugs not on this Drug List are not covered. For out-of-network prescription drugs, you may be balance billed. 1 <u>copay</u> for 30-day supply. 3 <u>copays</u> for 90-day supply (Tier 1 retail maintenance drugs only). 2 <u>copays</u> for 90-day supply (Mail order maintenance). <u>Specialty drugs</u> are covered only when obtained through the 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 <u>plan</u> .
	Tier 2	\$40 <u>copay</u> per prescription	\$40 <u>copay</u> per prescription	
	Tier 3	\$70 <u>copay</u> per prescription	\$70 <u>copay</u> per prescription	
	Tier 4	\$100 <u>copay</u> per prescription	\$100 <u>copay</u> per prescription	
	Specialty drugs	Preferred: \$50 <u>copay</u> per prescription Non-preferred: \$200 <u>copay</u> per prescription	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% <u>coinsurance</u>	Not covered	Waive cost-share for one colonoscopy/sigmoidoscopy per calendar year. Any additional colonoscopies/sigmoidoscopies in a calendar year are subject to <u>deductible</u> and <u>coinsurance</u> .
	Physician/surgeon fees	25% <u>coinsurance</u>	Not covered	
If you need immediate medical attention	<u>Emergency room care</u>	25% <u>coinsurance</u>	25% <u>coinsurance</u>	For <u>emergency medical conditions</u> treated out-of-network, you may be balance billed. Dental treatment for accidental injury is limited to care completed within 12 months of the injury. Benefits for non-participating ambulance <u>providers</u> are based on actual billed charges.
	<u>Emergency medical transportation</u>	25% <u>coinsurance</u>	25% <u>coinsurance</u>	
	<u>Urgent care</u>	\$35 <u>copay</u> per <u>provider</u> per date of service	Not covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	25% <u>coinsurance</u>	Not covered	-----None-----
	Physician/surgeon fees	25% <u>coinsurance</u>	Not covered	-----None-----

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-524-9242.

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 mental health, behavioral health, or substance abuse services	Outpatient services	Office: \$35 <u>copay</u> per <u>provider</u> per date of service Facility: 25% <u>coinsurance</u>	Not covered	-----None-----
	Inpatient services	25% <u>coinsurance</u>	Not covered	-----None-----
If you are pregnant	Office visits	No charge	Not covered	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 <u>in-network</u> services that fall outside of routine obstetric care, the office visit benefits shown above may apply.
	Childbirth/delivery professional services	No charge	Not covered	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	25% <u>coinsurance</u>	Not covered	-----None-----
If you need help recovering or have other special health needs	<u>Home health care</u>	25% <u>coinsurance</u>	Not covered	-----None-----
	<u>Rehabilitation services</u>	Office: \$35 <u>copay</u> per <u>provider</u> per date of service Facility: 25% <u>coinsurance</u>	Not covered	-----None-----
	<u>Habilitation services</u>	Office: \$35 <u>copay</u> per <u>provider</u> per date of service Facility: 25% <u>coinsurance</u>	Not covered	-----None-----
	<u>Skilled nursing care</u>	25% <u>coinsurance</u>	Not covered	-----None-----
	<u>Durable medical equipment</u>	25% <u>coinsurance</u>	Not covered	20% <u>coinsurance</u> applies to <u>in-network</u> prosthetic limbs.
	<u>Hospice services</u>	25% <u>coinsurance</u>	Not covered	Hospice respite care is limited to 15 inpatient and 15 outpatient days per lifetime.

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-524-9242.

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 your child needs dental or eye care	Children's eye exam	\$35 copay per <u>provider</u> per date of service	Not covered	One routine vision exam per calendar year. Must be performed by an in- <u>network provider</u> .
	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 Wellmark at 1-800-524-9242.

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
- Non-emergency care when traveling outside the U.S.
- 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.)

- Bariatric surgery
- Chiropractic care (12 visits per calendar year)
- Infertility treatment (\$15,000 LTM, excludes some services)
- 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 Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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: Wellmark at 1-800-524-9242.

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. _____

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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 <u>plan's</u> overall <u>deductible</u>	\$2,000
■ PCP <u>copayment</u>	\$35
■ Hospital(facility) <u>coinsurance</u>	25%
■ Other no charge	No Charge

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>	\$2,000
<u>Copayments</u>	\$20
<u>Coinsurance</u>	\$1,800
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$3,880

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

■ The <u>plan's</u> overall <u>deductible</u>	\$2,000
■ <u>Specialist</u> <u>copayment</u>	\$35
■ Hospital(facility) <u>coinsurance</u>	25%
■ Other <u>coinsurance</u>	25%

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
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In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$90
<u>Copayments</u>	\$2,100
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$200
The total Joe would pay is	\$2,390

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

■ The <u>plan's</u> overall <u>deductible</u>	\$2,000
■ <u>Specialist</u> <u>copayment</u>	\$35
■ Hospital(facility) <u>coinsurance</u>	25%
■ Other <u>coinsurance</u>	25%

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
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In this example, Mia would pay:

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

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.

