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, 1-800-373-1327. 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.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	The employer self-funds a portion of the deductible under the major medical plan. **In-network deductible:** **$1,500** person/ **$3,000** family **Out-of-network deductible:** **$1,500** person/ **$3,000** family	Generally, you must pay all of 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.
Are there services covered before you meet your deductible?	Yes. See the primary SBC of the insured group health plan.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. See the primary SBC of the insured group health plan.	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.
What is the out-of-pocket limit for this plan?	The employer self-funds a portion of the out-of-pocket maximum under the major medical plan. **In-network out-of-pocket maximum**: **$3,000** person/ **$6,000** family **Out-of-network out-of-pocket maximum:** **$3,000** person/ **$6,000** family	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.

Important Questions	Answers	Why This Matters:
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, drug copays and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See the SBC of your primary group health plan.	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.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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		Limitations, Exceptions, & Other Important Information
		In-Network (IN) Provider (You will pay the least)	Out-of-Network Provider (OON) Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.
	Specialist visit	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.
	Preventive care/screening/ immunization	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.
If you have a test	Diagnostic test (x-ray, blood work)	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.
	Imaging (CT/PET scans, MRIs)	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.[insert].com	Tier 1	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.
	Tier 2	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	
	Tier 3	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	
	Specialty drugs	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (IN) Provider (You will pay the least)	Out-of-Network Provider (OON) Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.
	Physician/surgeon fees	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.
If you need immediate medical attention	Emergency room care	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.
	Emergency medical transportation	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	
	Urgent care	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	
If you have a hospital stay	Facility fee (e.g., hospital room)	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.
	Physician/surgeon fees	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.
	Inpatient services	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	
If you are pregnant	Office visits	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.
	Childbirth/delivery professional services	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	
	Childbirth/delivery facility services	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	
If you need help recovering or have other special health needs	Home health care	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.
	Rehabilitation services	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.
	Habilitation services	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	
	Skilled nursing care	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.
	Durable medical equipment	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (IN) Provider (You will pay the least)	Out-of-Network Provider (OON) Provider (You will pay the most)	
	Hospice services	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.
If your child needs dental or eye care	Children's eye exam	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.
	Children's glasses	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.
	Children's dental check-up	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.

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.)

- See the primary insured group health plan

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

- See the primary insured group health plan

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: EBS at 1-800-373-1327 or the Iowa Insurance Division at 515-654-6600.

Does this plan provide Minimum Essential Coverage? **No**. However, this plan combined with your primary insurance plan does provide Minimum Essential Coverage. 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? **No**. However, this plan combined with your primary insurance plan does meet Minimum Value Standards. 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.

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al [319-752-3200].]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [319-752-3200].]

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码[319-752-3200].]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [319-752-3200].]

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

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

The plan's overall deductible	**$1,500**
PCP coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
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)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1,500
Copayments	$10
Coinsurance	$1,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,970**

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

The plan's overall deductible	**$1,500**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other 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)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles*	$100
Copayments	$800
Coinsurance	$200
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,120**

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

The plan's overall deductible	**$1,500**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other 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)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles*	$1,500
Copayments	$10
Coinsurance	$280
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,790**

The amounts shown in the maternity claim 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.

Wellmark Health Plan of Iowa

Coverage Period: 07/01/2025 – 06/30/2026
Coverage for: Single & Family | Plan Type: POS

Iowa Star Schools Plan D 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 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.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$4,000** person/**$8,000** family per calendar year.	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.
Are there services covered before you meet your deductible?	Yes. Well-child care, preventive care, colonoscopies, in-network independent labs, in-network physician maternity care, in-network prosthetic limbs and services subject to copayments are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. **$100** person/**$200** family per calendar year for drug card, which does not apply to Tier 1 Rx. There are no other specific deductibles.	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.
What is the out-of-pocket limit for this plan?	Health: **$7,000** person/**$14,000** family per calendar year. Drug Card: **$1,500** person/**$3,000** family per calendar year. The In-Network health and drug card out-of-pocket maximum amounts accumulate separately.	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.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why this Matters:
Will you pay less if you use a network provider?	Yes. See www.wellmark.com or call 1-800-524-9242 for a list of network providers.	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.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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% coinsurance	25% coinsurance	For this plan you must select a Designated Primary Care Provider (PCP). PCP provider types can be found in the What You Pay section of your plan document.
	Specialist visit	20% coinsurance	25% coinsurance	Applies to Non-PCP providers. Hearing exams are covered according to ACA guidelines.
	Preventive care/screening/ immunization	No charge	25% coinsurance	One preventive exam and 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 provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	25% coinsurance	------None------
	Imaging (CT/PET scans, MRIs)	20% coinsurance	25% coinsurance	------None------

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-524-9242. You can find your Coverage Manual at 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 drugs to treat your illness or condition More information about **prescription drug coverage** is at www.wellmark.com/prescriptions.	Tier 1	$10 copay per prescription	$10 copay per prescription	Refer to your Blue Rx Value Plus Drug List to determine the tier that applies to a covered drug. For out-of-network prescription drugs, you may be balance billed. 1 copay for 30-day supply. 3 copays for 90-day supply (retail). 2 copays for 90-day supply (mail order). Specialty drugs are covered only when obtained through the CVS Specialty Pharmacy Program. Specialty drugs on the PrudentRx drug list (found at Wellmark.com) will have 30% coinsurance. If you enroll with PrudentRx, you will have $0 member cost-share for drugs on the PrudentRx drug list. See wellmark.com/prescriptions for information about drugs and drug quantities that require prior authorization by Wellmark to be covered by your plan.
	Tier 2	$25 copay per prescription	$25 copay per prescription	
	Tier 3	$40 copay per prescription	$40 copay per prescription	
	Specialty drugs	$40 copay per prescription	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	25% coinsurance	------None------
	Physician/surgeon fees	20% coinsurance	25% coinsurance	------None------
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	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% coinsurance	20% coinsurance	For covered non-emergent situations, out-of-network ground ambulance services are NOT reimbursed at the in-network level. You 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% coinsurance	25% coinsurance	------None------

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-524-9242. You can find your Coverage Manual at 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 have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	25% coinsurance	------None------
	Physician/surgeon fees	20% coinsurance	25% coinsurance	------None------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	25% coinsurance	------None------
	Inpatient services	20% coinsurance	25% coinsurance	------None------
If you are pregnant	Office visits	No charge	25% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	No charge	25% coinsurance	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% coinsurance	25% coinsurance	------None------
If you need help recovering or have other special health needs	Home health care	20% coinsurance	25% coinsurance	------None------
	Rehabilitation services	20% coinsurance	25% coinsurance	$15 copay per date of service applies to in-network Physical and Occupational Therapists and Speech Language Pathologists.
	Habilitation services	20% coinsurance	25% coinsurance	$15 copay per date of service applies to in-network Physical and Occupational Therapists and Speech Language Pathologists.
	Skilled nursing care	20% coinsurance	25% coinsurance	------None------
	Durable medical equipment	20% coinsurance	25% coinsurance	------None------
	Hospice services	20% coinsurance	25% coinsurance	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	Not covered	Not covered	------None------
	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 1-800-524-9242. You can find your Coverage Manual at 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
- Eye exam
- Glasses
- Hearing aids
- Long-term care
- Routine eye care - Adult
- 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

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, you can contact: Wellmark at 1-800-524-9242 or the Iowa Insurance Division at 515-654-6600.

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.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About These Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

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

The plan's overall deductible	$4,000
PCP coinsurance	20%
Hospital(facility) coinsurance	20%
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*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$4,000
Copayments	$10
Coinsurance	$900
What isn't covered	
Limits or exclusions	**$60**
The total Peg would pay is	**$4,970**

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

The plan's overall deductible	$4,000
Specialist coinsurance	20%
Hospital(facility) coinsurance	20%
Other 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*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$100
Copayments	$800
Coinsurance	$200
What isn't covered	
Limits or exclusions	**$20**
The total Joe would pay is	**$1,120**

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

The plan's overall deductible	$4,000
Specialist coinsurance	20%
Hospital(facility) coinsurance	20%
Other 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*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,900
Copayments	$10
Coinsurance	$200
What isn't covered	
Limits or exclusions	**$0**
The total Mia would pay is	**$2,110**

Claim examples calculate benefits based on 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 complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes. Wellmark does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Wellmark

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance 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 3E417, Des Moines, IA 50309-2901, 515-376-6500, TTY 888-781-4262, Fax 515-376-9055, Email **CRC@Wellmark.com**. You can file a grievance in person or 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 or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

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 ٢٤٢٩-٤٢٥-٠٠٨ أو (خدمة الهاتف النصي: ٨٨٨-١٨٧-٢٦٢٤).

ສ່ວນ, ພາສາລາວ ຖ້າທ່ານເວົ້າ: ພວກເຮົາມີບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານ ໂດຍບໍ່ເສຍຄ່າ ຫຼື 800-524-9242 ຕິດຕໍ່ຫາ. (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 Deitsch 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).

တtill:ဒုးသူဉ်ညါ–နမ့ါကတိၤကညီကျိာ်,ကျိာ်တtill်မၤစၢၤတtill်ဖံးတtill်မၤတဖဉ်,လၢတဘဉ်လာ်ဘူးလဲ,အိဉ်လၢနှဂီၢ်လီၤ.ဆဲးကျိးဆူ ၈၀၀–၅၂၄–၉၂၄၂မ့တမ့ါ(TTY:၈၈၈–၇၈၁–၄၂၆၂)တကွာ်.

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: አማርኛ የሚናገሩ ከሆነ፣ የቋንቋ እገዛ አገልግሎቶች፣ ከክፍያ ነፃ፣ ያገኛሉ። በ 800-524-9242 ወይም (በTTY: 888-781-4262) ይውለው ያነጋግሩን።

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

FUULEFFANNAA: Yo isin Oromiffaa, kan dubbattan taatan, tajaajilooni 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 yáníłti'go níká bizaad bee áká' adoowoł, t'áá jiik'é, náhóló. Kojį' hólne' 800-524-9242 doodaii' (TTY: 888-781-4262)

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