Wellmark

EnhancedBlue℠ 1000 PPO

Coverage Period: 01/01/2016 – 12/31/2016
Coverage for: Single & Family | **Plan Type:** PPO

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.wellmark.com or by calling 1-800-990-1106.

Important Questions	Answers	Why this Matters:
What is the overall **deductible**?	**$1,000** person/**$2,000** family per calendar year Does not apply to well-child care, in-network preventive care, in-network independent labs, in-network prosthetic limbs and services subject to copayments.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the Common Medical Event chart on the following pages for how much you pay for covered services after you meet the **deductible**.
Are there other **deductibles** for specific services?	No. There are no other **deductibles**.	You don't have to meet **deductibles** for specific services, but see the Common Medical Event chart on the following pages for other costs for services this plan covers.
Is there an **out–of–pocket limit** on my expenses?	Yes. In-Network: **$4,000** person/ **$8,000** family per calendar year Out-Of-Network: **$8,000** person/ **$16,000** family per calendar year	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the **out–of–pocket limit**?	Premiums, pre-service review denials, 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**.
Is there an overall annual limit on what the plan pays?	No.	See the Common Medical Event chart on the following pages which describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a **network** of **providers**?	Yes. See www.wellmark.com for a list of in-network providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the Common Medical Event chart on the following pages for how this plan pays different kinds of **providers**.
Do I need a referral to see a **specialist**?	No. You do not need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.

Questions: Call 1-800-990-1106 or visit us at www.wellmark.com. If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at **www.cciio.cms.gov** or call 1-800-990-1106 to request a copy.

Important Questions	Answers	Why this Matters:
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments**, and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an		Limitations & Exceptions
		In-Network (IN) Provider	Out-of-Network (OON) Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay	30% coinsurance	Primary Care Practitioners (PCP) are defined as General and Family Practice, Internal Medicine, OB/GYN, Pediatricians, Nurse Practitioners, and PAs. In-network office radiation therapy/cardiac tests and certain imaging services apply deductible and 20% coinsurance.
	Specialist visit	$40 copay	30% coinsurance	Applies to Non-PCP providers. In-network office radiation therapy/cardiac tests and certain imaging services apply deductible and 20% coinsurance.
	Other practitioner office visit	$20 copay for Chiropractors	30% coinsurance for Chiropractors	In-network office certain imaging services apply deductible and 20% coinsurance.
	Preventive care/screening/ immunization	No charge	30% coinsurance	One preventive exam and one gynecological exam per calendar year. One mammogram per calendar year. Well-child care is covered to age 7.

Common Medical Event	Services You May Need	Your Cost If You Use an		Limitations & Exceptions
		In-Network (IN) Provider	Out-of-Network (OON) Provider	
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	30% coinsurance	For a test in a provider's office or clinic, your cost is included in the cost-share listed above. In-network independent labs for mental health/substance abuse services are not subject to coinsurance. Failure to obtain prior approval for services listed on Wellmark.com will result in denial with review rights.
	Imaging (CT /PET scans, MRIs)	20% coinsurance	30% coinsurance	Failure to obtain prior approval for imaging services listed on Wellmark.com will result in denial.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.wellmark.com.	Generic drugs	$5 copay	Not Covered	Drugs listed on Wellmark's Drug List are covered. Drugs not on the Drug List are not covered. 1 copay for 30-day supply. 3 copays for 90-day supply (Retail and mail order maintenance). Specialty drugs are covered only when obtained through the Specialty Pharmacy Program. Failure to obtain prior authorization or prior approval for drugs listed on Wellmark.com will result in denial with review rights.
	Preferred brand drugs	$35 copay	Not Covered	
	Non-preferred brand drugs	$70 copay	Not Covered	
	Select non-preferred brand drugs	$70 copay	Not Covered	
	Specialty drugs	Preferred: $70 copay Non-preferred: 50% coinsurance	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance	Failure to obtain prior approval for services listed on Wellmark.com will result in denial with review rights.
	Physician / surgeon fees	20% coinsurance	30% coinsurance	Failure to obtain prior approval for services listed on Wellmark.com will result in denial with review rights.

Common Medical Event	Services You May Need	Your Cost If You Use an		Limitations & Exceptions
		In-Network (IN) Provider	Out-of-Network (OON) Provider	
If you need immediate medical attention	Emergency room services	$250 copay	$250 copay	For emergency medical conditions treated OON, you may be balance billed. Dental treatment for accidental injury is limited to care completed within 12 months of the injury.
	Emergency medical transportation	20% coinsurance	20% coinsurance	------None------
	Urgent care	$20 PCP/$40 Non-PCP copay	30% coinsurance	In-network office cardiac tests and certain imaging services apply deductible and 20% coinsurance. Benefits shown apply to office/clinic practitioners. The cost you will pay for facility services will depend on how the facility bills the services.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance	Reduction for failure to precertify is 50% and will not exceed $500 per admission.
	Physician / surgeon fee	20% coinsurance	30% coinsurance	Failure to obtain prior approval for services listed on Wellmark.com will result in denial with review rights.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Office: $20 copay Facility: 20% coinsurance	30% coinsurance	In-network office certain imaging services apply deductible and 20% coinsurance.
	Mental/Behavioral health inpatient services	20% coinsurance	30% coinsurance	Reduction for failure to precertify is 50% and will not exceed $500 per admission.
	Substance use disorder outpatient services	Office: $20 copay Facility: 20% coinsurance	30% coinsurance	In-network office certain imaging services apply deductible and 20% coinsurance.
	Substance use disorder inpatient services	20% coinsurance	30% coinsurance	Reduction for failure to precertify is 50% and will not exceed $500 per admission.
If you are pregnant	Prenatal and postnatal care	20% coinsurance	30% coinsurance	------None------
	Delivery and all inpatient services	20% coinsurance	30% coinsurance	------None------

Common Medical Event	Services You May Need	Your Cost If You Use an		Limitations & Exceptions
		In-Network (IN) Provider	Out-of-Network (OON) Provider	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	30% coinsurance	Reduction for failure to precertify is 50%.
	Rehabilitation services	Office: $20 PCP/ $40 Non-PCP copay Facility: 20% coinsurance	30% coinsurance	Reduction for failure to precertify is 50% and will not exceed $500 per admission.
	Habilitative services	Office: $20 PCP/ $40 Non-PCP copay Facility: 20% coinsurance	30% coinsurance	Reduction for failure to precertify is 50% and will not exceed $500 per admission.
	Skilled nursing care	20% coinsurance	30% coinsurance	Reduction for failure to precertify is 50% and will not exceed $500 per admission.
	Durable medical equipment	20% coinsurance	30% coinsurance	Failure to obtain prior approval for services listed on Wellmark.com will result in denial with review rights.
	Hospice service	20% coinsurance	30% coinsurance	Hospice respite care is limited to 15 inpatient and 15 outpatient days per lifetime.
If your child needs dental or eye care	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.
	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 glasses) per calendar year.
	Dental check-up	Not covered	Not covered	This policy does not include pediatric dental services as required under the Federal Patient Protection and Affordable care Act. This coverage is available in the Iowa Insurance Marketplace and can be purchased as a stand-alone product.