

STATE OF SOUTH DAKOTA WASHINGTON HDHP

The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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 <u>www.wellmark.com</u> or call 1-800-846-9183. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-800-846-9183 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	In- <u>Network</u> : \$5,750 person/ \$11,500 family per benefit year. Out-of- <u>Network</u> : \$11,250 person/ \$22,500 family per benefit 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> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. Well-child care and <u>preventive care</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 <u>www.healthcare.gov/coverage/preventive-care-benefits/</u> .
Are there other <u>deductibles</u> for specific services?	No. There are no other <u>deductible</u> s.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> <u>limit f</u> or this <u>plan</u> ?	In- <u>Network</u> : \$5,750 person/ \$11,500 family per benefit year. Out-Of- <u>Network</u> : \$11,250 person/ 22,500 family per benefit 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.
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 <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See <u>www.wellmark.com</u> or call 1- 800-846-9183 for a list of <u>network</u> <u>providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan</u> 's <u>network</u> . You will pay the most if you use an out-of- <u>network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider</u> 's charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an out-of- <u>network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
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 <u>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> applies.

Common Medical Event	Services You May Need	What You Will Pay In- <u>Network</u> (IN) <u>Provider</u> (You will pay the least)	What You Will Pay Out-of- <u>Network</u> (OON) <u>Provider</u> (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Primary care visit to treat an injury or illness	0% coinsurance	0% coinsurance	Doctor on Demand contracted telehealth services are covered.
	Specialist visit	0% coinsurance	0% coinsurance	Hearing exams are covered according to ACA guidelines.
If you visit a health care <u>provider's</u> office or clinic	Preventive care/screening/ immunization	No charge	0% <u>coinsurance</u>	One preventive exam and one mammogram per benefit year. Well-child care is covered to age 7. Cholesterol, Glucose tests (not including A1c), and Venipuncture are covered when billed as preventive, waive cost share. 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	Diagnostic test (x-ray, blood work)	0% coinsurance	0% coinsurance	None
	Imaging (CT/PET scans, MRIs)	0% coinsurance	0% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay In- <u>Network</u> (IN) <u>Provider</u> (You will pay the least)	What You Will Pay Out-of- <u>Network</u> (OON) <u>Provider</u> (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Tier 1	Preventive cost share waived All other: 0% <u>coinsurance</u>	Preventive cost share waived All other: 0% <u>coinsurance</u>	Drugs listed on Wellmark's Blue Rx Value Plus Drug List
If you need drugs to	Tier 2	Preventive: \$55 <u>copay</u> per prescription All other: 0% <u>coinsurance</u>	Preventive: \$55 copay per prescription All other: 0% coinsurance	are covered. Drugs not on this Drug List are not covered. You pay the discounted cost of your <u>prescription drugs</u> until your overall <u>deductible</u> is met. For out-of- <u>network</u> <u>prescription drugs</u> , you may be balance billed.
treat your illness or condition More information about prescription drug coverage is at	Tier 3	Preventive: \$75 <u>copay</u> per prescription All other: 0% <u>coinsurance</u>	Preventive: \$75 <u>copay</u> per prescription All other: 0% <u>coinsurance</u>	30-day supply for <u>prescription drugs</u> . 90-day supply (Retail and Mail maintenance). HSA preventive drug list <u>copays</u> : 2.5 <u>copays</u> for 60-90-day supply <u>Specialty drugs</u> are covered only when obtained through
www.wellmark.com/ prescriptions.	Specialty drugs	Same as cost-share above depending on drug category Preventive Preferred: \$85 <u>copay</u> per prescription Preventive Non- Preferred: \$110 <u>copay</u> per prescription	Not covered	the Specialty Pharmacy Program. Waive cost share for Prenatal Vitamins. See wellmark.com/prescriptions for information about drugs and drug quantities that require prior authorization by Wellmark to be covered by your plan.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	0% coinsurance	None
outpatient surgery	Physician/surgeon fees	0% coinsurance	0% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay In- <u>Network</u> (IN) <u>Provider</u> (You will pay the least)	What You Will Pay Out-of- <u>Network</u> (OON) <u>Provider</u> (You will pay the most)	Limitations, Exceptions, & Other Important Information
16 I	Emergency room care	0% coinsurance	0% coinsurance	For <u>emergency medical conditions</u> treated out-of- <u>network</u> , it is likely you may not be balance billed pursuant to the federal rules developed for implementation of the No Surprises Act.
If you need immediate medical attention	Emergency medical transportation	0% coinsurance	0% <u>coinsurance</u>	For covered non-emergent situations, out-of- <u>network</u> ground ambulance services are NOT reimbursed at the in- <u>network</u> level. The member may be balance billed for any out-of- <u>network</u> service as established under the rules developed for implementation of the No Surprises Act.
	<u>Urgent care</u>	0% coinsurance	0% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	0% coinsurance	None
	Physician/surgeon fees	0% coinsurance	0% coinsurance	None
If you need mental	Outpatient services	0% coinsurance	0% coinsurance	None
health, behavioral health, or substance abuse services	Inpatient services	0% coinsurance	0% coinsurance	None
	Office visits	0% coinsurance	0% coinsurance	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> .
If you are pregnant	Childbirth/delivery professional services	0% coinsurance	0% 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	0% coinsurance	0% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay In- <u>Network</u> (IN) <u>Provider</u> (You will pay the least)	What You Will Pay Out-of- <u>Network</u> (OON) <u>Provider</u> (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Home health care	0% coinsurance	0% coinsurance	None
	Rehabilitation services	0% coinsurance	0% coinsurance	None
If you need help recovering or have other special health needs	Habilitation services	0% coinsurance	0% coinsurance	None
	Skilled nursing care	0% coinsurance	0% coinsurance	None
	Durable medical equipment	0% coinsurance	0% coinsurance	None
	Hospice services	0% coinsurance	0% coinsurance	Hospice respite care is limited to 15 inpatient and 15 outpatient days per lifetime.
	Children's eye exam	No charge	Not covered	One routine vision exam per benefit year.
dental or eye care	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Infertility treatment (excludes some 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.)				
 Cosmetic surgery Custodial care - in home or facility Dental care - Adult Dental check-up Extended home skilled nursing Glasses Long-term care 	 Routine foot care Some pharmacy drugs are not covered Weight loss programs 			
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)				
 Acupuncture (Limited to 12 visits per benefit year) Applied Behavior Analysis therapy Bariatric surgery Chiropractic care Hearing aids (Covered to age 9) 	 Most coverage provided outside the U.S. Private-duty nursing - short term intermittent home skilled nursing Routine eye care - Adult (one vision exam per benefit year) 			

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.doi.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your <u>Grievance</u> and <u>Appeals</u> Rights: There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, you can contact: Wellmark at 1-800-846-9183 or Employee Benefits Security Administration at 1-866-444-3272 or <u>www.dol.gov/ebsa/healthreform</u>.

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 <u>plan</u> might cover costs for a sample medical situation, see the next page. $_$

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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 <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plan</u>s. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in- <u>network</u> pre-natal care and a hospital delivery)		Managing Joe's type 2 Diabetes (a years of routine in- <u>network</u> care of a well- controlled condition)		Mia's Simple Fracture (in- <u>network</u> emergency room visit and follow up care)	
 The plan's overall <u>deductible</u> PCP <u>coinsurance</u> Hospital(facility) <u>coinsurance</u> Other <u>coinsurance</u> 	\$5,750 0% 0% 0%	 The plan's overall <u>deductible</u> <u>Specialist coinsurance</u> Hospital(facility) <u>coinsurance</u> Other <u>coinsurance</u> 	\$5,750 0% 0% 0%	 The plan's overall <u>deductible</u> <u>Specialist coinsurance</u> Hospital(facility) <u>coinsurance</u> Other <u>coinsurance</u> 	\$5,750 0% 0% 0%
This EXAMPLE event includes services like: <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>)		This EXAMPLE event includes servi <u>Primary care physician</u> office visits (includes and includes education) <u>Diagnostic tests</u> (blood work) <u>Prescription drugs</u> <u>Durable medical equipment</u> (glucose reference)	cluding	This EXAMPLE event includes serv Emergency room care (including medi supplies) Diagnostic test (x-ray) Durable medical equipment (crutches) Rehabilitation services (physical thera	ical)

\$5,600

Total Example Cost

In this example, Peg would pay:

Cost Sharing			
<u>Deductibles</u>	\$5,750		
<u>Copayments</u>	\$0		
Coinsurance	\$0		
What isn't covered			
Limits or exclusions \$60			
The total Peg would pay is	\$5,810		

\$12,700

Total Example Cost

In this example, Joe would pay:

Cost Sharing				
<u>Deductibles</u>	\$5,400			
<u>Copayments</u>	\$0			
<u>Coinsurance</u>	\$0			
What isn't covered				
Limits or exclusions \$20				
The total Joe would pay is	\$5,420			

In this example. Mia would pay:

Total Example Cost

in the example, the neuro pays			
Cost Sharing			
<u>Deductibles</u>	\$2,800		
<u>Copayments</u>	\$0		
<u>Coinsurance</u>	\$0		
What isn't covered			
Limits or exclusions \$0			
The total Mia would pay is	\$2,800		

The amounts shown in the maternity <u>claim</u> example above are based on amounts using a single per person <u>deductible</u>. Some <u>plans</u> may actually apply a two-person or family <u>deductible</u> to maternity services for the mother and newborn baby.

The <u>plan</u> would be responsible for the other costs of these EXAMPLE covered services.

\$2,800



Wellmark Language Assistance

Discrimination is against the law

Wellmark Blue Cross and Blue Shield complies with applicable state and federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

Wellmark provides:

- Free aids and services to people with disabilities so they may communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as: – Qualified interpreters
 - Information written in other languages

You have the right to get this information and help in your language for free. If you need these services, call 800-524-9242.

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

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

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

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

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

تنبيه: إذا كنت تتحدث اللغة العربية. فإننا نوفر لك خدمات المساعدة اللغوية، المجانية. اتصل بالرقم 800-524-9242 أو (خدمة الهاتف النصبي: 828-781-888).

ສິ່ງຄວນເອົາໃຈໃສ່, ພາສາລາວ ຖ້າທ່ານເວົ້າ: ພວກເຮົາມີບໍລິການຄວາມຊ່ວຍເຫຼືອດ້ານພາສາ ໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ ຫຼື 800-524-9242 ຕິດຕໍ່ທີ່. (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.

โปรดุทราบ: หากคุณพูด ไทย เรามีบริการช่วยเหลือด้านภาษาสำหรับคุณโดยไม่คิด ค่าใช้จ่าย 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).

တါဒုံးသွင်ညါ–နမ္နါကတိၤကညီကိုဂ်.ကျိဂ်တါမးစၤဟာဖ်းတာမၤတဖင်္ဂ.လၢတဘာဉ်လာဘာ့ၤလဲ.အိဉ်လၢနဂိၢိလိၤ.ဆဲးကျိုးဆူ ၈၀၀–၅၂၄–၉၂၄၂မှတမ့်(TTY:၈၈၈–၇၈၁–၄၂၆၂)တက္.

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 नि:शुल्क रूपमा भाषा सहायता सेवाहरू उपलब्ध गराइन्छ । 800-524-9242 वा (TTY: 888-781-4262) मा सम्पर्क गर्नुहोस् ।

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

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

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

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

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