The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.wellmark.com or call 1-800-524-9242. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-800-524-9242 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why this Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$0 person per calendar year.</td>
<td>Generally, you must pay all the costs from providers up to the deductible amount before this plan begins to pay. 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>Are there services covered before you meet your deductible?</td>
<td>No. This plan has no deductibles.</td>
<td>This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No. There are no other deductibles.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>$500 person/$1,000 family per calendar year.</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>What is not included in the out-of-pocket limit?</td>
<td>Premiums, urgent care copayments, your drug card costs, 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>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="http://www.wellmark.com">www.wellmark.com</a> or call 1-800-524-9242 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>Do you need a referral to see a specialist?</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 In-Network (IN) Provider (You will pay the least)</th>
<th>What You Will Pay Out-of-Network (OON) Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$5 copay per provider per date of service</td>
<td>Not covered</td>
<td>Primary Care Practitioners (PCP) are defined as General and Family Practice, Internal Medicine, OB/GYN, Pediatricians, Nurse Practitioners and PAs. Nutritional counseling is covered limited to three visits per calendar year. Copay does not continue after the out-of-pocket maximum is met. $5 copay per provider per date of service applies to telehealth services delivered by in-network primary care providers and providers contracting through Doctor on Demand.</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$5 copay per provider per date of service</td>
<td>Not covered</td>
<td>Applies to Non-PCP providers. One routine hearing exam per calendar year. Copay does not continue after the out-of-pocket maximum is met.</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>$5 copay per provider per date of service</td>
<td>Not covered</td>
<td>Preventive care must be provided by a PCP provider. 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. Copay does not continue after the out-of-pocket maximum is met.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>0% coinsurance</td>
<td>Not covered</td>
<td>For a test in a provider's office or clinic, your cost is included in the cost-share listed above.</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>0% coinsurance</td>
<td>Not covered</td>
<td>For a test in a provider's office or clinic, your cost is included in the cost-share listed above.</td>
</tr>
</tbody>
</table>

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-524-9242.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay In-Network (IN) Provider (You will pay the least)</th>
<th>What You Will Pay Out-of-Network (OON) Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Tier 1</td>
<td>Greater of $5 copay per prescription or 25% coinsurance</td>
<td>Greater of $5 copay per prescription or 25% coinsurance</td>
<td>Drugs listed on Wellmark’s Blue Rx Complete Drug List are covered. Drugs not on this Drug List are not covered. For out-of-network prescription drugs, you may be balance billed. 1 copay or coinsurance for 30-day supply (Specialty). 1 copay or coinsurance for 31-day supply. 3 copays or coinsurance for 93-day supply (Mail order maintenance). 1 copay for insulin and diabetic supplies up to a 93-day supply. Specialty drugs are covered only when obtained through the Specialty Pharmacy Program. 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 $5 copay per prescription or 25% coinsurance</td>
<td>Greater of $5 copay per prescription or 25% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 3</td>
<td>Greater of $5 copay per prescription or 25% coinsurance</td>
<td>Greater of $5 copay per prescription or 25% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 4</td>
<td>Greater of $5 copay per prescription or 25% coinsurance</td>
<td>Greater of $5 copay per prescription or 25% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>$0 copay per prescription</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>0% coinsurance</td>
<td>Not covered</td>
<td>-----None------</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>0% coinsurance</td>
<td>Not covered</td>
<td>-----None------</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$25 copay per facility per date of service for facility and physician(s) combined</td>
<td>$25 copay per facility per date of service for facility and physician(s) combined</td>
<td>For emergency medical conditions treated out-of-network, you may be balance billed. Copay does not continue after the out-of-pocket maximum is met.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>0% coinsurance</td>
<td>0% coinsurance</td>
<td>-----None------</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$5 copay per provider per date of service</td>
<td>Not covered</td>
<td>Copay does not continue after the out-of-pocket maximum is met.</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>0% coinsurance</td>
<td>Not covered</td>
<td>Reduction for failure to precertify out-of-network services is 50%.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>0% coinsurance</td>
<td>Not covered</td>
<td>-----None------</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>In-Network (IN)</td>
<td>Out-of-Network (OON)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Provider (You will pay the least)</td>
<td>Provider (You will pay the most)</td>
<td></td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Office: $5 copay per provider per date of service</td>
<td>Not covered</td>
<td>Copay does not continue after the out-of-pocket maximum is met.</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>0% coinsurance</td>
<td>Not covered</td>
<td>Reduction for failure to precertify out-of-network services is 50%.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge</td>
<td>Not covered</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>No charge</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>0% coinsurance</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 1-800-524-9242.
### Common Medical Event

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>What You Will Pay In-Network (IN) Provider (You will pay the least)</th>
<th>What You Will Pay Out-of-Network (OON) Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home health care</td>
<td>0% coinsurance</td>
<td>Not covered</td>
<td>Limit of 30 visits per calendar year. Reduction for failure to precertify is 50% per covered service.</td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>Office: $5 copay per provider per date of service</td>
<td>Facility: 0% coinsurance</td>
<td>Office-based cardiac rehabilitation, physical, speech, occupational and respiratory therapies are limited to 20 visits each per calendar year. Copay does not continue after the out-of-pocket maximum is met.</td>
</tr>
<tr>
<td>Habilitation services</td>
<td>Office: $5 copay per provider per date of service</td>
<td>Facility: 0% coinsurance</td>
<td>Office-based cardiac rehabilitation, physical, speech, occupational and respiratory therapies are limited to 20 visits each per calendar year. Copay does not continue after the out-of-pocket maximum is met.</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>0% coinsurance</td>
<td>Not covered</td>
<td>Limit of 90 days per calendar year. Reduction for failure to precertify out-of-network services is 50%.</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>$20 copay per date of service</td>
<td>Not covered</td>
<td>Copay does not continue after the out-of-pocket maximum is met. Copay does not apply to services for mental health/substance abuse.</td>
</tr>
<tr>
<td>Hospice services</td>
<td>0% coinsurance</td>
<td>Not covered</td>
<td>Hospice respite care is limited to 15 inpatient and 15 outpatient days per lifetime.</td>
</tr>
<tr>
<td><strong>If your child needs dental or eye care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children’s eye exam</td>
<td>$5 copay per provider per date of service</td>
<td>Not covered</td>
<td>One routine vision exam per calendar year. Must be performed by an in-network provider. Copay waived for optometrist. Copay does not continue after the out-of-pocket maximum is met.</td>
</tr>
<tr>
<td>Children’s glasses</td>
<td>Not covered</td>
<td>Not covered</td>
<td>------None------</td>
</tr>
<tr>
<td>Children’s dental check-up</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 1-800-524-9242.
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
- Glasses
- Hearing aids
- 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-covered subject to state mandate through age 18 subject to annual limits
- Bariatric surgery
- Chiropractic care (20 visits per calendar year)
- Extended home skilled nursing
- Infertility treatment (excludes some services)
- Private-duty nursing - short term intermittent home skilled nursing (applies to home health care limit)
- 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 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 1-800-524-9242.

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.

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.

<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 year 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</td>
<td>The plan’s overall deductible</td>
<td>The plan’s overall deductible</td>
</tr>
<tr>
<td>PCP copayment</td>
<td>Specialist copayment</td>
<td>Specialist copayment</td>
</tr>
<tr>
<td>Hospital(facility) coinsurance</td>
<td>Hospital(facility) coinsurance</td>
<td>Hospital(facility) copayment</td>
</tr>
<tr>
<td>Other no charge</td>
<td>Other copayment</td>
<td>Other copayment</td>
</tr>
<tr>
<td>No Charge</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>$12,800</td>
<td>$7,400</td>
<td>$1,900</td>
</tr>
</tbody>
</table>

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)

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)

This EXAMPLE event includes services like:
- Emergency room care (including medical supplies)
- Diagnostic test (x-ray)
- Durable medical equipment (crutches)
- Rehabilitation services (physical therapy)

| Total Example Cost | $12,800 | $7,400 | $1,900 |

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>Copayments</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0</td>
<td>$10</td>
<td>$0</td>
<td></td>
</tr>
</tbody>
</table>

What isn’t covered

| Limits or exclusions | $60 |

The total Peg would pay is

| The total Peg would pay is | $70 |

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>Copayments</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0</td>
<td>$300</td>
<td>$1,400</td>
<td></td>
</tr>
</tbody>
</table>

What isn’t covered

| Limits or exclusions | $200 |

The total Joe would pay is

| The total Joe would pay is | $1,900 |

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>Copayments</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0</td>
<td>$90</td>
<td>$0</td>
<td></td>
</tr>
</tbody>
</table>

What isn’t covered

| Limits or exclusions | $0 |

The total Mia would pay is

| The total Mia would pay is | $90 |

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.
Required Federal Accessibility and Nondiscrimination Notice

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