

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

**Coverage Period: 01/01/2024 – 12/31/2024**

Coverage for: Single & Family | Plan Type: PPO HDHP

**HEALTHAlliance Benefit Plan \$6850 Alliance Select QHDHP PPO**



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, [www.wellmark.com](http://www.wellmark.com) or call 1-800-524-9242. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or call 1-800-524-9242 to request a copy.

Important Questions	Answers	Why this Matters:
<b>What is the overall deductible?</b>	In- <u>Network</u> : <b>\$6,850</b> person/ <b>\$13,700</b> family per calendar year. Out-of- <u>Network</u> : <b>\$7,650</b> person/ <b>\$17,600</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 deductible?</b>	Yes. <u>Preventive care</u> , your drug card costs and well-child care 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 deductibles for specific services?</b>	No. There are no other <u>deductibles</u> .	You don't have to meet deductibles for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	Health In- <u>Network</u> : <b>\$7,500</b> person/ <b>\$15,000</b> family per calendar year. Health Out-Of- <u>Network</u> : <b>\$11,300</b> person/ <b>\$22,600</b> family per calendar year.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the out-of-pocket limit?</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> .

Important Questions	Answers	Why this Matters:
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="http://www.wellmark.com">www.wellmark.com</a> or call 1-800-524-9242 for a list of health <u>network providers</u> .	This plan uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-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 provider's office or clinic	Primary care visit to treat an injury or illness	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Contracted telehealth services are covered.
	<u>Specialist</u> visit	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Contracted telehealth services are covered. Hearing exams are covered according to ACA guidelines.
	<u>Preventive care/screening/immunization</u>	No charge	0% <u>coinsurance</u>	One preventive exam and one gynecological exam 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)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----
If you need drugs to treat your illness or condition  More information about <u>prescription drug coverage</u> is available at <a href="http://www.express-scripts.com">www.express-scripts.com</a> or contact RX Benefits by phone at 1-800-334-8134..	Tier 1	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Drugs listed on Express Scripts Preferred Drug List are covered. Drugs not on this Drug List are not covered.
	Tier 2	20% <u>coinsurance</u>	20% <u>coinsurance</u>	
	Tier 3	20% <u>coinsurance</u>	20% <u>coinsurance</u>	You pay the discounted cost of your prescription drugs until your <u>in-network deductible</u> is met. For <u>out-of-network</u> prescription drugs, you may be balance billed.
	Specialty drugs	20% <u>coinsurance</u>	Not covered	30-day supply for prescription drugs 90-day prescription maximum (maintenance). <u>Specialty drugs</u> are covered only when obtained through the Accredo Specialty Pharmacy.

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----
If you need immediate medical attention	Emergency room care	20% <u>coinsurance</u>	20% <u>coinsurance</u>	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.
	Emergency medical transportation	20% <u>coinsurance</u>	20% <u>coinsurance</u>	For covered non-emergent situations, out-of-network 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.
	Urgent care	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Contracted telehealth services are covered.
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----
If you are pregnant	Office visits	20% <u>coinsurance</u>	40% <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> .
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <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	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----

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 help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	-----None-----
	Rehabilitation services	20% coinsurance	40% coinsurance	-----None-----
	Habilitation services	20% coinsurance	40% coinsurance	-----None-----
	Skilled nursing care	20% coinsurance	40% coinsurance	-----None-----
	Durable medical equipment	20% coinsurance	40% coinsurance	-----None-----
	Hospice services	20% coinsurance	40% coinsurance	-----None-----
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	-----None-----
	Children's glasses	Not covered	Not covered	-----None-----
	Children's dental check-up	Not covered	Not covered	-----None-----

#### Excluded Services & Other Covered Services:

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

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

**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, RX Benefits at 1-800-334-8134, Iowa Insurance Division at 515-281-5705, 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**

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.](#)

*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 may 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.

<b>Peg is Having a Baby</b> (9 months of <u>in-network</u> pre-natal care and a hospital delivery)		<b>Managing Joe's type 2 Diabetes</b> (a year of routine <u>in-network</u> care of a well-controlled condition)		<b>Mia's Simple Fracture</b> ( <u>in-network</u> emergency room visit and follow up care)	
■ The <u>plan's</u> overall <u>deductible</u>	\$2,800	■ The <u>plan's</u> overall <u>deductible</u>	\$2,800	■ The <u>plan's</u> overall <u>deductible</u>	\$2,800
■ <u>PCP</u> <u>coinsurance</u>	20%	■ <u>Specialist</u> <u>coinsurance</u>	20%	■ <u>Specialist</u> <u>coinsurance</u>	20%
■ <u>Hospital(facility)</u> <u>coinsurance</u>	20%	■ <u>Tiers 1 &amp; 2 Rx</u> <u>copayments</u>	N/A	■ <u>Hospital(facility)</u> <u>coinsurance</u>	20%
■ <u>Tier 1 Rx</u> <u>copayment</u>	N/A	■ <u>Durable medical equip.</u> <u>coinsurance</u>	20%	■ <u>Durable medical equip.</u> <u>coinsurance</u>	20%
<b>This EXAMPLE event includes services like:</b> <u>Specialist</u> office visits ( <i>prenatal care</i> ) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services <u>Diagnostic tests</u> ( <i>ultrasounds and blood work</i> ) <u>Specialist</u> visit ( <i>anesthesia</i> )		<b>This EXAMPLE event includes services like:</b> <u>Primary care physician</u> office visits ( <i>including disease education</i> ) <u>Diagnostic tests</u> ( <i>blood work</i> ) <u>Prescription drugs</u> <u>Durable medical equipment</u> ( <i>glucose meter</i> )		<b>This EXAMPLE event includes services like:</b> <u>Emergency room care</u> ( <i>including medical supplies</i> ) <u>Diagnostic test</u> ( <i>x-ray</i> ) <u>Durable medical equipment</u> ( <i>crutches</i> ) Rehabilitation services ( <i>physical therapy</i> )	
<b>Total Example Cost</b>	<b>\$12,700</b>	<b>Total Example Cost</b>	<b>\$5,600</b>	<b>Total Example Cost</b>	<b>\$2,800</b>

In this example, Peg would pay:

In this example, Joe would pay:

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$2,800
Copayments	\$0
Coinsurance	\$700
What isn't covered	
Limits or exclusions	\$70
<b>The total Peg would pay is</b>	<b>\$3,570</b>

Cost Sharing	
Deductibles	\$1,200
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$4,300
<b>The total Joe would pay is</b>	<b>\$5,500</b>

Cost Sharing	
Deductibles	\$2,795
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$5
<b>The total Mia would pay is</b>	<b>\$2,800</b>

The amounts shown in the maternity claim example above are based on amounts using a single per person deductible. Some plans may actually apply a two-person or family deductible to maternity services for the mother and newborn baby. The plan would be responsible for the other costs of these EXAMPLE covered services.

Claim example administrative notes: Excluded charges include all pharmacy drugs and supplies. Immunizations in office are covered under medical at 100%. Maternity example: medical excludes OTC pre-natal vitamins. Diabetic example: Dietician services are covered subject to office benefits. OTC low dose aspirin is covered under medical at 100% as preventive. All Examples: All dollar amounts except deductible and total member pay amounts are rounded. Amounts over \$100 are rounded to the nearest \$100. Amounts under \$100 are rounded to the nearest \$10. Remove these notes prior to distributing to members.