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 1-800-643-9724. 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 1-800-643-9724 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>UIHC Providers: $0 person/$0 family. Person</td>
<td>See the Common Medical Events chart below for your costs for services this plan covers. 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>
</tr>
<tr>
<td><strong>Are there services covered before you meet your deductible?</strong></td>
<td>Deductibles do not apply.</td>
<td>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>
</tr>
<tr>
<td><strong>Are there other deductibles for specific services?</strong></td>
<td>No. There are no other deductibles.</td>
<td>You don't have to meet deductibles for specific services.</td>
</tr>
<tr>
<td><strong>What is the out-of-pocket limit for this plan?</strong></td>
<td>UIHC Providers: $1,000 person/$1,700 family. Drug Card: $1,000 person/$1,700 family. 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>
</tr>
<tr>
<td><strong>What is not included in the out-of-pocket limit?</strong></td>
<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>
</tr>
<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 1-800-643-9724 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>
All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay UIHC Providers (You will pay the least)</th>
<th>What You Will Pay Wellmark Health Plan of Iowa (IN) Providers (You will pay more)</th>
<th>What You Will Pay Out-of-Network (OON) Providers (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
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<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>Exam: $10 copay per provider per date of service &lt;br&gt;Other services: 10% coinsurance</td>
<td>Not covered &lt;br&gt;Not covered</td>
<td>Level 1: UIHC providers; Level 2: All other Wellmark Health Plan of Iowa and Allied providers. Members can see any UIHC provider and are not required to select a PCP.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>Exam: $10 copay &lt;br&gt;Other services: 10% coinsurance</td>
<td>Not covered &lt;br&gt;Not covered</td>
<td>Copay is per provider per date of service.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preventive care/ screening/ immunization</td>
<td>No charge</td>
<td>Not covered &lt;br&gt;Not covered</td>
<td>Unlimited preventive, gynecological exams and mammograms. Preventive medical examinations performed for administrative purposes are covered in addition to a preventive exam. 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.</td>
<td></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>Not covered &lt;br&gt;Not covered</td>
<td>UIHC independent labs for mental health/substance abuse services are not subject to coinsurance.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>10% coinsurance</td>
<td>Not covered &lt;br&gt;Not covered</td>
<td>------None------</td>
<td></td>
</tr>
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For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-643-9724.
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<td>If you need drugs to treat your illness or condition</td>
<td>Tier 1</td>
<td>Greater of $7 copay or 25% coinsurance per prescription</td>
<td>Greater of $7 copay or 25% coinsurance per prescription</td>
<td>Greater of $7 copay or 25% coinsurance 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 OON prescription drugs, you may be balance billed. 34-day supply for prescription drugs. 100-day supply prescription maximum (Maintenance). Injectable specialty drugs are covered under health and oral specialty drugs are covered under the drug card plan and your cost-share is determined by their placement on Wellmark’s Drug List. See wellmark.com/prescriptions for information about drugs and drug quantities that require prior authorization by Wellmark to be covered by your plan.</td>
</tr>
<tr>
<td></td>
<td>Tier 2</td>
<td>Greater of $7 copay or 25% coinsurance per prescription</td>
<td>Greater of $7 copay or 25% coinsurance per prescription</td>
<td>Greater of $7 copay or 25% coinsurance per prescription</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 3</td>
<td>Greater of $7 copay or 25% coinsurance per prescription</td>
<td>Greater of $7 copay or 25% coinsurance per prescription</td>
<td>Greater of $7 copay or 25% coinsurance per prescription</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 4</td>
<td>Greater of $7 copay or 25% coinsurance per prescription</td>
<td>Greater of $7 copay or 25% coinsurance per prescription</td>
<td>Greater of $7 copay or 25% coinsurance per prescription</td>
<td></td>
</tr>
<tr>
<td>Specialty drugs</td>
<td></td>
<td>Same as cost-share above depending on drug category.</td>
<td>Same as cost-share above depending on drug category.</td>
<td>Same as cost-share above depending on drug category.</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>Not covered</td>
<td>Not covered</td>
<td>------None------</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% coinsurance</td>
<td>Not covered</td>
<td>Not covered</td>
<td>------None------</td>
</tr>
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<td>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td>No charge</td>
<td>$10 copay per provider per date of service</td>
<td>Not covered</td>
<td>Must be performed by an in-network provider.</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
<td>-----None------</td>
</tr>
<tr>
<td></td>
<td>Children's dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
<td>-----None------</td>
</tr>
</tbody>
</table>

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-643-9724.
### 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
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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
- Private-duty nursing - short term intermittent home skilled nursing
- Routine eye care - Adult (unlimited routine exams by UIHC provider)

### 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 1-800-643-9724.

### Does this plan provide Minimum Essential Coverage?

Yes

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

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.

---

<table>
<thead>
<tr>
<th>Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)</th>
<th>Managing Joe's type 2 Diabetes (a years of routine in-network care of a well-controlled condition)</th>
<th>Mia's Simple Fracture (in-network emergency room visit and follow up care)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The plan's overall deductible $0</td>
<td>The plan's overall deductible $0</td>
<td>The plan's overall deductible $0</td>
</tr>
<tr>
<td>PCP exam copay services coinsurance $10 and 10%</td>
<td>Specialist exam copay services coinsurance $10 and 10%</td>
<td>Specialist exam copay services coinsurance $10 and 10%</td>
</tr>
<tr>
<td>Hospital(facility) copayment $125</td>
<td>Hospital(facility) coinsurance 10%</td>
<td>Hospital(facility) copay and coinsurance $50 and 10%</td>
</tr>
<tr>
<td>Other exam copay services coinsurance $10 and 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
- Primary care physician office visits (including disease education)
- Diagnostic tests (blood work)
- Prescription drugs
- Emergency room care (including medical supplies)
- Diagnostic test (x-ray)

| Total Example Cost | $12,700 | $5,600 | $2,800 |
| Cost Sharing | Deductibles | $0 | $0 | $0 |
| | Copayments | $300 | $300 | $70 |
| | Coinsurance | $800 | $800 | $300 |

In this example, Peg would pay:
- Deductibles $0
- Copayments $300
- Coinsurance $800
- Limits or exclusions $60
- The total Peg would pay is $1,160

In this example, Joe would pay:
- Deductibles $0
- Copayments $300
- Coinsurance $800
- Limits or exclusions $20
- The total Joe would pay is $1,120

In this example, Mia would pay:
- Deductibles $0
- Copayments $70
- Coinsurance $300
- Limits or exclusions $0
- The total Mia would pay is $370

Claim examples calculate benefits based on services provided by domestic providers.

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.
Discrimination is against the law

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


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AHORA RÁPIDO: Alarmas para personas con discapacidades no son válidas en inglés, tampoco las que se ofrecen en español o en otro idioma. Por favor llame al 800-524-9242 para comunicarnos (TTY: 888-781-4262).

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.


警告：如果您会说普通话，我们可以为您提供语言帮助服务。请拨打 800-524-9242 或 (听障专线: 888-781-4262)。

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