



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.midwestbenefits.com or by calling 1-800-344-3766.

Important Questions	Answers	Why this Matters:
<p>What is the overall <u>deductible</u>?</p>	<p>The fully insured Wellmark plan deductibles are: Single: \$6,000 Family: \$12,000</p> <p>NEISIT Partial Self-funds down the deductible, so your actual deductible becomes: Single: \$500 Family: \$1,000 Does not apply to well-child care and preventive care.</p>	<p>This benefit is in addition to the Wellmark Blue Cross Blue Shield 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.</p> <p>You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use.</p> <p>This plan covers some items and services even if you haven't yet met the deductible amount. 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/.</p>
<p>Are there other <u>deductibles</u> for specific services?</p>	<p>No.</p>	<p>You don't have to meet deductibles for specific services, but see the Common Medical Event chart on the following pages for other costs for services this plan covers.</p>
<p>Is there an <u>out-of-pocket limit</u> on my expenses?</p>	<p>Yes. NEISIT Partial Self-funds down the out of pocket limit, so your actual out of pocket becomes: Single: \$900 In Network Family: \$1,800 In Network Single: \$1,300 Out of Network Family: \$2,600 Out of Network</p>	<p>The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.</p>

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<p>What is not included in the <u>out-of-pocket limit</u>?</p>	<p>Premiums, pre-service review penalties, balance-billed charges, and health care this plan doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.</p>
<p>Is there an overall annual limit on what the plan pays?</p>	<p>No</p>	<p>There are no annual limits on Essential Benefits.</p>
<p>Does this plan use a <u>network of providers</u>?</p>	<p>Yes. See www.wellmark.com for a list of in-network providers.</p>	<p>If you use an in-network doctor or other health care <u>provider</u>, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u>, or participating for <u>providers</u> in their <u>network</u>. See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u>.</p> <p><i>Please refer to the SBC of the group health plan</i></p>
<p>Do I need a referral to see a <u>specialist</u>?</p>	<p>No.</p>	<p>You can see the <u>specialist</u> you choose without permission from this plan.</p>
<p>Are there services this plan doesn't cover?</p>	<p>Yes.</p>	<p>Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about <u>excluded services</u>.</p>

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- **Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** 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 plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-network Provider	Out-of-network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% Coinsurance	40% Coinsurance	Please refer to the SBC of the group health plan
	Specialist visit	20% Coinsurance	40% Coinsurance	Please refer to the SBC of the group health plan
	Other practitioner office visit	20% Coinsurance	40% Coinsurance	Please refer to the SBC of the group health plan
	Preventive care/screening/immunization	No Charge	40% Coinsurance	Please refer to the SBC of the group health plan
If you have a test	Diagnostic test (x-ray, blood work)	20% Coinsurance	40% Coinsurance	Please refer to the SBC of the group health plan
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	40% Coinsurance	Please refer to the SBC of the group health plan
If you need drugs to treat your illness or condition	Generic drugs	20% Coinsurance	40% Coinsurance	Please refer to the SBC of the group health plan
	Preferred brand drugs	20% Coinsurance	40% Coinsurance	Please refer to the SBC of the group health plan
	Non-preferred brand drugs	20% Coinsurance	40% Coinsurance	Please refer to the SBC of the group health plan
More information about prescription drug coverage is available at www.wellmark.com	Specialty drugs	20% Coinsurance	40% Coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	40% Coinsurance	Please refer to the SBC of the group health plan
	Physician/surgeon fees	20% Coinsurance	40% Coinsurance	Please refer to the SBC of the group health plan
If you need immediate medical attention	Emergency room services	20% Coinsurance	40% Coinsurance	Please refer to the SBC of the group health plan
	Emergency medical transportation	20% Coinsurance	40% Coinsurance	Please refer to the SBC of the group health plan
	Urgent care	20% Coinsurance	40% Coinsurance	Please refer to the SBC of the group health plan

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Northeast Iowa Schools Insurance Trust Partial Self Funded Plan 1
Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 07/01/2018 – 06/30/2019
Coverage for: Single & Family | Plan Type: PSF

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-network Provider	Out-of-network Provider	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	40% Coinsurance	Please refer to the SBC of the group health plan
	Physician/surgeon fee	20% Coinsurance	40% Coinsurance	Please refer to the SBC of the group health plan
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% Coinsurance	40% Coinsurance	Please refer to the SBC of the group health plan
	Mental/Behavioral health inpatient services	20% Coinsurance	40% Coinsurance	Please refer to the SBC of the group health plan
	Substance use disorder outpatient services	20% Coinsurance	40% Coinsurance	Please refer to the SBC of the group health plan
	Substance use disorder inpatient services	20% Coinsurance	40% Coinsurance	Please refer to the SBC of the group health plan
If you are pregnant	Prenatal and postnatal care	20% Coinsurance	40% Coinsurance	Please refer to the SBC of the group health plan
	Delivery and all inpatient services	20% Coinsurance	40% Coinsurance	Please refer to the SBC of the group health plan
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	40% Coinsurance	Please refer to the SBC of the group health plan
	Rehabilitation services	20% Coinsurance	40% Coinsurance	Please refer to the SBC of the group health plan
	Habilitation services	20% Coinsurance	40% Coinsurance	Please refer to the SBC of the group health plan
	Skilled nursing care	20% Coinsurance	40% Coinsurance	Please refer to the SBC of the group health plan
	Durable medical equipment	20% Coinsurance	40% Coinsurance	Please refer to the SBC of the group health plan
	Hospice service	20% Coinsurance	40% Coinsurance	Please refer to the SBC of the group health plan
If your child needs dental or eye care	Eye exam	Please refer to the SBC of the group health plan		
	Glasses	Please refer to the SBC of the group health plan		
	Dental check-up	Please refer to the SBC of the group health plan		

Questions: Call 1-800-344-3766 or visit us at www.midwestbenefits.com. If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can Call 1-800-344-3766 to request a copy.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other **excluded services**.)

Please refer to the SBC of the group health plan

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

Please refer to the SBC of the group health plan

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-344-3766. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: .

- Your health plan at 1-800-344-3766, the Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthscarereform.

Additionally, a consumer assistance program can help you file your appeal. Contact Iowa Insurance Division at 515-281-5705. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and <http://cciio.cms.gov/programs/consumer/capgrants/index.html>.

Does this Coverage Provide Minimum Essential Coverage? The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.”

This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard? The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value).

This health coverage does meet the minimum value standard for the benefits it provides.

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](#) \$500
- [Specialist](#) co-pay *n/a*
- 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	\$12,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$386
Copayments	\$0
Coinsurance	\$514
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$960

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

- The [plan's](#) overall [deductible](#) \$500
- [Specialist](#) co-pay *n/a*
- 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	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$0
Coinsurance	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$55
The total Joe would pay is	\$955

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

- The [plan's](#) overall [deductible](#) \$500
- [Specialist](#) co-pay *n/a*
- 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	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$0
Coinsurance	\$385
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$885

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include [premiums](#).
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network [providers](#). If the patient had received care from out-of-network [providers](#), costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how [deductibles](#), [co-payments](#), and [co-insurance](#) can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your [providers](#) charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the [premium](#) you pay. Generally, the lower your [premium](#), the more you'll pay in out-of-pocket costs, such as [co-payments](#), [deductibles](#), and [co-insurance](#). You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.



NEISIT HDHP 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	Answers	Why this Matters:
What is the overall <u>deductible</u>?	\$6,000 person/ \$12,000 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> .
Are there services covered before you meet your <u>deductible</u>?	Yes. Well-child care and <u>preventive care</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 www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No. There are no other <u>deductibles</u> .	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	In-Network: \$6,400 person/ \$12,800 family per calendar year. Out-Of-Network: \$12,000 person/ \$24,000 family per calendar year.	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.
What is not included in the <u>out-of-pocket limit</u>?	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> .
Will you pay less if you use a <u>network provider</u>?	Yes. See www.wellmark.com 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-network <u>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-network <u>provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
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
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Doctor on Demand contracted telehealth services are covered.
	<u>Specialist</u> visit	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----
	<u>Preventive care/screening/immunization</u>	No charge	40% <u>coinsurance</u>	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 <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----
If you need drugs to treat your illness or condition	Pharmacy Drugs	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Prescription drugs are covered under the medical <u>plan</u> . You pay the discounted cost of your prescription drugs until your overall <u>deductible</u> is met. For out-of-network prescription drugs, you may be balance billed. See wellmark.com/prescriptions Blue Rx Complete <u>formulary</u> list for information about drugs and drug quantities that require prior authorization by Wellmark to be covered by your health <u>plan</u> .
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----
	<u>Physician/surgeon</u> fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-524-9242. To find your Coverage Manual visit www.wellmark.com/coveragemanual, click on "Large Group Plans" and enter the following number, including dashes, into the search field. **115319-149**

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	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	For <u>emergency medical conditions</u> treated out-of-network, you may be balance billed.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----
	<u>Urgent care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Reduction for failure to precertify out-of-network services is 50% and will not exceed \$500 per admission.
	<u>Physician/surgeon fees</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Reduction for failure to precertify out-of-network services is 50% and will not exceed \$500 per admission.
If you are pregnant	Office visits	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Cost sharing does not apply to certain <u>preventive services</u> .
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	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% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limit of 100 visits per calendar year. Reduction for failure to precertify is 50% per covered service.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----
	<u>Habilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limit of 90 days per calendar year. Reduction for failure to precertify out-of-network services is 50% and will not exceed \$500 per admission.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----
	<u>Hospice services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Hospice respite care is limited to 15 inpatient and 15 outpatient days per lifetime.

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-524-9242. To find your Coverage Manual visit www.wellmark.com/coveragemanual, click on "Large Group Plans" and enter the following number, including dashes, into the search field. **115319-149**

Common Medical Event	Services You May Need	What You Will Pay In- <u>Network</u> (IN) <u>Provider</u> (You will pay the least)	What You Will Pay Out-of- <u>Network</u> (OON) <u>Provider</u> (You will pay the most)	Limitations, Exceptions, & Other Important Information
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. To find your Coverage Manual visit www.wellmark.com/coveragemanual, click on "Large Group Plans" and enter the following number, including dashes, into the search field. **115319-149**

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-covered subject to state mandate through age 18 subject to annual limits
- 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 (applies to home health care limit)

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.

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 515-281-5705, 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

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. _____

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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 <u>plan's</u> overall <u>deductible</u>	\$6,000
■ PCP <u>coinsurance</u>	20%
■ Hospital(facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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	\$12,800
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In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$6,000
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$400
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$6,460

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

■ The <u>plan's</u> overall <u>deductible</u>	\$6,000
■ <u>Specialist</u> <u>coinsurance</u>	20%
■ Hospital(facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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	\$7,400
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In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$6,000
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$200
What isn't covered	
Limits or exclusions	\$200
The total Joe would pay is	\$6,400

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

■ The <u>plan's</u> overall <u>deductible</u>	\$6,000
■ <u>Specialist</u> <u>coinsurance</u>	20%
■ Hospital(facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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	\$1,900
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In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,900
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,900

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.