

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services



Coverage Period: 01/01/2025 – 12/31/2025
Coverage for: Single & Family | Plan Type: HMO

G and A Outsourcing Plan 13 HMO



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? | \$4,000 person/ \$8,000 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, <u>preventive care</u> from in- <u>network</u> providers, physician maternity care, routine vision exams, in- <u>network</u> prosthetic limbs and services subject to <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 deductibles for specific services? | Yes. \$100 person/ \$200 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 out-of-pocket limit for this plan? | Health: \$8,000 person/ \$16,000 family per calendar year. Drug Card: \$8,000 person/ \$16,000 family per calendar year. The In- <u>Network</u> health and drug card <u>out-of-pocket</u> maximum amounts accumulate together. | 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, <u>balance-billed</u> charges, 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> . |
| 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 <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 out-of- <u>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 out-of- <u>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 <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.

| 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 Designated PCP copay per provider per date of service \$40 copay per provider per date of service | Not covered | For this <u>plan</u> you must select a Designated <u>Primary Care Provider</u> (PCP). PCP <u>provider</u> types can be found in the What You Pay section of your <u>plan</u> document. |
| | <u>Specialist</u> visit | \$80 copay per provider per date of service | Not covered | Applies to Non-PCP providers. \$40 copay per provider per date of service for in-network chiropractic services. Hearing exams are covered according to ACA guidelines. |
| | <u>Preventive care/screening/immunization</u> | No charge | Not covered | One preventive 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 needed 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: \$80 copay per provider per date of service Facility: 30% coinsurance | 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 on in-network independent lab services for mental health/substance abuse. |
| | Imaging (CT/PET scans, MRIs) | 30% coinsurance | Not covered | For a test in a <u>provider's</u> office or clinic, your cost is included in the cost-share listed above. |

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-524-9242. You can find your Coverage Manual at sbccmfinder.wellmark.com.

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|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| If you need drugs to treat your illness or condition More information about prescription drug coverage is at www.wellmark.com/prescriptions . | Tier 1 | \$30 <u>copay</u> per prescription | Not covered | Refer to your Blue Rx Value Plus Drug List to determine the tier that applies to a covered drug. 1 <u>copay</u> for 30-day supply. 3 <u>copays</u> for 90-day supply (Retail). 2 <u>copays</u> for 90-day supply (Mail order). <u>Specialty drugs</u> are covered only when obtained through the CVS Specialty Pharmacy Program. <u>Specialty drugs</u> on the PrudentRx drug list (found at Wellmark.com) will have 30% <u>coinsurance</u> . If you enroll with PrudentRx, you will have \$0 member cost-share for drugs on the PrudentRx drug list. See wellmark.com/prescriptions for information about drugs and drug quantities that require prior authorization by Wellmark to be covered by your plan. |
| | Tier 2 | \$60 <u>copay</u> per prescription | Not covered | |
| | Tier 3 | \$150 <u>copay</u> per prescription | Not covered | |
| | Specialty drugs | Generic: \$100 <u>copay</u> per prescription Preferred: \$250 <u>copay</u> per prescription Non-Preferred: \$500 <u>copay</u> per prescription | Not covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 30% <u>coinsurance</u> | Not covered | -----None----- |
| | <u>Physician/surgeon fees</u> | 30% <u>coinsurance</u> | Not covered | -----None----- |
| If you need immediate medical attention | <u>Emergency room care</u> | \$500 <u>copay</u> and 30% <u>coinsurance</u> per facility per date of service for facility and physician(s) combined | \$500 <u>copay</u> and 30% <u>coinsurance</u> per facility per date of service for facility and physician(s) combined | For <u>emergency medical conditions</u> treated out-of-network, it is likely you may not be balance billed pursuant to the federal rules developed for implementation of the No Surprises Act. |
| | <u>Emergency medical transportation</u> | 30% <u>coinsurance</u> | 30% <u>coinsurance</u> | For covered non-emergent situations, out-of-network ground ambulance services are NOT reimbursed at the in-network level. You may be balance billed for any out-of-network service as established under the rules developed for implementation of the No Surprises Act. |
| | <u>Urgent care</u> | \$40 <u>copay</u> | Not covered | <u>Copay</u> applies per provider per date of service for facility and physician(s) combined. |

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|---------------------------------------------------------------------------|-------------------------------------------|------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| If you have a hospital stay | Facility fee (e.g., hospital room) | 30% <u>coinsurance</u> | Not covered | -----None----- |
| | Physician/surgeon fees | 30% <u>coinsurance</u> | Not covered | -----None----- |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Office: \$40 <u>copay</u> per provider per date of service Facility: 30% <u>coinsurance</u> | Not covered | -----None----- |
| | Inpatient services | 30% <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 for <u>preventive services</u> . For any in-network 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 | 30% <u>coinsurance</u> | Not covered | -----None----- |

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|----------------------------------------------------------------|----------------------------------|------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|
| If you need help recovering or have other special health needs | <u>Home health care</u> | 30% <u>coinsurance</u> | Not covered | -----None----- |
| | <u>Rehabilitation services</u> | Office: \$40 PCP/\$80 Non-PCP <u>copay</u> per <u>provider</u> per date of service Facility: 30% <u>coinsurance</u> | Not covered | \$40 <u>copay</u> per <u>provider</u> per date of service applies to in-network Physical and Occupational Therapists and Speech Language Pathologists. |
| | <u>Habilitation services</u> | Office: \$40 PCP/\$80 Non-PCP <u>copay</u> per <u>provider</u> per date of service Facility: 30% <u>coinsurance</u> | Not covered | \$40 <u>copay</u> per <u>provider</u> per date of service applies to in-network Physical and Occupational Therapists and Speech Language Pathologists. |
| | <u>Skilled nursing care</u> | 30% <u>coinsurance</u> | Not covered | -----None----- |
| | <u>Durable medical equipment</u> | 30% <u>coinsurance</u> | Not covered | 20% <u>coinsurance</u> applies to in-network prosthetic limbs. |
| | <u>Hospice services</u> | 30% <u>coinsurance</u> | Not covered | Hospice respite care is limited to 15 inpatient and 15 outpatient days per lifetime. |
| If your child needs dental or eye care | Children's eye exam | No charge | Not covered | One routine vision exam per calendar year. Must be performed by an in-network provider. |
| | 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. You can find your Coverage Manual at sbccmfinder.wellmark.com.

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
- 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
- Bariatric surgery
- Chiropractic care
- Infertility treatment (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.dol.gov/ebsa/healthreform. 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, you can contact: Wellmark at 1-800-524-9242, Iowa Insurance Division at 515-654-6600, 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

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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.

Wellmark Health Plan of Iowa, Inc. 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 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 <u>deductible</u> | \$4,000 |
| ■ PCP <u>copayment</u> | \$35 |
| ■ Hospital(facility) <u>coinsurance</u> | 30% |
| ■ 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 | \$12,700 |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$4,000 |
| <u>Copayments</u> | \$10 |
| <u>Coinsurance</u> | \$1,300 |
| What isn't covered | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$5,370 |

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

| | |
|-----------------------------------------|---------|
| ■ The plan's overall <u>deductible</u> | \$4,000 |
| ■ <u>Specialist</u> <u>copayment</u> | \$80 |
| ■ Hospital(facility) <u>coinsurance</u> | 30% |
| ■ Other <u>coinsurance</u> | 30% |

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 | \$5,600 |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$100 |
| <u>Copayments</u> | \$2,000 |
| <u>Coinsurance</u> | \$0 |
| What isn't covered | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$2,120 |

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

| | |
|----------------------------------------|---------|
| ■ The plan's overall <u>deductible</u> | \$4,000 |
| ■ <u>Specialist</u> <u>copayment</u> | \$80 |
| ■ Hospital(facility) <u>copayment</u> | \$500 |
| ■ Other <u>coinsurance</u> | 30% |

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 | \$2,800 |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$1,200 |
| <u>Copayments</u> | \$900 |
| <u>Coinsurance</u> | \$100 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$2,200 |

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.

