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 deductible?	The employer self-funds a portion of the deductible under the major medical plan insured by Wellmark, so your actual deductible becomes **$1,500** per individual for a calendar year, and **$3,000** for a family per calendar year.	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. See the primary SBC of the insured group health plan.	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 deductibles for specific services.
What is the out-of-pocket limit for this plan?	The employer self-funds a portion of the out of pocket maximum under the major medical plan insured by Wellmark so your actual out of pocket maximum becomes **$3,000** per individual for a calendar year, and **$6,000** for a family per calendar year. Drug Card out-of-pocket limit: See the primary SBC of the insured group health plan.	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, pre-service review penalties, your drug card costs, balance-billing 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.
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 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.

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All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies. This is a summary of your enhanced benefits after your primary plan processes the claim. Your **copayment** and **coinsurance** remains the same as the primary plan unless otherwise noted.

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	See the primary SBC of the insured group health plan.	20% coinsurance	See the primary SBC of the insured group health plan.
	Specialist visit	See the primary SBC of the insured group health plan.	20% coinsurance	See the primary SBC of the insured group health plan.
	Preventive care/screening/ immunization	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	20% coinsurance	See the primary SBC of the insured group health plan.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	20% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.wellmark.com/prescritions.	Tier 1	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.
	Tier 2	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	
	Tier 3	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	
	Specialty drugs	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	20% coinsurance	See the primary SBC of the insured group health plan.
	Physician/surgeon fees	20% coinsurance	20% coinsurance	See the primary SBC of the insured group health plan.
If you need immediate medical attention	Emergency room care	$150 copayment	$150 copayment	See the primary SBC of the insured group health plan.
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	See the primary SBC of the insured group health plan.	20% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	20% coinsurance	See the primary SBC of the insured group health plan.
	Physician/surgeon fees	20% coinsurance	20% coinsurance	See the primary SBC of the insured

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)	
				group health plan.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: See the primary SBC of the insured group health plan. Facility: 20% coinsurance	20% coinsurance	See the primary SBC of the insured group health plan.
	Inpatient services	20% coinsurance	20% coinsurance	
If you are pregnant	Office visits	20% coinsurance	20% coinsurance	See the primary SBC of the insured group health plan.
	Childbirth/delivery professional services	20% coinsurance	20% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	20% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	See the primary SBC of the insured group health plan.
	Rehabilitation services	Office: See the primary SBC of the insured group health plan. Facility: 20% coinsurance	20% coinsurance	See the primary SBC of the insured group health plan.
	Habilitation services	Office: See the primary SBC of the insured group health plan. Facility: 20% coinsurance	20% coinsurance	
	Skilled nursing care	20% coinsurance	20% coinsurance	See the primary SBC of the insured group health plan.
	Durable medical equipment	20% coinsurance	20% coinsurance	See the primary SBC of the insured group health plan.
	Hospice services	20% coinsurance	20% coinsurance	See the primary SBC of the insured group health plan.
If your child needs dental or eye care	Children's eye exam	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.
	Children's glasses	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.
	Children's dental check-up	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.

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
- Eye exam
- Glasses
- Hearing aids
- Long-term care
- Routine eye care – Adult
- 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 annual limits
- 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

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. 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 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: Wellmark at 1-800-524-9242 or the Iowa Insurance Division at 515-281-5705.

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 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 [319-752-3200].]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [319-752-3200].]
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 [319-752-3200].]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [319-752-3200].]

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

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	$1,500
PCP 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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$20
Coinsurance	$1,480
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 condition)

The plan's overall deductible	$1,500
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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$90
Copayments	$1,400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$200
The total Joe would pay is	**$1,690**

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

The plan's overall deductible	$1,500
Specialist copayment	$20
Hospital (facility) coinsurance	20%
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	**$1,900**

In this example, Mia would pay:

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

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.