

Mid Iowa Cooperative 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](http://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](http://www.healthcare.gov/sbc-glossary) or call 1-800-524-9242 to request a copy.

Important Questions	Answers	Why this Matters:
<b>What is the overall <u>deductible</u>?</b>	<b>\$3,000</b> person/ <b>\$6,000</b> 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> .
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Yes. Well-child care, <u>preventive care</u> from in- <u>network</u> <u>providers</u> , physician maternity care, 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 <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <u>deductibles</u> for specific services?</b>	No. There are no other <u>deductibles</u> .	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	Health: <b>\$6,000</b> person/ <b>\$12,000</b> family per calendar year. Drug Card: <b>\$6,000</b> person/ <b>\$12,000</b> 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.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	Premiums, <u>balance-billed charges</u> , and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. See <a href="http://www.wellmark.com">www.wellmark.com</a> 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
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$20 Designated PCP copay per provider per date of service \$35 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	\$50 copay per provider per date of service	Not covered	Applies to Non-PCP <u>providers</u> . \$35 copay per provider per date of service for in- <u>network</u> chiropractic services. Hearing exams are covered according to ACA guidelines.
	<u>Preventive care/screening/immunization</u>	No charge	Not covered	One preventive exam and one mammogram per calendar year. Well-child care is covered to age 7. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	Independent Lab: \$50 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- <u>network</u> independent lab services for mental health/substance abuse.
	Imaging (CT/PET scans, MRIs)	30% <u>coinsurance</u>	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](http://sbccmfinder.wellmark.com).

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
<p><b>If you need drugs to treat your illness or condition</b></p> <p>More information about <b>prescription drug coverage</b> is available at <a href="http://www.wellmark.com/prescriptions">www.wellmark.com/prescriptions</a>.</p>	Tier 1	\$25 <u>copay</u> per prescription	Not covered	<p>Refer to your Blue Rx Complete Drug List to determine the tier that applies to a covered drug.</p> <p>1 <u>copay</u> for 30-day supply. 3 <u>copays</u> for 90-day supply (retail and mail order).</p> <p><u>Specialty drugs</u> are covered only when obtained through the CVS Specialty Pharmacy Program.</p> <p><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.</p> <p>See <a href="http://wellmark.com/prescriptions">wellmark.com/prescriptions</a> for information about drugs and drug quantities that require prior authorization by Wellmark to be covered by your plan.</p>
	Tier 2	\$50 <u>copay</u> per prescription	Not covered	
	Tier 3	\$100 <u>copay</u> per prescription	Not covered	
	Tier 4	\$100 <u>copay</u> per prescription	Not covered	
	Specialty drugs	Generic: \$160 <u>copay</u> per prescription Preferred: \$225 <u>copay</u> per prescription Non-Preferred: \$275 <u>copay</u> per prescription	Not covered	
<p><b>If you have outpatient surgery</b></p>	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-----
<p><b>If you need immediate medical attention</b></p>	<u>Emergency room care</u>	\$350 <u>copay</u> per visit for facility and physician(s) combined	\$350 <u>copay</u> per visit 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>	\$35 <u>copay</u>	Not covered	<u>Copay</u> applies per <u>provider</u> per date of service for facility and physician(s) combined.

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](http://sbccmfinder.wellmark.com).

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 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: \$35 <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 <u>in-network</u> services that fall outside of routine obstetric care, the office visit benefits shown above may apply.
	Childbirth/delivery professional services	No charge	Not covered	Benefits shown reflect OB/GYN practitioner services which are typically globally billed at time of delivery for pre-natal, post-natal and delivery services.
	Childbirth/delivery facility services	30% <u>coinsurance</u>	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](http://sbccmfinder.wellmark.com).

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 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: \$35 PCP/\$50 Non-PCP <u>copay</u> per <u>provider</u> per date of service Facility: 30% <u>coinsurance</u>	Not covered	\$35 <u>copay</u> per <u>provider</u> per date of service applies to in- <u>network</u> Physical and Occupational Therapists and Speech Language Pathologists.
	<u>Habilitation services</u>	Office: \$35 PCP/\$50 Non-PCP <u>copay</u> per <u>provider</u> per date of service Facility: 30% <u>coinsurance</u>	Not covered	\$35 <u>copay</u> per <u>provider</u> per date of service applies to in- <u>network</u> 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- <u>network</u> 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	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 1-800-524-9242. You can find your Coverage Manual at [sbccmfinder.wellmark.com](http://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
- Eye exam
- Glasses
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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
- 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](http://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](http://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](http://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 deductible \$3,000
- PCP copayment \$20
- Hospital(facility) coinsurance 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
---------------------------	-----------------

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

Cost Sharing	
<u>Deductibles</u>	\$3,000
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$1,600
What isn't covered	
<b>Limits or exclusions</b>	<b>\$60</b>
<b>The total Peg would pay is</b>	<b>\$4,670</b>

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

- The plan's overall deductible \$3,000
- Specialist copayment \$50
- Hospital(facility) coinsurance 30%
- Other coinsurance 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
---------------------------	----------------

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

Cost Sharing	
<u>Deductibles</u>	\$50
<u>Copayments</u>	\$1,600
<u>Coinsurance</u>	\$0
What isn't covered	
<b>Limits or exclusions</b>	<b>\$20</b>
<b>The total Joe would pay is</b>	<b>\$1,670</b>

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

- The plan's overall deductible \$3,000
- Specialist copayment \$50
- Hospital(facility) copayment \$350
- Other coinsurance 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
---------------------------	----------------

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

Cost Sharing	
<u>Deductibles</u>	\$1,200
<u>Copayments</u>	\$600
<u>Coinsurance</u>	\$0
What isn't covered	
<b>Limits or exclusions</b>	<b>\$0</b>
<b>The total Mia would pay is</b>	<b>\$1,800</b>

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.

