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

Wellmark.

BlueSimplicity℠ Silver PPO

Coverage Period: 01/01/2018 – 12/31/2018
Coverage for: Single & Family | Plan Type: 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, visit www.wellmark.com or call 1-800-941-4410. 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 1-800-941-4410 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0** person .	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?	No. This plan has no deductibles.	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?	No. There are no deductibles on this plan.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: **$7,350** person/**$14,700** family . Out-Of-Network: **$14,700** person/**$29,400** 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.
What is not included in the out-of-pocket limit?	Premiums, pre-service review penalties, 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.
Will you pay less if you use a network provider?	Yes. See www.wellmark.com or call 1-800-941-4410 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	$35 copay	$105 copay	Primary Care Practitioners (PCP) are defined as General and Family Practice, Internal Medicine, OB/GYN, Pediatricians, Nurse Practitioners and PAs. Copays apply per provider per date of service. $35 copay per provider per date of service applies to Doctor on Demand contracted telehealth services.
	Specialist visit	$70 copay	$210 copay	Applies to Non-PCP providers. Copays apply per provider per date of service.
	Preventive care/screening/ immunization	No charge	Copay applies based on type of service which may be described elsewhere in the SBC.	One preventive exam, one gynecological exam with Pap smear and one mammogram per calendar year. Well-child care is covered to age 7. Copays apply per provider per date of service. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$35 copay	$105 copay	For a test in a provider's office or clinic, your cost is included in the cost-share listed above. Copay applies per date of service to covered services for physician(s) and facility combined.
	Imaging (CT/PET scans, MRIs)	$500 copay	$1,500 copay	For a test in a provider's office or clinic, your cost is included in the cost-share listed above. Copay applies per date of service to covered services for physician(s) and facility combined.

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-941-4410. You can find your Coverage Manual at www.wellmark.com/coveragemanual.

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 available at www.wellmark.com/prescriptions.	Level 1	No charge	Not covered	In-Network providers for your drug card plan are any Wellmark BlueSimplicity RX™ participating pharmacies. Drugs listed on Wellmark's BlueSimplicity RX™ Formulary Drug List are covered. Drugs not on this Drug List are not covered. Drugs on this formulary are illustrated by drug "Level" which is determined based on drug effectiveness and cost. Please refer to the Wellmark BlueSimplicity RX™ Drug List provided at www.wellmark.com for a list of covered medications and their assigned drug Levels. Drug card copays are applied per prescription for up to a 30 day supply. 3 copays apply for a 90-day supply on retail and mail order maintenance drugs. Specialty drugs are covered only when obtained through the Specialty Pharmacy Program. See wellmark.com/prescriptions for information about drugs and drug quantities that require prior authorization by Wellmark to be covered by your plan.
	Level 2	$30 copay	Not covered	
	Level 3	$125 copay	Not covered	
	Level 4	$225 copay	Not covered	
	Level 5	$350 copay	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$2,550 copay	$7,650 copay	Copays apply per date of service and are applied to covered services for physician(s) and facility combined. Copay is not waived for Facility Lab/X-ray or Diagnostic Imaging/Studies and Radiation Therapy.
	Physician/surgeon fees	Combined with facility copay	Combined with facility copay	------None------

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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	Emergency room care	$500 copay	$500 copay	For emergency medical conditions treated out-of-network, you may be balance billed. Dental treatment for accidental injury is limited to care completed within 12 months of the injury. Copays apply per date of service and are applied to covered services for physician(s) and facility combined.
	Emergency medical transportation	Copays: Ground: $500 Air: $5,750	Copays: Ground: $500 Air: $14,700	Copays apply per provider per date of service. Waive copay for in-network air ambulance for mental health/ substance abuse.
	Urgent care	$35 copay	$105 copay	Copay applies per provider per date of service.
If you have a hospital stay	Facility fee (e.g., hospital room)	$5,750 copay	$14,700 copay	Copay applies per admission to physician(s) and facility combined. Reduction for failure to precertify out-of-network services is 50% and will not exceed $500 per admission.
	Physician/surgeon fees	Combined with facility copay	Combined with facility copay	------None------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Copays: Office: $35 Facility: $2,550	Copays: Office: $105 Facility: $7,650	Office copay applies per provider per date of service. Facility copay applies per provider per date of service to covered services for physician(s) and facility combined.
	Inpatient services	$5,750 copay	$14,700 copay	Copay applies per admission to physician(s) and facility combined. Reduction for failure to precertify out-of-network services is 50% and will not exceed $500 per admission.
If you are pregnant	Office visits	$35 copay	$105 copay	Copays apply per provider per date of service. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	Combined with inpatient services	Combined with inpatient services	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	$5,750 copay	$14,700 copay	Copay applies per admission to physician(s) and facility combined. Healthy newborn is subject to a separate inpatient facility copay.

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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	$70 copay	$210 copay	$2,550 in-network/$7,650 out-of-network copay applies to home infusion therapies. Home health care copays apply per provider per date of service. Reduction for failure to precertify is 50% per covered service.
	Rehabilitation services	Copays: Office: $35 Outpatient: $70	Copays: Office: $105 Outpatient: $210	Copay applies per provider per date of service.
	Habilitation services	Copays: Office: $35 Outpatient: $70	Copays: Office: $105 Outpatient: $210	Copay applies per provider per date of service.
	Skilled nursing care	$5,750 copay	$14,700 copay	Copay applies per admission to physician(s) and facility combined. Reduction for failure to precertify out-of-network services is 50% and will not exceed $500 per admission.
	Durable medical equipment	$70 copay	$210 copay	Copays apply per date of service.
	Hospice services	$5,750 copay	$14,700 copay	Hospice respite care is limited to 15 inpatient and 15 outpatient days per lifetime. Copays apply per date of service and are applied to covered services for physician(s) and facility combined.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Vision services apply to members under age 19 and are provided by Avesis participating providers. One diagnostic vision exam per calendar year.
	Children's glasses	$130 allowance followed by cost-share	Not covered	No cost-share for vision services up to $130 per calendar year. Amounts in excess apply cost-share of 80% for frames/lenses or 85% for contact lenses. Limited to two spectacle lenses/one frame or contact lenses (in lieu of eye glasses) per calendar year.
	Children's dental check-up	No charge	Not covered	Dental services apply to members under age 19 and are provided by Delta Dental of South Dakota. Limited to twice per calendar year for diagnostic and preventive services.

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-941-4410. You can find your Coverage Manual at www.wellmark.com/coveragemanual.

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.)	
• Abortion (except for complications of non-covered abortion, or when the life of the mother is at risk) • Acupuncture • Cosmetic surgery • Custodial care - in home or facility • Dental care - Adult • Extended home skilled nursing	• Hearing aids • Long-term care • Routine eye care - Adult • 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.)	
• Bariatric surgery ($5,750 IN/$14,700 OON copays apply) • Chiropractic care • Infertility treatment (excludes some services) • 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 Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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 1-800-941-4410, South Dakota Division of Insurance at 605-773-3563, or Employee Benefits Security Administration at 1-866-444-3272 or 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.

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	$0
PCP copayment	$35
Hospital(facility) copayment	$5,750
Other not covered	Not Covered

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$5,750
Coinsurance	$0
What isn't covered	
Limits or exclusions	**$60**
The total Peg would pay is	**$5,800**

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

The plan's overall deductible	$0
Specialist copayment	$70
Hospital(facility) copayment	$2,550
Other copayment	$70

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$2,600
Coinsurance	$0
What isn't covered	
Limits or exclusions	**$200**
The total Joe would pay is	**$2,800**

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

The plan's overall deductible	$0
Specialist copayment	$70
Hospital(facility) copayment	$500
Other copayment	$70

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,400
Coinsurance	$0
What isn't covered	
Limits or exclusions	**$0**
The total Mia would pay is	**$1,400**

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.