**Summary of Benefits and Coverage:** What This Plan Covers & What You Pay For Covered Services
**Cedar County Buy Down Plan: $500 Deductible POS**

**Coverage Period:** 07/01/2026-06/30/2027
**Coverage for:** Individuals & Families
**Plan Type:** Buy Down

The Summary of Benefits and Coverage (SBC) document will help you understand your health plan. The SBC shows 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 buy-down coverage, call Midwest Group Benefits at (800) 344-3766. For information on the core plan, or to get a copy of the complete terms of coverage, call Wellmark at (800) 247-0961.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall Deductible? | The insurance plan starts at:<br>In-Network: **$5,750 / Individual** or **$11,500 / Family** per Calendar Year.<br>Out-of-Network: **$7,000 / Individual** or **$14,000 / Family** per Calendar Year.<br>The employer then "buys down" the Deductible:<br>In-Network: **$500 / Individual** or **$1,000 / Family** per Calendar Year<br>Out-of-Network: **$2,500 / Individual** or **$5,000/ Family** per Calendar Year | This benefit is in addition to the Wellmark Blue Cross Blue Sheild plan already in place. Refer to the Wellmark Blue Cross Blue Shield of Iowa Summary of Benefits and Coverage for covered services for your particular plan.<br>Generally, you must pay for all of the costs from providers up to the Deductible amount before this plan begins to pay. This buy down benefit will then be paid as reimbursement to the covered service provider or member based on your plan design. Check your policy or plan document to see when the Deductible starts over. |
| Are there other Deductibles for specific services? | Yes. **$100 Individual** / **$200 Family** per Calendar Year for Drug Card. There are no other specific deductibles. | You must pay all of the costs for these services up to the specific deductible amount. |
| What is the Out-of-Pocket limit for this plan? | In-Network: **$8,000 / Individual** or **$16,000 / Family** per Calendar Year.<br>Out-of-Network: **$14,000 / Individual** or **$28,000 / Family** per Calendar Year. | The Out-of-Pocket Limit is the most you could pay in a year for covered services. This limit helps you plan for health care expenses.<br>The Medical Deductible, Coinsurance, Drug Card Deductible and Copays are included in the In-Network or Out-of-Network Out-of-Pocket Limit. |

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| | The employer then "buys down" the Out-of-Pocket:<br>In-Network: **$2,000 / Individual** or **$4,000 / Family** per Calendar Year<br>Out-of-Network: **$9,000 / Individual** or **$18,000/ Family** per Calendar Year | |
| What is not included in the Out-of-Pocket Limit? | Benefits not covered under the Wellmark Blue Cross and Blue Shield plan. | See your Wellmark Blue Cross Blue Shield Plan for covered benefits and limitations or exclusions. Even though you pay these expenses, they do not count toward the Out-of-Pocket Limit. |
| What is the Coinsurance benefit? | Network: **20%**<br>Out-of-Network: **40%** | 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 plans' allowed amount for an overnight hospital stay is $1,000, your Coinsurance payment of 20% would be $200. This may change if you have not met your Deductible. |

| Services you May Need | What You Will Pay Your Designated Primary Care Provider (PCP) | What You Will Pay In-Network (IN) Provider | What You Will Pay Out-of-Network (OON) Provider |
|---|---|---|---|
| Primary care visit to treat an injury or illness | $15 Designated PCP copay per date of service | $20 PCP copay per date of service | 40% coinsurance |
| Specialist Visit | N / A | $40 copay per date of service | 40% coinsurance |
| Preventive Care / Screening / Immunization | No charge | No charge | 40% coinsurance |
| Emergency Services | N / A | $250 copay per date of service for facility and physician(s) combined | $250 copay per date of service for facility and physician(s) combined |

* For more information about limitations and exceptions, see your Wellmark Core Plan SBC.

| | Services you May Need | What You Will Pay Your Designated Primary Care Provider (PCP) | What You Will Pay In-Network (IN) Provider | What You Will Pay Out-of-Network (OON) Provider |
|---|---|---|---|---|
| **If you need drugs to treat your illness or condition** | Tier 1 | N/A | $8 copay per prescription | $8 copay per prescription |
| | Tier 2 | N/A | $35 copay per prescription | $35 copay per prescription |
| | Tier 3 | N/A | $50 copay per prescription | $50 copay per prescription |
| | Tier 4 | N/A | $50 copay per prescription | $50 copay per prescription |
| | Specialty drugs | N/A | Generic/Preferred: $250 copay per prescription<br>Non-Preferred: $500 copay per prescription | Not Covered |

* For more information about limitations and exceptions, see your Wellmark Core Plan SBC.