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

Wellmark Health Plan of Iowa

**Coverage Period: 01/01/2024 – 12/31/2024**
Coverage for: Single & Family | Plan Type: HMO

## Cooperative Health Care Plan 1000 POS

**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 1-800-747-4370. 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 1-800-747-4370 to request a copy.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | **$1,000** person/**$2,000** family per calendar year. | Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| **Are there services covered before you meet your deductible?** | Yes. Well-child care, prescription drugs, in-network preventive care, in-network urgent care, in-network colonoscopies/ sigmoidoscopies, breast pumps, office services and independent labs for mental health/substance abuse services and services subject to copayments. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | No. There are no other specific deductibles. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | Health: **$3,000** person/**$6,000** family per calendar year. Drug Card: **$3,000** person/**$6,000** family per calendar year. 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 in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | Premiums, 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. |
| **Will you pay less if you use a network provider?** | Yes. See www.wellmark.com or call 1-800-747-4370 for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **Do you need a referral to see a specialist?** | No. | You can see the specialist you choose without a referral. |

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 | Exam: $25 copay and 20% coinsurance per date of service<br>Other services: 20% coinsurance | 30% coinsurance | For this plan you must select a designated Primary Care Provider. PCP provider types can be found in the What You Pay section of your plan document. $25 copay per date of service applies to telehealth services delivered by in-network primary care providers and providers contracting through Doctor on Demand. |
| | Specialist visit | Exam: $25 copay and 20% coinsurance per date of service<br>Other services: 20% coinsurance | 30% coinsurance | One routine hearing exam per calendar year. $25 copay per date of service applies to covered telehealth services provided by in-network specialists. |
| | Preventive care/screening/ immunization | No charge | 30% coinsurance | One preventive exam, one gynecological exam with Pap smear, and one mammogram per calendar year. Well-child care is covered to age 7. Preventive medical examinations performed for administrative purposes are covered in lieu of a preventive exam. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Preventive care must be provided by a PCP provider. |

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-747-4370.

| 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 have a test** | Diagnostic test (x-ray, blood work) | 20% coinsurance | 30% coinsurance | For a test in a provider's 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) | 20% coinsurance | 30% coinsurance | For a test in a provider's office or clinic, your cost is included in the cost-share listed above. |
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.wellmark.com/ prescriptions. | Tier 1 | 20% coinsurance | 20% coinsurance | Drugs listed on Wellmark's Blue Rx Complete 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 or coinsurance for 30-day supply (Specialty)<br>1 copay and/or coinsurance for 34-day suppy (Retail)<br>2 copays and/or coinsurance for 35-90 day supply (Retail and mail order maintenance)<br><br>Specialty drugs are covered only when obtained through the CVS Specialty Pharmacy Program.<br><br>Your plan includes coverage for certain specialty drugs through PrudentRx. If you choose to opt into the PrudentRx program, your deductible and coinsurance will be waived for drugs listed on the PrudentRx drug list. Information about the PrudentRx program can be found in your plan document in these sections: What You Pay, Details-Covered and Not Covered, Choosing a Provider, Factors Affecting What You Pay, and the Glossary.<br><br>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 | $10 copay and 25% coinsurance per prescription | $10 copay and 25% coinsurance per prescription | |
| | Tier 3 | $10 copay and 30% coinsurance per prescription | $10 copay and 30% coinsurance per prescription | |
| | Tier 4 | $10 copay and 30% coinsurance per prescription | $10 copay and 30% coinsurance per prescription | |
| | Specialty drugs | Generic: 10% coinsurance up to $100 per prescription<br>Preferred: 10% coinsurance up to $150 per prescription<br>Non-preferred: 10% coinsurance up to $200 per prescription | Not covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 30% coinsurance | Waive coinsurance for in-network colonoscopies / sigmoidoscopies. |
| | Physician/surgeon fees | 20% coinsurance | 30% coinsurance | ------None------ |

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-747-4370.

| 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 need immediate medical attention** | Emergency room care | $100 copay and 20% coinsurance per date of service for facility and physician(s) services combined | $100 copay and 20% coinsurance per date of service for facility and physician(s) services combined | For emergency medical conditions 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. |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | For covered non-emergent situations, out-of-network ambulance services are NOT reimbursed at the in-network level. The member may be balance billed for any out-of-network service as established under the rules developed for implementation of the No Surprises Act. |
| | Urgent care | Exam: $25 copay and 20% coinsurance per date of service<br>Other services: 20% coinsurance | 30% coinsurance | Waive copay on urgent care services for mental health/ substance abuse. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | 30% coinsurance | ------None------ |
| | Physician/surgeon fees | 20% coinsurance | 30% coinsurance | ------None------ |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Office: No charge<br>Facility: 20% coinsurance | 30% coinsurance | Waive copay on telehealth services for mental health/ substance abuse. |
| | Inpatient services | 20% coinsurance | 30% coinsurance | ------None------ |

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-747-4370.

| 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 are pregnant** | Office visits | No charge | 30% coinsurance | Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Cost sharing does not apply for preventive services. 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 | 30% 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 | 20% coinsurance | 30% coinsurance | ------None------ |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | 30% coinsurance | ------None------ |
| | Rehabilitation services | 20% coinsurance | 30% coinsurance | ------None------ |
| | Habilitation services | 20% coinsurance | 30% coinsurance | ------None------ |
| | Skilled nursing care | 20% coinsurance | 30% coinsurance | ------None------ |
| | Durable medical equipment | 20% coinsurance | 30% coinsurance | Waive cost-share for breast pumps. |
| | Hospice services | 20% coinsurance | 30% coinsurance | ------None------ |
| **If your child needs dental or eye care** | Children's eye exam | Not covered | Not covered | ------None------ |
| | 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 1-800-747-4370.

## Excluded Services & Other Covered Services:

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- Acupuncture
- Cosmetic surgery
- Custodial care - in home or facility
- Dental care - Adult
- Dental check-up
- Extended home skilled nursing
- Eye exam
- Glasses
- Hearing aids
- Long-term care
- Routine eye care - Adult
- Routine foot care
- 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)
- Most coverage provided outside the U.S.
- Private-duty nursing - short term intermittent home skilled nursing

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of 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 1-800-747-4370 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.

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

## About These Coverage Examples:

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible $1,000
- PCP copay and coinsurance $25 and 20%
- Hospital(facility) coinsurance 20%
- 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* | |
|---|---|
| Deductibles | $1,000 |
| Copayments | $0 |
| Coinsurance | $1,500 |
| *What isn't covered* | |
| **Limits or exclusions** | **$60** |
| **The total Peg would pay is** | **$2,560** |

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

- The plan's overall deductible $1,000
- Specialist copay and coinsurance $25 and 20%
- Hospital(facility) coinsurance 20%
- Other coinsurance 20%

**This EXAMPLE event includes services like:**
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

| **Total Example Cost** | **$5,600** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $50 |
| Copayments | $500 |
| Coinsurance | $1,100 |
| *What isn't covered* | |
| **Limits or exclusions** | **$20** |
| **The total Joe would pay is** | **$1,670** |

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

- The plan's overall deductible $1,000
- Specialist copay and coinsurance $25 and 20%
- Hospital(facility) copay and coinsurance $100 and 20%
- Other coinsurance 20%

**This EXAMPLE event includes services like:**
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)

| **Total Example Cost** | **$2,800** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,000 |
| Copayments | $200 |
| Coinsurance | $300 |
| *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.

# 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.**

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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).

ສ່ຽງຄວນເອົາໃຈໃສ່, ພາສາລາວ ຖ້າທ່ານເວົ້າ: ພວກເຮົາມີບໍລິການຄວາມຊ່ວຍເຫຼືອດ້ານພາສາ ໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ 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, नि:शुल्क 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).

တၢ်နှးသ့ဉ်ညါ–နမ့ၢ်ကတိၤကညီကျိာ်.ကျိာ်တၢ်မၤစၢၤတၢ်ဖံးတၢ်မၤတဖဉ်.လၢတဘဉ်လာ်ဘူးလဲ.ဆိဉ်လၢနဂၢ်လီၤ.ဆဲးကျိးဆူ ၈၀၀–၅၂၄–၉၂၄၂မ့တမ့ၢ်(TTY:၈၈၈–၇၈၁–၄၂၆၂)တက့ၢ်.

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

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



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