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

**Wellmark. **

[Logo]

**UNI 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.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 or call 1-800-524-9242 to request a copy.

### Important Questions

<table>
<thead>
<tr>
<th><strong>What is the overall deductible?</strong></th>
<th><strong>Answers</strong></th>
<th><strong>Why this Matters:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Network: $350 person/$700 family per calendar year. Out-of-Network: $1,000 person/$2,000 family per calendar year.</td>
<td>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.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Are there services covered before you meet your deductible?</strong></th>
<th><strong>Answers</strong></th>
<th><strong>Why this Matters:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes. Well-child care, in-network preventive care, in-network routine vision exams, in-network independent labs, in-network prosthetic limbs and services subject to health and drug card copayments are covered before you meet your deductible.</td>
<td>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 <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Are there other deductibles for specific services?</strong></th>
<th><strong>Answers</strong></th>
<th><strong>Why this Matters:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>No. There are no other deductibles.</td>
<td>You don’t have to meet deductibles for specific services.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>What is the out-of-pocket limit for this plan?</strong></th>
<th><strong>Answers</strong></th>
<th><strong>Why this Matters:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Health In-Network: $1,750 person/$3,500 family per calendar year. Health Out-Of-Network: $4,000 person/$8,000 family per calendar year. Drug Card: $2,600 person/$5,200 family per calendar year. The In-Network health and drug card out-of-pocket maximum amounts accumulate separately.</td>
<td>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.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>What is not included in the out-of-pocket limit?</strong></th>
<th><strong>Answers</strong></th>
<th><strong>Why this Matters:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Premiums, balance-billed charges, and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
<td></td>
</tr>
</tbody>
</table>
### Important Questions

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<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why this Matters:</th>
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<tr>
<td><strong>Will you pay less if you use a network provider?</strong></td>
<td>Yes. See <a href="http://www.wellmark.com">www.wellmark.com</a> or call 1-800-524-9242 for a list of network providers.</td>
<td>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.</td>
</tr>
<tr>
<td><strong>Do you need a referral to see a specialist?</strong></td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>

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**All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.**

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For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-524-9242.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay In-Network (IN) Provider (You will pay the least)</th>
<th>What You Will Pay Out-of-Network (OON) Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>$20 copay per date of service</td>
<td>30% coinsurance</td>
<td>Primary Care Practitioners (PCP) are defined as General and Family Practice, Internal Medicine, OB/GYN, Pediatricians, Nurse Practitioners and PAs. If covered by Medicare Part A, benefits will be coordinated with benefits available under Medicare Part A and Part B, even if not enrolled in Part B. Payment will be calculated by reducing allowed charges by 80% for benefits attributable to Part B eligibility. $20 copay per date of service applies to telehealth services delivered by in-network primary care providers and providers contracting through Doctor on Demand.</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$40 copay per date of service</td>
<td>30% coinsurance</td>
<td>Applies to Non-PCP providers. $20 copay per date of service for in-network chiropractic services. $40 copay per date of service applies to covered telehealth services provided by in-network specialists.</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>30% coinsurance</td>
<td>One preventive exam and one gynecological exam per calendar year. 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 provider if the services you need are preventive. Then check what your plan will pay for.</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>For a test in a provider's office or clinic, your cost is included in the cost-share listed above. In-network independent labs for mental health/substance abuse services are not subject to coinsurance.</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>For a test in a provider's office or clinic, your cost is included in the cost-share listed above.</td>
</tr>
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<tr>
<td>If you need drugs to treat your illness or condition</td>
<td></td>
<td>$10 copay per prescription</td>
<td>$10 copay per prescription</td>
<td>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. 1 copay for 30-day supply. 3 copays for 90-day supply (Retail maintenance). 2 copays for 90-day supply (Mail order maintenance).</td>
</tr>
<tr>
<td></td>
<td>Tier 1</td>
<td>$30 copay per prescription</td>
<td>$30 copay per prescription</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 2</td>
<td>$50 copay per prescription</td>
<td>$50 copay per prescription</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 3</td>
<td>$50 copay per prescription</td>
<td>$50 copay per prescription</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 4</td>
<td>Preferred: $100 copay per prescription</td>
<td>Preferred: $100 copay per prescription</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>Non-Preferred: $200 copay per prescription</td>
<td>Non-Preferred: $200 copay per prescription</td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>-----None-----</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>-----None-----</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$100 copay and 10% coinsurance per visit for facility and physician(s) combined</td>
<td>$100 copay and 10% coinsurance per visit for facility and physician(s) combined</td>
<td>For emergency medical conditions treated out-of-network, you may be balance billed. Waive cost-share on services for mental health/substance abuse.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
<td>For emergency medical conditions treated out-of-network, you may be balance billed. Benefits for non-participating ambulance providers are based on actual billed charges.</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$20 copay per date of service</td>
<td>30% coinsurance</td>
<td>-----None-----</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>Reduction for failure to precertify out-of-network services is 50% and will not exceed $500 per admission.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>-----None-----</td>
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<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Office: $20 copay per date of service Facility: 10% coinsurance</td>
<td>30% coinsurance</td>
<td>Contracted telehealth services are covered.</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>Reduction for failure to precertify out-of-network services is 50% and will not exceed $500 per admission.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Cost sharing does not apply to certain preventive services. For any in-network services that fall outside of routine obstetric care, the office visit benefits shown above may apply.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>Benefits shown reflect OB/GYN practitioner services which are typically globally billed at time of delivery for pre-natal, post-natal and delivery services.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>------None------</td>
</tr>
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<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home health care</td>
<td>10% coinsurance</td>
<td>30% coinsurance</td>
<td>Reduction for failure to precertify is 50% per covered service.</td>
</tr>
</tbody>
</table>
| Rehabilitation services | Office: $20 PCP/$40 Non-PCP copay per date of service  
                   Facility: 10% coinsurance | 30% coinsurance | $20 copay per date of service applies to in-network  
                   Physical and Occupational Therapists and Speech Language Pathologists. |
| Habilitation services | Office: $20 PCP/$40 Non-PCP copay per date of service  
                   Facility: 10% coinsurance | 30% coinsurance | $20 copay per date of service applies to in-network  
                   Physical and Occupational Therapists and Speech Language Pathologists. |
| Skilled nursing care | 10% coinsurance | 30% coinsurance | Reduction for failure to precertify out-of-network services is 50% and will not exceed $500 per admission. |
| Durable medical equipment | 10% coinsurance | 30% coinsurance | ------None------ |
| Hospice services | 10% coinsurance | 30% coinsurance | 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 | No charge | 30% coinsurance | One routine vision exam per calendar year. |
| 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.
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
- Glasses
- Hearing aids
- Long-term care
- 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-covered through age 18
- Bariatric surgery
- Chiropractic care
- Infertility treatment
- Most coverage provided outside the U.S.
- Private-duty nursing - short term intermittent home skilled nursing
- Routine eye care - Adult (one vision exam per calendar year)

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.

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.

Does this plan provide Minimum Essential Coverage? Yes

If you don’t have Minimum Essential Coverage for a month, you’ll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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.

Wellmark Blue Cross and Blue Shield of Iowa 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.

<table>
<thead>
<tr>
<th>Peg is Having a Baby</th>
<th>Managing Joe’s type 2 Diabetes</th>
<th>Mia’s Simple Fracture</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>(9 months of in-network pre-natal care and a hospital delivery)</strong></td>
<td><strong>(a year of routine in-network care of a well-controlled condition)</strong></td>
<td><strong>(in-network emergency room visit and follow up care)</strong></td>
</tr>
<tr>
<td>- The plan’s overall deductible $350</td>
<td>- The plan’s overall deductible $350</td>
<td>- The plan’s overall deductible $350</td>
</tr>
<tr>
<td>- PCP copayment $20</td>
<td>- Specialist copayment $40</td>
<td>- Specialist copayment $40</td>
</tr>
<tr>
<td>- Hospital(facility) coinsurance 10%</td>
<td>- Hospital(facility) coinsurance 10%</td>
<td>- Hospital(facility) copay and coinsurance $100 and 10%</td>
</tr>
<tr>
<td>- Other coinsurance 10%</td>
<td>- Other coinsurance 10%</td>
<td>- Other coinsurance 10%</td>
</tr>
</tbody>
</table>

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)

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)

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

<table>
<thead>
<tr>
<th>Total Example Cost</th>
<th>$12,800</th>
<th>$7,400</th>
<th>$1,900</th>
</tr>
</thead>
</table>

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles $350</th>
<th>Copayments $100</th>
<th>Coinsurance $1,100</th>
</tr>
</thead>
</table>

What isn’t covered:
- Limits or exclusions $60
- The total Peg would pay is $1,610

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles $90</th>
<th>Copayments $1,700</th>
<th>Coinsurance $0</th>
</tr>
</thead>
</table>

What isn’t covered:
- Limits or exclusions $200
- The total Joe would pay is $1,990

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles $350</th>
<th>Copayments $300</th>
<th>Coinsurance $90</th>
</tr>
</thead>
</table>

What isn’t covered:
- Limits or exclusions $0
- The total Mia would pay is $740

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.

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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, HHIB Building, Washington DC 20201, 800-368-1019, 800-537-7697 (TDD).