

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



Coverage Period: 01/01/2018 – 12/31/2018  
 Coverage for: Single & Family | Plan Type: HMO

Woodbury County Health Plan Access 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:
What is the overall <u>deductible</u> ?	<b>\$250</b> person/ <b>\$500</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> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. Well-child care, <u>preventive care</u> , physician maternity care, <u>in-network</u> prosthetic limbs, independent lab and office services for mental health/ substance abuse and services subject to <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.
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> ?	<b>\$750</b> person/ <b>\$1,250</b> 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> ?	<u>Premiums</u> , <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 <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.
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 <u>copay</u> per date of service	Not covered	Primary Care Practitioners (PCP) are defined as General and Family Practice, Internal Medicine, OB/GYN, Pediatricians, Nurse Practitioners and PAs. For this <u>plan</u> you must designate a personal doctor from the above <u>provider</u> types. \$20 <u>copay</u> per date of service applies to Doctor on Demand contracted telehealth services. X-rays, labs and in- <u>network</u> office surgeries waive office <u>copay</u> and apply <u>deductible</u> and 10% <u>coinsurance</u> . 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.
	<u>Specialist</u> visit	\$20 <u>copay</u> per date of service	Not covered	Applies to Non-PCP <u>providers</u> . X-rays, labs and in- <u>network</u> office surgeries waive office <u>copay</u> and apply <u>deductible</u> and 10% <u>coinsurance</u> .
	<u>Preventive care/screening/immunization</u>	\$20 <u>copay</u> per date of service	Not covered	One preventive exam, one gynecological exam with Pap smear and one mammogram per calendar year. Well-child care is covered to age 7. \$20 <u>copay</u> for <u>preventive services</u> applies once annually to any <u>provider</u> . <u>Preventive care copay</u> aggregates with in- <u>network</u> office visit <u>copayment</u> and only one <u>copay</u> will apply per date of service.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	Independent labs: 0% <u>coinsurance</u> Facility: 10% <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. Waive cost-share on in- <u>network</u> independent lab services for mental health/substance abuse.
	Imaging (CT/PET scans, MRIs)	10% <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.

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 at <a href="http://www.wellmark.com/prescriptions">www.wellmark.com/prescriptions</a>.</p>	Tier 1	Greater of \$6 <u>copay</u> or 20% <u>coinsurance</u> per prescription	Greater of \$6 <u>copay</u> or 20% <u>coinsurance</u> per prescription	<p>Drugs listed on Wellmark's Blue Value Plus Drug List are covered. Drugs not on this Drug List are not covered. For out-of-network prescription drugs, you may be balance billed.</p> <p>1 <u>copay</u> or <u>coinsurance</u> for 30-day supply.</p> <p>3 <u>copays</u> or <u>coinsurance</u> for 90-day supply (Maintenance).</p> <p>Out-of-network Specialty benefits are not covered after first script fill.</p> <p>10% <u>coinsurance</u> for oral Chemotherapy drugs.</p> <p>Fluoride scripts are covered.</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 <u>plan</u>.</p>
	Tier 2	Greater of \$25 <u>copay</u> or 20% <u>coinsurance</u> per prescription	Greater of \$25 <u>copay</u> or 20% <u>coinsurance</u> per prescription	
	Tier 3	Greater of \$50 <u>copay</u> or 20% <u>coinsurance</u> per prescription	Greater of \$50 <u>copay</u> or 20% <u>coinsurance</u> per prescription	
	Specialty drugs	Same as cost-share above depending on drug category.	Same as cost-share above depending on drug category.	
<p><b>If you have outpatient surgery</b></p>	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	Not covered	-----None-----
	Physician/surgeon fees	10% <u>coinsurance</u>	Not covered	-----None-----
<p><b>If you need immediate medical attention</b></p>	<u>Emergency room care</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	For <u>emergency medical conditions</u> treated out-of-network, you may be balance billed.
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	-----None-----
	<u>Urgent care</u>	\$20 <u>copay</u> per date of service	Not covered	-----None-----
<p><b>If you have a hospital stay</b></p>	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	Not covered	-----None-----
	Physician/surgeon fees	10% <u>coinsurance</u>	Not covered	-----None-----
<p><b>If you need mental health, behavioral health, or substance abuse services</b></p>	Outpatient services	Office: No charge Facility: 10% <u>coinsurance</u>	Not covered	-----None-----
	Inpatient services	10% <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.

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 are pregnant	Office visits	No charge	Not covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). For any in-network 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	10% <u>coinsurance</u>	Not covered	-----None-----
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	Not covered	-----None-----
	<u>Rehabilitation services</u>	Office: \$20 <u>copay</u> per date of service Facility: 10% <u>coinsurance</u>	Not covered	In-network physical therapy waives office <u>copay</u> and applies <u>deductible</u> and 10% <u>coinsurance</u> .
	<u>Habilitation services</u>	Office: \$20 <u>copay</u> per date of service Facility: 10% <u>coinsurance</u>	Not covered	In-network physical therapy waives office <u>copay</u> and applies <u>deductible</u> and 10% <u>coinsurance</u> .
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	Not covered	-----None-----
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	Not covered	-----None-----
	<u>Hospice services</u>	10% <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.

**Excluded Services & Other Covered Services:**

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"><li>• Acupuncture</li><li>• Cosmetic surgery</li><li>• Custodial care - in home or facility</li><li>• Dental care - Adult</li><li>• Dental check-up</li><li>• Extended home skilled nursing</li><li>• Eye exam</li></ul>	<ul style="list-style-type: none"><li>• Glasses</li><li>• Hearing aids</li><li>• Long-term care</li><li>• Non-emergency care when traveling outside the U.S.</li><li>• Routine eye care - Adult</li><li>• Routine foot care</li></ul>	<ul style="list-style-type: none"><li>• Some pharmacy drugs are not covered</li><li>• Weight loss programs</li></ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none"><li>• Applied Behavior Analysis therapy-covered subject to state mandate through age 18 subject to annual limits</li><li>• Bariatric surgery</li><li>• Chiropractic care</li><li>• Infertility treatment (excludes some services)</li></ul>	<ul style="list-style-type: none"><li>• Private-duty nursing - short term intermittent home skilled nursing</li></ul>	

**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](http://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. \_\_\_\_\_

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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 plan's overall deductible \$250
- PCP copayment \$20
- Hospital(facility) coinsurance 10%
- 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>\$12,800</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$500
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$710</b>

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

- The plan's overall deductible \$250
- Specialist copayment \$20
- Hospital(facility) coinsurance 10%
- Other coinsurance 10%

**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>\$7,400</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$200
<b>The total Joe would pay is</b>	<b>\$950</b>

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

- The plan's overall deductible \$250
- Specialist copayment \$20
- Hospital(facility) coinsurance 10%
- Other coinsurance 10%

**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>\$1,900</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$450</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.

