### The University of Iowa UIGradCare Advantage 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 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</td>
<td>See the Common Medical Events chart below for your costs for services this plan</td>
</tr>
<tr>
<td></td>
<td></td>
<td>covers. If you have other family members on the plan, each family member must</td>
</tr>
<tr>
<td></td>
<td></td>
<td>meet their own individual deductible until the total amount of deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>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</td>
</tr>
<tr>
<td></td>
<td></td>
<td>and before you meet your deductible. See a list of covered preventive services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>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</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></td>
<td>Drug Card: $1,000 person/$1,700 family</td>
<td>The in-Network health and drug card out-of-pocket maximum amounts accumulate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>separately.</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>
</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>Exam: $10 <strong>copay</strong> per provider per date of service&lt;br&gt;Other services: 10% <strong>coinsurance</strong></td>
<td>Not covered</td>
<td>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>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>Exam: $10 <strong>copay</strong>&lt;br&gt;Other services: 10% <strong>coinsurance</strong></td>
<td>Not covered</td>
<td>Not covered</td>
<td><strong>Copay is per provider per date of service.</strong></td>
</tr>
<tr>
<td></td>
<td>Preventive care/ screening/ immunization</td>
<td>No charge</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Unlimited preventive, gynecological exams and mammograms. One routine hearing exam per calendar year. 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>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>10% <strong>coinsurance</strong></td>
<td>Not covered</td>
<td>Not covered</td>
<td>UIHC independent labs for mental health/substance abuse services are not subject to <strong>coinsurance.</strong></td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>10% <strong>coinsurance</strong></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.
### Common Medical Event Services You May Need

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<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<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></td>
<td>Specialty drugs</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>
</tbody>
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<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$50 copay and 10% coinsurance per visit for facility and physician(s) combined</td>
<td>$50 copay and 10% coinsurance per visit for facility and physician(s) combined</td>
<td>$50 copay and 10% coinsurance per visit for facility and physician(s) combined</td>
<td>For emergency medical conditions treated out-of-network, it is likely you may not be balance billed pursuant to the federal rules developed for implementation of the No Surprises Act.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
<td>For covered non-emergent situations, OON ambulance services are NOT reimbursed at the in-network level. The member may be balance billed for any out-of-network service as established under the rules developed for implementation of the No Surprises Act.</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$10 copay for exam Other services: 10% coinsurance</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Copay is applied per provider per date of service.</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>$125 per day copay and 10% coinsurance</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Transplants must be done at UIHC or Blue Distinction Centers for Transplant.</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>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Office: 0% coinsurance Facility: 10% coinsurance</td>
<td>Office: 0% coinsurance Facility: 10% coinsurance</td>
<td>50% coinsurance</td>
<td>OON mental health and substance abuse limited to 50 visits per calendar year.</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>Facility: $125 per day copay and 10% coinsurance Practitioner: 10% coinsurance</td>
<td>Facility: $125 per day copay and 10% coinsurance Practitioner: 10% coinsurance</td>
<td>Facility: $125 per day copay and 50% coinsurance Practitioner: 50% coinsurance</td>
<td>Residential treatment is covered with no 24 hour nursing supervision requirement. The member may be balance billed for any out-of-network service.</td>
</tr>
</tbody>
</table>

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-643-9724.
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</tr>
</thead>
<tbody>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>Exam: $10 copay per provider per date of service Other services: 10% coinsurance</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Cost sharing does not apply for preventive services.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>Exam: $10 copay per provider per date of service Other services: 10% coinsurance</td>
<td>Not covered</td>
<td>Not covered</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>Facility: $125 per day copay and 10% coinsurance</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Copay is waived for newborn's initial hospitalization.</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
<td>Not covered</td>
<td>-----None-----</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
<td>Not covered</td>
<td>-----None-----</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
<td>Not covered</td>
<td>-----None-----</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>$125 per day copay and 10% coinsurance</td>
<td>Not covered</td>
<td>Not covered</td>
<td>-----None-----</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
<td>Not covered</td>
<td>Manual and electric breast pumps covered no charge. Orthotics, including shoes, are covered. Hospital grade breast pumps subject to coinsurance.</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>10% coinsurance</td>
<td>10% coinsurance</td>
<td>Not covered</td>
<td>Hospice respite care is limited to 15 inpatient and 15 outpatient days per lifetime.</td>
</tr>
</tbody>
</table>

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-643-9724.
For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-643-9724.
### Excluded Services & Other Covered Services:

<table>
<thead>
<tr>
<th>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</th>
</tr>
</thead>
</table>
| • 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 |

<table>
<thead>
<tr>
<th>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)</th>
</tr>
</thead>
</table>
| • Applied Behavior Analysis therapy  
• Bariatric surgery  
• Chiropractic care  
• Private-duty nursing - short term intermittent home skilled nursing  
• Routine eye care - Adult (one vision exam per calendar year) |

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**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. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

**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.

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**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.

Wellmark Health Plan of Iowa, Inc. 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.

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible: $0
- PCP exam copay services coinsurance: $10 and 10%
- Hospital(facility) copayment: $125
- Other exam copay services coinsurance: $10 and 10%

**This EXAMPLE event includes services like:**
- Specialist office visits (prenatal care)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services

**Total Example Cost:** $12,700

**In this example, Peg would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$250</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$750</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions: $60

**The total Peg would pay is:** $1,060

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

- The plan's overall deductible: $0
- Specialist exam copay services coinsurance: $10 and 10%
- 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

**Total Example Cost:** $5,600

**In this example, Joe would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$300</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$800</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions: $20

**The total Joe would pay is:** $1,120

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

- The plan's overall deductible: $0
- Specialist exam copay services coinsurance: $10 and 10%
- Hospital(facility) copay and coinsurance: $50 and 10%
- Other coinsurance: 10%

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

**Total Example Cost:** $2,800

**In this example, Mia would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$80</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$300</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions: $0

**The total Mia would pay is:** $380

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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.
Wellmark Language Assistance

Discrimination is against the law
Wellmark Blue Cross and Blue Shield complies with applicable state and federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

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

You have the right to get this information and help in your language for free. If you need these services, call 800-524-9242.