

## IAED 750 POS



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 1-866-807-9430. 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 1-866-807-9430 to request a copy.

| Important Questions                                                       | Answers                                                                                                                                                                                                                                                                                                  | Why this Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|---------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>What is the overall <u>deductible</u>?</b>                             | <b>\$750</b> person/ <b>\$1,500</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> .                                                                                                                                                                    |
| <b>Are there services covered before you meet your <u>deductible</u>?</b> | Yes. Well-child care, <u>preventive care</u> from in- <u>network</u> <u>providers</u> , in- <u>network</u> physician maternity care, in- <u>network</u> prosthetic limbs, mammograms and services subject to health and drug card <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. 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 <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                                       |
| <b>Are there other <u>deductibles</u> for specific services?</b>          | No. There are no other <u>deductibles</u> .                                                                                                                                                                                                                                                              | You don't have to meet <u>deductibles</u> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>       | Health: <b>\$1,500</b> person/ <b>\$3,000</b> family per calendar year. Drug Card: <b>\$1,500</b> person/ <b>\$3,000</b> family per calendar year. The In- <u>Network</u> health and drug card <u>out-of-pocket</u> maximum amounts accumulate separately.                                               | 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.                                                                                                                                                                                                                                                                                       |
| <b>What is not included in the <u>out-of-pocket limit</u>?</b>            | 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> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Will you pay less if you use a <u>network provider</u>?</b>            | Yes. See <a href="http://www.wellmark.com">www.wellmark.com</a> or call 1-866-807-9430 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. |

| Important Questions                                        | Answers | Why this Matters:                                                        |
|------------------------------------------------------------|---------|--------------------------------------------------------------------------|
| 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 <u>provider's</u> office or clinic | Primary care visit to treat an injury or illness | \$10 designated PCP <u>copay</u> per <u>provider</u> per date of service<br>\$15 <u>copay</u> per <u>provider</u> per date of service | 20% <u>coinsurance</u>                                                  | For this <u>plan</u> you must select a designated <u>Primary Care Provider</u> . PCP <u>provider</u> types can be found in the What You Pay section of your <u>plan</u> document.                                                                                                                                              |
|                                                               | <u>Specialist</u> visit                          | \$30 <u>copay</u> per <u>provider</u> per date of service                                                                             | 20% <u>coinsurance</u>                                                  | Applies to Non-PCP <u>providers</u> . \$15 <u>copay</u> per <u>provider</u> per date of service for in-network chiropractic services. Hearing exams are covered according to ACA guidelines.                                                                                                                                   |
|                                                               | <u>Preventive care/screening/immunization</u>    | No charge                                                                                                                             | Not covered                                                             | One preventive exam and one gynecological exam with Pap smear 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 <u>provider</u> if the services needed 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)       | Indep Labs: \$30 <u>copay</u> per <u>provider</u> per date of service<br>Facility: 10% coins                                          | 20% <u>coinsurance</u>                                                  | 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-network independent lab services for mental health/substance abuse.                                                                                                                           |
|                                                               | Imaging (CT/PET scans, MRIs)                     | 10% <u>coinsurance</u>                                                                                                                | 20% <u>coinsurance</u>                                                  | 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 1-866-807-9430. You can find your Coverage Manual at [sbccmfinder.wellmark.com](http://sbccmfinder.wellmark.com).

| 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 need drugs to treat your illness or condition</b><br><br>More information about <b>prescription drug coverage</b> is at <a href="http://www.wellmark.com/prescriptions">www.wellmark.com/prescriptions</a> . | Tier 1                                         | \$8 <u>copay</u> per prescription                                                                                                                  | \$8 <u>copay</u> per prescription                                       | Drugs listed on Wellmark's Blue Rx Value Plus Drug List are covered. Drugs not on this Drug List are not covered. For out-of- <u>network</u> <u>prescription drugs</u> , you may be balance billed.<br>1 <u>copay</u> for 30-day supply.<br>3 <u>copays</u> for 90-day supply (Retail maintenance).<br>2 <u>copays</u> for 90-day supply (Mail order maintenance).<br><u>Specialty drugs</u> are covered only when obtained through the CVS Specialty Pharmacy Program.<br>Your <u>plan</u> includes coverage for certain <u>specialty drugs</u> through PrudentRx. If you choose to opt into the PrudentRx program, your <u>deductible</u> and <u>coinsurance</u> will be waived for drugs listed on the PrudentRx drug list. Information about the PrudentRx program can be found in your <u>plan</u> document in these sections: What You Pay, Details-Covered and Not Covered, Choosing a <u>Provider</u> , Factors Affecting What You Pay, and the Glossary. 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 plan. |
|                                                                                                                                                                                                                        | Tier 2                                         | \$35 <u>copay</u> per prescription                                                                                                                 | \$35 <u>copay</u> per prescription                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|                                                                                                                                                                                                                        | Tier 3                                         | \$50 <u>copay</u> per prescription                                                                                                                 | \$50 <u>copay</u> per prescription                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|                                                                                                                                                                                                                        | Specialty drugs                                | Generic: \$50 <u>copay</u> per prescription<br>Preferred: \$85 <u>copay</u> per prescription<br>Non-preferred: \$100 <u>copay</u> per prescription | Not covered                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>If you have outpatient surgery</b>                                                                                                                                                                                  | Facility fee (e.g., ambulatory surgery center) | 10% <u>coinsurance</u>                                                                                                                             | 20% <u>coinsurance</u>                                                  | -----None-----                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|                                                                                                                                                                                                                        | Physician/surgeon fees                         | 10% <u>coinsurance</u>                                                                                                                             | 20% <u>coinsurance</u>                                                  | -----None-----                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-866-807-9430. You can find your Coverage Manual at [sbccmfinder.wellmark.com](http://sbccmfinder.wellmark.com).

| 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>              | 10% <u>coinsurance</u>                                                                         | 10% <u>coinsurance</u>                                                  | For <u>emergency medical conditions</u> treated OON, it is likely you may not be balance billed pursuant to the federal rules developed for implementation of the No Surprises Act.                                                              |
|                                                                           | <u>Emergency medical transportation</u> | 10% <u>coinsurance</u>                                                                         | 10% <u>coinsurance</u>                                                  | For covered non-emergent situations, OON ground ambulance services are NOT reimbursed at the IN level. The member may be balance billed for any OON service as established under the rules developed for implementation of the No Surprises Act. |
|                                                                           | <u>Urgent care</u>                      | \$30 copay per provider per date of service for facility and physician(s) combined             | 20% <u>coinsurance</u>                                                  | \$15 copay per provider per date of service applies to services for mental health/substance abuse.                                                                                                                                               |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)      | 10% <u>coinsurance</u>                                                                         | 20% <u>coinsurance</u>                                                  | -----None-----                                                                                                                                                                                                                                   |
|                                                                           | <u>Physician/surgeon fees</u>           | 10% <u>coinsurance</u>                                                                         | 20% <u>coinsurance</u>                                                  | -----None-----                                                                                                                                                                                                                                   |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                     | Office: \$15 <u>copay</u> per provider per date of service<br>Facility: 10% <u>coinsurance</u> | 20% <u>coinsurance</u>                                                  | -----None-----                                                                                                                                                                                                                                   |
|                                                                           | Inpatient services                      | 10% <u>coinsurance</u>                                                                         | 20% <u>coinsurance</u>                                                  | -----None-----                                                                                                                                                                                                                                   |

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-866-807-9430. You can find your Coverage Manual at [sbccmfinder.wellmark.com](https://sbccmfinder.wellmark.com).

| 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                                                                                      | 20% <u>coinsurance</u>                                                  | Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Cost sharing does not apply for <u>preventive services</u> . 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                                                                                      | 20% <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     | 10% <u>coinsurance</u>                                                                         | 20% <u>coinsurance</u>                                                  | -----None-----                                                                                                                                                                                                                                                                         |
| If you need help recovering or have other special health needs | <u>Home health care</u>                   | 10% <u>coinsurance</u>                                                                         | 20% <u>coinsurance</u>                                                  | -----None-----                                                                                                                                                                                                                                                                         |
|                                                                | <u>Rehabilitation services</u>            | Office: \$15 <u>copay</u> per provider per date of service<br>Facility: 10% <u>coinsurance</u> | 20% <u>coinsurance</u>                                                  | -----None-----                                                                                                                                                                                                                                                                         |
|                                                                | <u>Habilitation services</u>              | Office: \$15 <u>copay</u> per provider per date of service<br>Facility: 10% <u>coinsurance</u> | 20% <u>coinsurance</u>                                                  | -----None-----                                                                                                                                                                                                                                                                         |
|                                                                | <u>Skilled nursing care</u>               | 10% <u>coinsurance</u>                                                                         | 20% <u>coinsurance</u>                                                  | -----None-----                                                                                                                                                                                                                                                                         |
|                                                                | <u>Durable medical equipment</u>          | 10% <u>coinsurance</u>                                                                         | 20% <u>coinsurance</u>                                                  | Orthopedic shoes, shoe inserts and accessories are covered. Trusses for back or hernia support are covered.                                                                                                                                                                            |
|                                                                | <u>Hospice services</u>                   | 10% <u>coinsurance</u>                                                                         | 20% <u>coinsurance</u>                                                  | 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                                                                                      | 20% <u>coinsurance</u>                                                  | One routine vision exam per calendar year. Must be performed by an in-network provider.                                                                                                                                                                                                |
|                                                                | 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 1-866-807-9430. You can find your Coverage Manual at [sbccmfinder.wellmark.com](http://sbccmfinder.wellmark.com).

## 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
- Some pharmacy drugs are not covered
- 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
- Infertility treatment (\$15,000 LTM)
- 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 Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). 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](http://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 1-866-807-9430, Iowa Insurance Division at 515-654-6600, or Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

### 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 <u>deductible</u>  | \$750     |
| ■ PCP <u>copayment</u>                  | \$15      |
| ■ Hospital(facility) <u>coinsurance</u> | 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>\$12,700</b> |
|---------------------------|-----------------|

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

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$750          |
| <u>Copayments</u>                 | \$10           |
| <u>Coinsurance</u>                | \$740          |
| What isn't covered                |                |
| <b>Limits or exclusions</b>       | <b>\$60</b>    |
| <b>The total Peg would pay is</b> | <b>\$1,560</b> |

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

|                                         |       |
|-----------------------------------------|-------|
| ■ The plan's overall <u>deductible</u>  | \$750 |
| ■ <u>Specialist</u> <u>copayment</u>    | \$30  |
| ■ Hospital(facility) <u>coinsurance</u> | 10%   |
| ■ Other <u>coinsurance</u>              | 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>\$5,600</b> |
|---------------------------|----------------|

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

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$50           |
| <u>Copayments</u>                 | \$1,200        |
| <u>Coinsurance</u>                | \$0            |
| What isn't covered                |                |
| <b>Limits or exclusions</b>       | <b>\$20</b>    |
| <b>The total Joe would pay is</b> | <b>\$1,270</b> |

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

|                                         |       |
|-----------------------------------------|-------|
| ■ The plan's overall <u>deductible</u>  | \$750 |
| ■ <u>Specialist</u> <u>copayment</u>    | \$30  |
| ■ Hospital(facility) <u>coinsurance</u> | 10%   |
| ■ Other <u>coinsurance</u>              | 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>\$2,800</b> |
|---------------------------|----------------|

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

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$750          |
| <u>Copayments</u>                 | \$200          |
| <u>Coinsurance</u>                | \$100          |
| What isn't covered                |                |
| <b>Limits or exclusions</b>       | <b>\$0</b>     |
| <b>The total Mia would pay is</b> | <b>\$1,050</b> |

Claim examples calculate benefits based on Level 1 services provided by your designated primary care provider.

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.**

ATENCIÓN: Si habla español, los servicios de asistencia de idiomas se encuentran disponibles gratuitamente para usted. Comuníquese al 800-524-9242 o al (TTY: 888-781-4262).

注意：如果您说普通话，我们可免费为您提供语言协助服务。请拨打 800-524-9242 或（听障专线：888-781-4262）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho quý vị. Xin hãy liên hệ 800-524-9242 hoặc (TTY: 888-781-4262).

NAPOMENA: Ako govorite hrvatski, dostupna Vam je besplatna podrška na Vašem jeziku. Kontaktirajte 800-524-9242 ili (tekstualni telefon za osobe oštećena sluha: 888-781-4262).

ACHTUNG: Wenn Sie deutsch sprechen, stehen Ihnen kostenlose sprachliche Assistenzdienste zur Verfügung. Rufnummer: 800-524-9242 oder (TTY: 888-781-4262).

تنبيه: إذا كنت تتحدث اللغة العربية، فإننا نوفر لك خدمات المساعدة اللغوية، المجانية. اتصل بالرقم 800-524-9242 أو (خدمة الهاتف النصي: 888-781-4262).

ສິ່ງຄວນເອົາໃຈໃສ່, ພາສາລາວ ຖ້າທ່ານເວົ້າ: ພວກເຮົາມີບໍລິການຄວາມຊ່ວຍເຫຼືອດ້ານພາສາ ໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ ຫຼື 800-524-9242 ຕິດຕໍ່ກັບ. (TTY: 888-781-4262.)

주의: 한국어 를 사용하시는 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 800-524-9242번 또는 (TTY: 888-781-4262)번으로 연락해 주십시오.

ध्यान रखें : अगर आपकी भाषा हिन्दी है, तो आपके लिए भाषा सहायता सेवाएँ, निःशुल्क उपलब्ध हैं। 800-524-9242 पर संपर्क करें या (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).

Geb Acht: Wann du Deutsch schwetze duscht, kannscht du Hilf in dei eegni Schprooch koschdefrei griege. Ruf 800-524-9242 odder (TTY: 888-781-4262) uff.

โปรดทราบ: หากคุณพูด ไทย เรามีบริการช่วยเหลือด้านภาษาสำหรับคุณโดยไม่คิดค่าใช้จ่าย ติดต่อ 800-524-9242 หรือ (TTY: 888-781-4262)

PAG-UKULAN NG PANSIN: Kung Tagalog ang wikang ginagamit mo, may makukuha kang mga serbisyong tulong sa wika na walang bayad. Makipag-ugnayan sa 800-524-9242 o (TTY: 888-781-4262).

တၢ်ဒုးသုၣ်ညါ-နမ့ၢ်ကတိၢ်ကေညါကျိၣ်, ကျိၣ်တၢ်မၤစၢၤတၢ်ဖဲတၢ်မၤတဖၣ်, လၢတဘျီလၢတဘျီလၢ, ဆိၣ်လၢနီၣ်လီၤဆဲးကျိၣ်ဆူ ၈၀၀-၅၂၄-၉၂၄ နမ့ၢ် (TTY: ၈၈၈-၇၈၁-၄၂၆၂) တက့ၢ်.

ВНИМАНИЕ! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. Обращайтесь 800-524-9242 (телетайп: 888-781-4262).

सावधान: यदि तपाईं नेपाली बोल्नुहुन्छ भने, तपाईंका लागि निःशुल्क रूपमा भाषा सहायता सेवाहरू उपलब्ध गराइन्छ। 800-524-9242 वा (TTY: 888-781-4262) मा सम्पर्क गर्नुहोस्।

ማሳሰቢያ: ከግርግር ሃሚናገሩ ከሆነ፣ የቋንቋ አገዛ አገልግሎቶች ከክፍያ ነፃ፣ ያገኛሉ። በ 800-524-9242 ወይም (በTTY: 888-781-4262) ደውሎ ያነጋግሩ።

HEETINA To a wolwa Fulfulde laabi walliinde dow wolde, naa e njobdi, ene ngoodi ngam maada. Hebir 800-524-9242 malla (TTY: 888-781-4262).

FUULEFFANNAA: Yo isin Oromiffaa, kan dubbattan taatan, tajaajiloonni gargaarsa afaanii, kaffaltii malee, isiniif ni jiru. 800-524-9242 yookin (TTY: 888-781-4262) quunnamaa.

УВАГА! Якщо ви розмовляєте українською мовою, для вас доступні безкоштовні послуги мовної підтримки. Зателефонуйте за номером 800-524-9242 або (телетайп: 888-781-4262).

Ge': Diné k'ehjí yánílti'go níká bizaad bee áká' adoowoł, t'áá jiik'é, náhóíł. Kojí' hólne' 800-524-9242 doodaii' (TTY: 888-781-4262)