

State of Iowa National Choice Active 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 1-800-622-0043. 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 1-800-622-0043 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$250 person/ \$500 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, independent labs, in- <u>network preventive care</u> , in- <u>network</u> prosthetic limbs 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 <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: \$1,000 person/ \$2,000 family per calendar year. Drug Card: \$5,850 person/ \$11,700 family per calendar year. The In- <u>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 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 <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See <u>www.wellmark.com</u> or call 1- 800-622-0043 for a list of <u>network</u> <u>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</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'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 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.

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	\$15 <u>copay</u> per <u>provider</u> per date of service	\$15 <u>copay</u> per <u>provider</u> per date of service	Primary Care Practitioners (PCP) are defined as General and Family Practice, Internal Medicine, OB/GYN, Pediatricians, Nurse Practitioners, Certified Nurse Midwives and PAs. \$15 <u>copay</u> per <u>provider</u> per date of service applies to telehealth services delivered by in- <u>network primary care providers</u> . \$10 <u>copay</u> per <u>provider</u> per date of service for <u>providers</u> contracting through Doctor on Demand. \$100 <u>copay</u> per <u>provider</u> per date of service for office administered <u>specialty drugs</u> .
	<u>Specialist</u> visit	\$30 <u>copay</u> per <u>provider</u> per date of service	\$30 <u>copay</u> per <u>provider</u> per date of service	Applies to Non-PCP <u>providers</u> . \$15 <u>copay</u> per <u>provider</u> per date of service for chiropractic services. \$30 <u>copay</u> per <u>provider</u> per date of service applies to covered telehealth services provided by in- <u>network specialist</u> s. One routine hearing exam per calendar year. \$100 <u>copay</u> per <u>provider</u> per date of service for office administered <u>specialty drugs</u> .
	Preventive care/screening/ immunization	No charge	20% 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 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)	10% coinsurance	20% coinsurance	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)	10% coinsurance	20% coinsurance	None

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
	Tier 1	\$10 <u>copay</u> per prescription	\$10 <u>copay</u> per prescription	
If you need drugs to treat your illness or	Tier 2	\$25 <u>copay</u> per prescription	\$25 <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.
condition	Tier 3	\$50 <u>copay</u> per prescription	\$50 <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 about prescription drug coverage is	Tier 4	\$75 <u>copay</u> per prescription	\$75 <u>copay</u> per prescription	2 <u>copays</u> for 90-day supply (maintenance). Specialty drugs are covered only when obtained through
drug coverage is available at www.wellmark.com/ prescriptions.	Specialty drugs	Generic/Preferred: \$100 <u>copay</u> per prescription Non-preferred: \$200 <u>copay</u> per prescription	Generic/Preferred: \$100 <u>copay</u> per prescription Non-preferred: \$200 <u>copay</u> per prescription	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)	10% coinsurance	20% coinsurance	None
outpatient surgery	Physician/surgeon fees	10% coinsurance	20% coinsurance	None
	Emergency room care	\$100 <u>copay</u> per visit for facility and physician(s) services combined	\$100 <u>copay</u> per visit for facility and physician(s) services combined	For <u>emergency medical conditions</u> treated out-of- <u>network</u> , it is likely you may not be balance billed pursuant to the federal rules developed for implementation of the No Surprises Act.
If you need immediate medical attention	Emergency medical transportation	10% coinsurance	10% coinsurance	For covered non-emergent situations, out-of- <u>network</u> ambulance services are NOT reimbursed at the in- <u>network</u> level. The member may be balance billed for any out-of- <u>network</u> service as established under the rules developed for implementation of the No Surprises Act.
	<u>Urgent care</u>	\$15 <u>copay</u> per <u>provider</u> per date of service	\$15 <u>copay</u> per <u>provider</u> per date of service	\$100 <u>copay</u> per <u>provider</u> per date of service for office administered <u>specialty drugs</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 have a hospital	Facility fee (e.g., hospital room)	10% coinsurance	20% coinsurance	Reduction for failure to precertify is 50% and will not exceed \$500 per benefit period.
stay	Physician/surgeon fees	10% <u>coinsurance</u>	20% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: \$15 <u>copay</u> per <u>provider</u> per date of service Facility: 10% <u>coinsurance</u>	Office: \$15 <u>copay</u> per <u>provider</u> per date of service Facility: 20% <u>coinsurance</u>	Contracted telehealth services are covered. \$100 <u>copay</u> per <u>provider</u> per date of service for office administered <u>specialty drugs</u> .
	Inpatient services	10% coinsurance	20% coinsurance	Reduction for failure to precertify is 50% and will not exceed \$500 per benefit period.
If you are pregnant	Office visits	10% <u>coinsurance</u>	20% coinsurance	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- <u>network</u> services that fall outside of routine obstetric care, the office visit benefits shown above may apply.
	Childbirth/delivery professional services	10% coinsurance	20% 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	10% coinsurance	20% coinsurance	None

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	10% coinsurance	20% coinsurance	Reduction for failure to precertify is 50% and will not exceed \$500 per benefit period.
If you need help recovering or have other special health needs	Rehabilitation services	Office: \$15 PCP/\$30 Non-PCP <u>copay</u> per <u>provider</u> per date of service Facility: 10% <u>coinsurance</u>	Office: \$15 PCP/\$30 Non-PCP <u>copay</u> per <u>provider</u> per date of service Facility: 20% <u>coinsurance</u>	\$15 <u>copay</u> per <u>provider</u> per date of service applies to Physical and Occupational Therapists and Speech Language Pathologists.
	Habilitation services	Office: \$15 PCP/\$30 Non-PCP <u>copay</u> per <u>provider</u> per date of service Facility: 10% <u>coinsurance</u>	Office: \$15 PCP/\$30 Non-PCP <u>copay</u> per <u>provider</u> per date of service Facility: 20% <u>coinsurance</u>	\$15 <u>copay</u> per <u>provider</u> per date of service applies to Physical and Occupational Therapists and Speech Language Pathologists.
	Skilled nursing care	10% coinsurance	20% coinsurance	Reduction for failure to precertify is 50% and will not exceed \$500 per benefit period.
	Durable medical equipment	10% coinsurance	20% coinsurance	Wigs are covered with a diagnosis of cancer or alopecia, limited to \$1,000 per calendar year.
	Hospice services	10% coinsurance	20% coinsurance	Hospice respite care is limited to 15 inpatient and 15 outpatient days per lifetime.
If your child needs	Children's eye exam	\$30 <u>copay</u> per <u>provider</u> per date of service	\$30 <u>copay</u> per <u>provider</u> per date of service	One routine vision exam per calendar year.
dental or eye care	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Services Your <u>Plan</u> Generally Does NOT Cov	ver (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)
 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 Weight loss programs
Other Covered Services (Limitations may ap	ply to these services. This isn't a complete list. Please see your <u>plan</u> document.)
 Applied Behavior Analysis therapy 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)

• Private-duty 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 <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 1-800-622-0043.

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.

$_$ 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 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- <u>network</u> pre-natal care an delivery)	d a hospital	Managing Joe's type 2 Dia (a years of routine in- <u>network</u> care controlled condition)	betes of a well-	Mia's Simple Fracture (in- <u>network</u> emergency room visit and f	e ollow up care)
 The plan's overall <u>deductible</u> PCP <u>copayment</u> Hospital(facility) <u>coinsurance</u> Other <u>coinsurance</u> 	\$250 \$15 10% 10%	 The plan's overall <u>deductible</u> <u>Specialist copayment</u> Hospital(facility) <u>coinsurance</u> Other <u>coinsurance</u> 	\$250 \$30 10% 10%	 The plan's overall <u>deductible</u> <u>Specialist copayment</u> Hospital(facility) <u>copayment</u> Other <u>coinsurance</u> 	\$250 \$30 \$100 10%
This EXAMPLE event includes service <u>Specialist</u> office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services <u>Diagnostic tests</u> (<i>ultrasounds and blood w</i> <u>Specialist</u> visit (<i>anesthesia</i>)		This EXAMPLE event includes service <u>Primary care physician</u> office visits (<i>includes ase education</i>) <u>Diagnostic tests</u> (<i>blood work</i>) <u>Prescription drugs</u> <u>Durable medical equipment</u> (<i>glucose m</i>	luding	This EXAMPLE event includes servit Emergency room care (including medit supplies) Diagnostic test (x-ray) Durable medical equipment (crutches) Rehabilitation services (physical therap	cal

Total Example Cost

In this example, Peg would pay:

Cost Sharing			
<u>Deductibles</u>	\$250		
<u>Copayments</u>	\$90		
Coinsurance	\$700		
What isn't covered			
Limits or exclusions	\$60		
The total Peg would pay is	\$1,100		

\$12,700

In this example, Joe would pay:				
Cost Sharing				
<u>Deductibles</u>	\$50			
<u>Copayments</u>	\$1,100			
Coinsurance	\$0			
What isn't covered				
Limits or exclusions	\$20			

\$5,600

\$1,170

Total Example Cost

The total Joe would pay is

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Total Example Cost

In this example, Mia would pay:				
Cost Sharing				
<u>Deductibles</u>	\$250			
<u>Copayments</u>	\$300			
Coinsurance	\$90			
What isn't covered				
Limits or exclusions \$0				
The total Mia would pay is	\$640			

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.

\$2,800



Wellmark Language Assistance

Discrimination is against the law

Wellmark Blue Cross and Blue Shield complies with applicable state and federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

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

You have the right to get this information and help in your language for free. 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).

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).

တါဒုံးသွင်ညါ–နမ္နါကတိၤကညီကိုဂ်.ကျိဂ်တါမးစၤဟာဖ်းတာမၤတဖင်္ဂ.လၢတဘာဉ်လာဘာ့ၤလဲ.အိဉ်လၢနဂိၢိလိၤ.ဆဲးကျိုးဆူ ၈၀၀–၅၂၄–၉၂၄၂မှတမ့်(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 ।

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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