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

Coverage Period: 07/01/2026 – 06/30/2027

Coverage for: Single & Family | Plan Type: PPO

Pleasant Valley CSD PPO

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.webaddress.com or call 1-000-000-0000. 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 1-000-000-0000 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$750** person/**$1,500** 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. In-network preventive care, your drug card costs, in-network independent labs, in-network prosthetic limbs and services covered before you meet your deductible.	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?		
What is the out-of-pocket limit for this plan?	Health: **$2,250** person/**$4,500** family per calendar year. Drug Card: **$0** person/**$0** family per calendar year. The In-Network health and drug card out-of-pocket maximum amounts accumulate together.	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 1-800-524-9242 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.
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	20% coinsurance	40% coinsurance	------None------
	Specialist visit	20% coinsurance	40% coinsurance	------None------
	Preventive care/screening/ immunization	No charge	40% coinsurance	One preventive exam and one mammogram per calendar year. Preventive medical examinations performed for administrative purposes are covered in addition to a preventive exam. Well-child care is covered to age 7. 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.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	------None------
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	------None------
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.webaddress.com/prescriptions.	Pharmacy Drugs	**1 – 30 Day Supply** Generic: $5 Brand: $25 **31 – 60 Day Supply** Generic: $10 Brand: $50 **61 – 90 Day**	**1 – 30 Day Supply** Generic: $35 Brand: $55	The plan includes a network of pharmacies locally and nationwide, excluding **CVS**. Register for the MedOne Member Portal at **www.medone-rx.com** to search for an in-network pharmacy or call MedOne at **1-866-335-9057** for assistance. A prescription may not be refilled until at least 75% of a 30-day supply (or 60% of a 90-day supply) has been utilized. For example, 23 days of a 30-day supply must be utilized before the

		Supply Generic: $15 Brand: $75		pharmacy is able to process another fill. **ACA required medications subject to standard copay.**

For more information about limitations and exceptions, see your plan document or call Group name at 1-000-000-0000.

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 outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	------None------
	Physician/surgeon fees	20% coinsurance	40% coinsurance	------None------
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	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 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.
	Urgent care	20% coinsurance	40% coinsurance	------None------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	------None------
	Physician/surgeon fees	20% coinsurance	40% coinsurance	------None------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	------None------
	Inpatient services	20% coinsurance	40% coinsurance	------None------
If you are	Office visits	20% coinsurance	40% 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.

pregnant	Childbirth/delivery professional services	20% coinsurance	40% 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	40% coinsurance	------None------

For more information about limitations and exceptions, see your plan document or call Group name at 1-000-000-0000.

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	Home health care	20% coinsurance	40% coinsurance	------None------
	Rehabilitation services	20% coinsurance	40% coinsurance	------None------
	Habilitation services	20% coinsurance	40% coinsurance	------None------
	Skilled nursing care	20% coinsurance	40% coinsurance	------None------
	Durable medical equipment	20% coinsurance	40% coinsurance	------None------
	Hospice services	20% coinsurance	40% 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 Group name at 1-000-000-0000.

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
- 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
- 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 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 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: Group name at 1-000-000-0000.

Does this plan provide Minimum Essential Coverage? Yes/No

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/No

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.

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	$750
PCP coinsurance	20%
Hospital(facility) coinsurance	20%
Other coinsurance	20%

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	$750
Copayments	$0
Coinsurance	$1,500
What isn't covered	
Limits or exclusions	**$70**
The total Peg would pay	**$2,320**

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

The plan's overall deductible	$750
Specialist coinsurance	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	$750
Copayments	$0
Coinsurance	$200
What isn't covered	
Limits or exclusions	**$4,300**
The total Joe would pay	**$5,140**

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

The plan's overall deductible	$750
Specialist coinsurance	20%
Hospital(facility) coinsurance	20%
Other coinsurance	20%

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	
Deductibles	$750
Copayments	$0
Coinsurance	$400
What isn't covered	
Limits or exclusions	**$10**
The total Mia would pay	**$1,160**

RX Admin Note: Excluded charges include all pharmacy drugs. Immunizations in office are covered under medical as preventive. All amounts rounded to nearest $10

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

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  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance 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 3E417, Des Moines, IA 50309-2901, 515-376-6500, TTY 888-781-4262, Fax 515-376-9055, Email **CRC@Wellmark.com**. You can file a grievance in person or 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 or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

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

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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 800-425-2429 أو (خدمة الهاتف النصي: 888-187-2624).

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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).

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