Wellmark

# Program 3+

**Coverage Period: 01/01/2017 – 12/31/2017**
Coverage for: Single & Family | Plan Type: PPO

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.wellmark.com or by calling 1-800-622-0043.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| What is the overall **deductible**? | **$300** person/**$400** family Deductible applies per contract. Does not apply to well-child care, in-network preventive care, in-network prosthetic limbs and services subject to copayments. Deductible applies only to inpatient services and urgent care. The entire family deductible must be satisfied before benefits are available for any family member. | You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the Common Medical Event chart on the following pages for how much you pay for covered services after you meet the **deductible**. |
| Are there other **deductibles** for specific services? | No. There are no other deductibles. | You don't have to meet **deductibles** for specific services, but see the Common Medical Event chart on the following pages for other costs for services this plan covers. |
| Is there an **out–of–pocket limit** on my expenses? | Yes. Health: **$1,000** person/**$2,000** family Drug Card: **$500** person/ **$1,000** family per contract. The In-Network health and drug card out-of-pocket maximum amounts accumulate separately. | The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |
| What is not included in the **out–of–pocket limit**? | Premiums, pre-service review penalties, balance-billed 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**. |
| Is there an overall annual limit on what the plan pays? | No. | See the Common Medical Event chart on the following pages which describes any limits on what the plan will pay for *specific* covered services, such as office visits. |

**Questions:** Call 1-800-622-0043 or visit us at www.wellmark.com. If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-800-622-0043 to request a copy.

12/30/2015;01/01/2017;___;___;114160-64;224783-2;00032642;N;NGF

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| Does this plan use a **network** of **providers**? | Yes. See www.wellmark.com for a list of in-network providers. | If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the Common Medical Event chart on the following pages for how this plan pays different kinds of **providers**. |
| Do I need a referral to see a **specialist**? | No. You do not need a referral to see a specialist. | You can see the **specialist** you choose without permission from this plan. |
| Are there services this plan doesn't cover? | Yes. | Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about **excluded services**. |

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments**, and **coinsurance** amounts.

| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network (IN) Provider | Your Cost If You Use an Out-of-Network (OON) Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $15 copay for exam<br>20% coinsurance other services | $15 copay for exam<br>20% coinsurance other services | Office surgery and accident care within 72 hours of injury are not subject to coinsurance. |
| | Specialist visit | $15 copay for exam<br>20% coinsurance other services | $15 copay for exam<br>20% coinsurance other services | Office surgery and accident care within 72 hours of injury are not subject to coinsurance. |
| | Other practitioner office visit | $15 copay for Chiropractor exam<br>20% coinsurance other services | $15 copay for Chiropractor exam<br>20% coinsurance other services | ------None------ |
| | Preventive care/screening/ immunization | No charge | Exams: No charge<br>20% coinsurance other services | One preventive exam and one gynecological exam per calendar year. One mammogram per calendar year. Well-child care is covered to age 7. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% coinsurance | 20% coinsurance | Waive cost-share on outpatient services for mental health/substance abuse. Waive coinsurance for x-ray/ lab for outpatient surgery. Failure to obtain prior approval for services listed on Wellmark.com will result in denial with review rights. |
| | Imaging (CT /PET scans, MRIs) | 20% coinsurance | 20% coinsurance | Failure to obtain prior approval for imaging services listed on Wellmark.com will result in denial. |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network (IN) Provider | Your Cost If You Use an Out-of-Network (OON) Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.wellmark.com. | Generic drugs | $5 copay | $5 copay | Drugs listed on Wellmark's Drug List are covered. Drugs not on this Drug List are not covered. For out-of-network prescription drugs, you may be balance billed.<br><br>1 copay for 30-day supply.<br>3 copays for 90-day supply (Retail maintenance).<br>2 copays for 90 day supply (Mail order maintenance).<br><br>Failure to obtain prior authorization or prior approval for drugs listed on Wellmark.com will result in denial with review rights. |
| | Preferred brand drugs | $15 copay | $15 copay | |
| | Non-preferred brand drugs | $30 copay | $30 copay | |
| | Select non-preferred brand drugs | $30 copay | $30 copay | |
| | Specialty drugs | Same as cost-share above depending on drug category. | Same as cost-share above depending on drug category. | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 20% coinsurance | Waive cost-share on outpatient services for mental health/substance abuse. Waive coinsurance for outpatient surgery and related x-ray/lab. Failure to obtain prior approval for services listed on Wellmark.com will result in denial with review rights. |
| | Physician / surgeon fees | 20% coinsurance | 20% coinsurance | Waive cost-share on outpatient services for mental health/substance abuse. Failure to obtain prior approval for services listed on Wellmark.com will result in denial with review rights. |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network (IN) Provider | Your Cost If You Use an Out-of-Network (OON) Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need immediate medical attention** | Emergency room services | 0% coinsurance | 0% coinsurance | For emergency medical conditions treated out-of-network, you may be balance billed. Dental treatment for accidental injury is limited to care completed within 6 months of the injury. Accident care within 72 hours is not subject to coinsurance. |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | Waive cost-share on outpatient services for mental health/ substance abuse. |
| | Urgent care | 20% coinsurance | 20% coinsurance | Waive cost-share on outpatient services for mental health/ substance abuse. Benefits shown will apply to providers credentialed through Wellmark as urgent care. Urgent care providers can be located on wellmark.com beginning 1/1/2016. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | 20% coinsurance | Reduction for failure to precertify is 50% and will not exceed $500 per calendar year. |
| | Physician / surgeon fee | 20% coinsurance | 20% coinsurance | Failure to obtain prior approval for services listed on Wellmark.com will result in denial with review rights. |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | Office: $15 copay for exam<br>Facility: 0% coinsurance | 0% coinsurance | ------None------ |
| | Mental/Behavioral health inpatient services | 20% coinsurance | 20% coinsurance | Reduction for failure to precertify is 50% and will not exceed $500 per calendar year. |
| | Substance use disorder outpatient services | Office: $15 copay for exam<br>Facility: 0% coinsurance | 0% coinsurance | ------None------ |
| | Substance use disorder inpatient services | 20% coinsurance | 20% coinsurance | Reduction for failure to precertify is 50% and will not exceed $500 per calendar year. |
| **If you are pregnant** | Prenatal and postnatal care | 20% coinsurance | 20% coinsurance | ------None------ |
| | Delivery and all inpatient services | 20% coinsurance | 20% coinsurance | Waive coinsurance for newborn care for initial hospitilization from 0-6 days. |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network (IN) Provider | Your Cost If You Use an Out-of-Network (OON) Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | 20% coinsurance | Waive cost-share on outpatient services for mental health/ substance abuse. Reduction for failure to precertify is 50% and will not exceed $500 per calendar year. |
| | Rehabilitation services | 20% coinsurance | 20% coinsurance | Waive cost-share on outpatient services for mental health/ substance abuse. Reduction for failure to precertify is 50% and will not exceed $500 per calendar year. |
| | Habilitative services | 20% coinsurance | 20% coinsurance | Waive cost-share on outpatient services for mental health/ substance abuse. Reduction for failure to precertify is 50% and will not exceed $500 per calendar year. |
| | Skilled nursing care | 20% coinsurance | 20% coinsurance | Reduction for failure to precertify is 50% and will not exceed $500 per calendar year. |
| | Durable medical equipment | 20% coinsurance | 20% coinsurance | Failure to obtain prior approval for services listed on Wellmark.com will result in denial with review rights. |
| | Hospice service | 20% coinsurance | 20% coinsurance | Waive cost-share on outpatient services for mental health/ substance abuse. Hospice respite care is limited to 15 inpatient and 15 outpatient days per lifetime. |
| **If your child needs dental or eye care** | Eye exam | Not covered | Not covered | ------None------ |
| | Glasses | Not covered | Not covered | ------None------ |
| | Dental check-up | Not covered | Not covered | ------None------ |

## Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover** (This isn't a complete list. Check your policy or plan document for 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
- Weight loss programs

**Other Covered Services** (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care
- Infertility treatment ($25,000 LTM, excludes some services)
- Most coverage provided outside the U.S.
- Private-duty nursing - short term intermittent home skilled nursing

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact your employer or group sponsor.

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Wellmark at 1-800-622-0043.

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

## Language Access Services:

Para recibir asistencia en espanõl, por favor comuníquense al servicio de cliente, al número que aparence en su tarjeta de identificación.

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

## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

## Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,380
- **Patient pays** $1,160

**Sample care costs:**

| | |
|---|---|
| Hospital charges (mother) | $2,700 |
| Routine obstetric care | $2,100 |
| Hospital charges (baby) | $900 |
| Anesthesia | $900 |
| Laboratory tests | $500 |
| Prescriptions | $200 |
| Radiology | $200 |
| Vaccines, other preventive | $40 |
| **Total** | **$7,540** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $300 |
| Copays | $10 |
| Coinsurance | $700 |
| Limits or exclusions | $150 |
| **Total** | **$1,160** |

## Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,580
- **Patient pays** $820

**Sample care costs:**

| | |
|---|---|
| Prescriptions | $2,900 |
| Medical Equipment and Supplies | $1,300 |
| Office Visits and Procedures | $700 |
| Education | $300 |
| Laboratory tests | $100 |
| Vaccines, other preventive | $100 |
| **Total** | **$5,400** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $20 |
| Copays | $590 |
| Coinsurance | $50 |
| Limits or exclusions | $160 |
| **Total** | **$820** |

*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.*

# Questions and answers about the Coverage Examples:

## What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

## What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

## Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

## Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

## Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

## Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

***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.***

**Wellmark Blue Cross and Blue Shield of Iowa is an Independent Licensee of the Blue Cross and Blue Shield Association.**

**Questions:** Call 1-800-622-0043 or visit us at www.wellmark.com. If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-800-622-0043 to request a copy.

12/30/2015;01/01/2017;___;___;114160-64;224783-2;00032642;N;NGF

# 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.

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

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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 النصي: 888-781-4262).

ສິ່ງຄວນເອົາໃຈໃສ່, ພາສາລາວ ຖ້າທ່ານເວົ້າ: ພວກເຮົາມີບໍລິການຄວາມຊ່ວຍເຫຼືອດ້ານພາສາ ໃຫ້ທ່ານໂດຍບໍເສຍຄ່າ ຫຼື 800-524-9242 ຕິດຕໍ່ທີ. (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.

โปรดทราบ: หากคุณพูด ไทย เรามีบริการช่วยเหลือด้านภาษาสำหรับคุณโดยไม่คิดค่าใช้จ่าย 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).

တၢ်ဒုးသ့ၣ်ညၢ်–နမ့ၢ်ကတိၤကညီကျိာ်.ကျိာ်တၢ်မၤစၢၤတၢ်ဖံးတၢ်မၤတဖၣ်.လၢတဘဉ်လၢ်ဘူးလဲ.ဆိုဉ်လၢနၣ်ၢလီၤ.ဆဲးကျိုးဆူ ၈၀၀–၅၂၄–၉၂၄၂မ့တမ့ၢ်(TTY:၈၈၈–၇၈၁–၄၂၆၂)တကၢ်.

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 निःशुल्क रूपमा भाषा सहायता सेवाहरू उपलब्ध गराइन्छ । 800-524-9242 वा (TTY: 888-781-4262) मा सम्पर्क गर्नुहोस् ।

ማሳሰቢያ፦ አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ እገዛ አገልግሎቶች፣ ከክፍያ ነፃ፣ ያገኛሉ። በ 800-524-9242 ወይም (በTTY: 888-781-4262) ደውሉ ያነጋግሩን።

HEETINA To a wolwa Fulfulde laabi walliinde dow wolde, naa e njobdi, ene ngoodi ngam maaɗa. Heƀir 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, náhóǫ́. Kojį' hólne' 800-524-9242 doodaii' (TTY: 888-781-4262)

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