

Blue Access[®] \$2,000

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 1-800-252-2122. 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 underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-800-252-2122 to reguest 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> , physician maternity care, routine vision exams, in- <u>network</u> prosthetic limbs and services subject to health and drug <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 <u>www.healthcare.gov/coverage/preventive-care-benefits/</u> .
Are there other <u>deductibles</u> for specific services?	No. There are no other <u>deductible</u> s.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	Health: \$4,000 person/ \$8,000 family per calendar year. Drug Card: \$1,500 person/ \$3,000 family per calendar year. The <u>In-Network</u> 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, 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 out-of-pocket limit.
Will you pay less if you use a <u>network provider</u> ?	Yes. See <u>www.wellmark.com</u> or call 1- 800-252-2122 for a list of <u>network</u> <u>providers</u> .	This plan uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an o <u>ut-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's 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.

Important Questions	Answers	Why this Matters:
Do you need a <u>referral</u> to see a specialist?	No.	You can see the specialist you choose without a referral.

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.

Complete-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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$20 <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. \$20 <u>copay</u> per <u>provider</u> per date of service applies to Doctor on Demand contracted telehealth services.
	<u>Specialist</u> visit	\$40 <u>copay</u> per <u>provider</u> per date of service	Not covered	Applies to Non-DPD <u>providers</u> .
	Preventive care/screening/ immunization	No charge	Not covered	Preventive care must be provided by a PDP. One preventive exam, one gynecological exam with Pap smear, and 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)	Independent Lab: \$40 <u>copay</u> per <u>provider</u> per date of service Facility: 20% <u>coinsurance</u>	Not covered	For a test in a <u>provider</u> 's office or clinic, your cost is included in the cost-share listed above.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered	For a test in a <u>provider</u> 's office or clinic, your cost is included in the cost-share listed above.

Complete-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	\$8 <u>copay</u> per prescription	\$8 <u>copay</u> per prescription	Drugs listed on Wellmark's Blue Rx Complete Drug List
treat your illness or condition	Tier 2	\$25 <u>copay</u> per prescription	\$25 <u>copay</u> per prescription	are covered. Drugs not on this Drug List are not covered. For out-of- <u>network</u> prescription drugs, you may be balance billed.
More information about prescription	Tier 3	\$40 <u>copay</u> per prescription	\$40 <u>copay</u> per prescription	1 <u>copay</u> for 30-day supply. 3 <u>copays</u> for 90-day supply (Retail maintenance).
drug coverage is available at www.wellmark.com/	Tier 4	\$40 <u>copay</u> per prescription	\$40 <u>copay</u> per prescription	2 <u>copays</u> for 90-day supply (Mail order maintenance). See wellmark.com/prescriptions for information about drugs and drug quantities that require prior authorization
prescriptions.	Specialty drugs	\$85 <u>copay</u> per prescription	\$85 <u>copay</u> per prescription	by Wellmark to be covered by your <u>plan</u> .
lf you have	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	None
outpatient surgery	Physician/surgeon fees	20% coinsurance	Not covered	None
If you need immediate medical attention	Emergency room care	\$100 <u>copay</u> per facility per date of service for facility and physician(s) combined	\$100 <u>copay</u> per facility per date of service for facility and physician(s) combined	For <u>emergency medical conditions</u> treated out-of- <u>network</u> , you may be balance billed. Dental treatment for accidental injury is limited to care completed within 12 months of the injury.
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	<u>Urgent care</u>	\$20 <u>copay</u> per <u>provider</u> per date of service	Not covered	None
If you have a hospital	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	None
stay	Physician/surgeon fees	20% <u>coinsurance</u>	Not covered	None

Complete-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 abuse services	Outpatient services	Office: \$20 <u>copay</u> per <u>provider</u> per date of service Facility: 20% <u>coinsurance</u>	Not covered	None
	Inpatient services	20% coinsurance	Not covered	None
lf 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 in- <u>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	Practitioner: No charge Facility: 20% <u>coinsurance</u>	Not covered	None

Complete-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	Not covered	None
If you need help recovering or have other special health needs	Rehabilitation services	Office: \$20 PCP, PTs,OTs,SLPs/ \$40 Non-PCP <u>copay</u> per <u>provider</u> per date of service Facility: 20% <u>coinsurance</u>	Not covered	None
	Habilitation services	Office: \$20 PCP, PTs,OTs,SLPs/ \$40 Non-PCP <u>copay</u> per <u>provider</u> per date of service Facility: 20% <u>coinsurance</u>	Not covered	None
	Skilled nursing care	20% coinsurance	Not covered	None
	Durable medical equipment	20% coinsurance	Not covered	None
	Hospice services	20% coinsurance	Not covered	Hospice respite care is limited to 15 inpatient and 15 outpatient days per lifetime.
If your child needs	Children's eye exam	No charge	Not covered	One routine vision exam per calendar year. Must be performed by an in- <u>network provider</u> .
dental or eye care	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

 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
 Bariatric surgery Chiropractic care 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 Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.doi.gov/ebsa/healthreform.

Your <u>Grievance</u> and <u>Appeals</u> Rights: There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, you can contact: Wellmark at 1-800-252-2122, lowa Insurance Division at 515-281-5705, or Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <u>www.dol.gov/ebsa/healthreform</u>.

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. $_$

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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 <u>plan</u> 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- <u>network</u> pre-natal care and a hospital delivery)		Managing Joe's type 2 Diabetes (a year of routine in- <u>network</u> care of a well-controlled condition)		Mia's Simple Fracture (in- <u>network</u> emergency room visit and follow up care)	
The <u>plan</u> 's overall <u>deductible</u>	\$2,000	The plan's overall <u>deductible</u>	\$2,000	The <u>plan</u> 's overall <u>deductible</u>	\$2,000
PCP <u>copayment</u>	\$20	Specialist copayment	\$40	Specialist copayment	\$40
 Hospital(facility) <u>coinsurance</u> 	20%	 Hospital(facility) <u>coinsurance</u> 	20%	 Hospital(facility) <u>copayment</u> 	\$100
 Other no charge 	No Charge	 Other <u>coinsurance</u> 	20%	 Other <u>coinsurance</u> 	20%
This EXAMPLE event includes se	rvices like:	This EXAMPLE event includes serv	ices like:	This EXAMPLE event includes serv	vices like:
Specialist office visits (prenatal care)		Primary care physician office visits (including		Emergency room care (including med	lical
Childbirth/Delivery Professional Ser	vices	disease education)		supplies)	

Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (ultrasounds and blood work)
Specialist visit (anesthesia)

Total Example Cost

In this example, Peg would pay:

Cost Sharing			
<u>Deductibles</u>	\$2,000		
<u>Copayments</u>	\$20		
Coinsurance	\$1,400		
What isn't covered			
Limits or exclusions	\$60		
The total Peg would pay is	\$3,480		

\$12,800

 Other <u>coinsurance</u> 	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

In this example, Joe would pay:

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

\$7,400

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	
<u>Deductibles</u>	\$1,300
<u>Copayments</u>	\$200
Coinsurance	\$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.

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.

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 800-524-9242 أو (خدمة الهاتف النصبي: 828-781-888).

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).

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 <u>CRC@Wellmark.com</u>. 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 <u>https://ocrportal.hhs.gov/ocr/portal/lobby.jsf</u>, 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 <u>http://www.hhs.gov/ocr/office/file/index.html</u>.

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.

โปรดทราบ: 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).

တါဒုးသွင်္ဂညါ–နမ္)ကတိၤကညီကိုဂ်ိ.ကိုဂ်ိတာ်မာစားတာဖ်းတာ်မာတစင်္ဂလာတာဉ်လာဘာ့လဲ.အိခ်လာနဂိၢိလိၤ.ဆဲးကျိုးဆူ စဝဝ–၅၂၄–၉၂၄၂မှတမ့်(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 ।

ማሳሰቢያ፦ አማርኛ የሚና7ሩ ከሆነ፣ የቋንቋ እንዛ አንልግሎቶዥ፣ ከክፍያ ነፃ፣ ያንኛሉ። በ 800-524-9242 ወይም (በTTY: 888-781-4262) ደውለው ያነጋግሩን።

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) quunnamaa.

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. Koji' hólne' 800-524-9242 doodaii' (TTY: 888-781-4262)

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