


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: HMO

HEALTHAlliance Benefit Plan \$2000 BlueHMO

 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 1-800-355-2031. 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 1-800-355-2031 to request a copy.

Important Questions	Answers	Why this Matters:
<b>What is the overall deductible?</b>	<b>\$2,000</b> person/ <b>\$4,000</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. Well-child care, your drug card costs, <u>preventive care</u> , physician maternity care, <u>in-network</u> prosthetic limbs, telehealth services and services subject to <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 deductibles for specific services?</b>	Yes. <b>\$100</b> person/ <b>\$200</b> family per calendar year for drug card, which does not apply to Tier 1 Rx. There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
<b>What is the out-of-pocket limit for this plan?</b>	Health: <b>\$5,000</b> person/ <b>\$10,000</b> family per calendar year. Drug Card: <b>\$5,000</b> person/ <b>\$10,000</b> family per calendar year. The <u>In-Network</u> health and drug card out-of-pocket maximum amounts accumulate together.	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:
Will you pay less if you use a <u>network provider</u> ?	Yes. See <a href="http://www.wellmark.com">www.wellmark.com</a> or call 1-800-355-2031 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.
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 office</u> or clinic	Primary care visit to treat an injury or illness	\$30 <u>copay</u> per <u>provider</u> per date of service	Not covered	Primary Care Practitioners (PCP) are defined as General and Family Practice, Internal Medicine, OB/GYN, Pediatricians, Nurse Practitioners, Certified Nurse Midwives and PAs. \$30 <u>copay</u> per <u>provider</u> per date of service applies to telehealth services delivered by <u>in-network primary care providers</u> . Waive cost-share for Doctor on Demand contracted telehealth services.
	<u>Specialist</u> visit	\$50 <u>copay</u> per <u>provider</u> per date of service	Not covered	Applies to Non-PCP <u>providers</u> . \$50 <u>copay</u> per <u>provider</u> per date of service applies to covered telehealth services provided by <u>in-network specialists</u> . \$30 <u>copay</u> per date of service for <u>in-network chiropractic</u> services. Hearing exams are covered according to ACA guidelines.
	<u>Preventive care/screening/immunization</u>	No charge	Not covered	<u>Preventive care</u> must be provided by a PCP <u>provider</u> . 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.

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 a test	<u>Diagnostic test</u> (x-ray, blood work)	Independent Lab: \$50 <u>copay</u> per <u>provider</u> per date of service Facility: 20% <u>coinsurance</u>	Not covered	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- <u>network</u> independent lab services for mental health/substance abuse.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	Not covered	For a test in a <u>provider's</u> office or clinic, your cost is included in the cost-share listed above.
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	\$10 <u>copay</u> per prescription	\$10 <u>copay</u> per prescription	Drugs listed on Express Scripts Preferred 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 for 30-day supply.
	Tier 2	\$25 <u>copay</u> per prescription	\$25 <u>copay</u> per prescription	
	Tier 3	\$45 <u>copay</u> per prescription	\$45 <u>copay</u> per prescription	
	Specialty drugs	Preferred: \$100 <u>copay</u> per prescription Non-Preferred: \$200 <u>copay</u> per prescription	Not covered	3 copays for 90-day supply (Retail maintenance). 2 copays for 90-day supply (Mail order maintenance). Specialty drugs are covered only when obtained through the Accredo Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	Not covered	-----None-----
	<u>Physician/surgeon</u> fees	20% <u>coinsurance</u>	Not covered	-----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 immediate medical attention	<u>Emergency room care</u>	\$150 <u>copay</u> per facility per date of service for facility and physician(s) combined	\$150 <u>copay</u> per facility per date of service for facility and physician(s) combined	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.
	<u>Emergency medical transportation</u>	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.
	<u>Urgent care</u>	\$30 <u>copay</u> per <u>provider</u> per date of service	Not covered	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	Not covered	-----None-----
	<u>Physician/surgeon fees</u>	20% <u>coinsurance</u>	Not covered	-----None-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: \$30 <u>copay</u> /\$50 Non-PCP <u>copay</u> per <u>provider</u> per date of service Facility: 20% <u>coinsurance</u>	Not covered	-----None-----
	Inpatient services	20% <u>coinsurance</u>	Not covered	-----None-----
If you are pregnant	Office visits	No charge	Not covered	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 <u>in-network</u> services that fall outside of routine obstetric care, the office visit benefits shown above may apply.
	Childbirth/delivery professional	No charge	Not covered	Benefits shown reflect OB/GYN practitioner services which are typically globally billed at time of delivery for

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
	services			pre-natal, post-natal and delivery services.
	Childbirth/delivery facility services	20% <u>coinsurance</u>	Not covered	-----None-----
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	Not covered	-----None-----
	<u>Rehabilitation services</u>	Office: \$30 <u>copay</u> /\$50 Non-PCP <u>copay</u> per <u>provider</u> per date of service Facility: 20% <u>coinsurance</u>	Not covered	-----None-----
	<u>Habilitation services</u>	Office: \$30 <u>copay</u> /\$50 Non-PCP <u>copay</u> per <u>provider</u> per date of service Facility: 20% <u>coinsurance</u>	Not covered	-----None-----
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	Not covered	-----None-----
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	Not covered	-----None-----
	<u>Hospice services</u>	20% <u>coinsurance</u>	Not covered	-----None-----
	If your child needs dental or eye care	Children's eye exam	\$30 <u>copay</u> per <u>provider</u> per date of service	Not covered
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 Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Custodial care - in home or facility
- Dental care - Adult
- Dental check-up
- Extended home skilled nursing
- Glasses
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Applied Behavior Analysis therapy
- Bariatric surgery
- Chiropractic care
- Private-duty nursing – short term intermittent home skilled nursing
- Routine eye care – Adult (one vision exam per calendar year)
- Infertility treatment (\$20,000 LTM)

**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.



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

- The plan's overall deductible \$2,000
- PCP copayment \$30
- Hospital(facility) coinsurance 20%
- Tier 1 Rx copayment \$10

**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)

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

- The plan's overall deductible \$2,000
- Specialist copayment \$50
- Tiers 1 & 2 Rx copayments \$10 & \$25
- Durable medical equip. coinsurance 20%

**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)

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

- The plan's overall deductible \$2,000
- Specialist copayment \$50
- Emergency room copayment \$150
- Durable medical equip. coinsurance 20%

**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>\$12,700</b>
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In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$2,000
<u>Copayments</u>	\$30
<u>Coinsurance</u>	\$1,300
What isn't covered	
<b>Limits or exclusions</b>	<b>\$70</b>
<b>The total Peg would pay is</b>	<b>\$3,370</b>

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$50
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$0
What isn't covered	
<b>Limits or exclusions</b>	<b>\$4,300</b>
<b>The total Joe would pay is</b>	<b>\$4,750</b>

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,200
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$0
What isn't covered	
<b>Limits or exclusions</b>	<b>\$10</b>
<b>The total Mia would pay is</b>	<b>\$1,610</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.