Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services **Coverage Period: 11/01/2025 – 10/31/2026**

Coverage for: Single & Family | Plan Type: PPO

Washington County Plan D 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 1-800-524-9242. 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 (319) 653-7777 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$750** person/**$1,500** 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. In-network urgent care, in-network preventive care, in-network outpatient labs, in-network routine vision exams, in-network prosthetic limbs, in-network colonoscopies, in-network office services, services subject to drug copayments and transplant services.	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?		
What is the out-of-pocket limit for this plan?	Health: **$1,500** person/**$3,000** family per calendar year. Drug Card: **$5,600** person/**$11,200** 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, transplant services, 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- 800-524-9242 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.
Important Questions	**Answers**	**Why this Matters:**
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 copay per provider per date of service	20% coinsurance	If covered by Medicare Part A, benefits will be coordinated with benefits available under Medicare Part A and Part B, even if not enrolled in Part B. Payment will be calculated by reducing allowed charges by 80% for benefits attributable to Part B eligibility.
	Specialist visit	$20 copay per provider per date of service	20% coinsurance	Hearing exams are covered according to ACA guidelines.
	Preventive care/screening/ immunization	No charge	20% coinsurance	One preventive exam 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 provider if the services needed are preventive. Then check what your plan will pay for.
	Diagnostic test (x-ray, blood work)	10% coinsurance	20% coinsurance	For a test in a provider's office or clinic, your cost is included in the cost-share listed above. In-network labs are not subject to coinsurance.

If you have a test	Imaging (CT/PET scans, MRIs)	10% coinsurance	20% coinsurance	For a test in a provider's office or clinic, your cost is included in the cost-share listed above.

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-524-9242.

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.webaddress.com/prescriptions.	Tier 1	$5 copay per prescription	$5 copay per prescription	Refer to your Blue Rx Complete 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 or coinsurance for 30-day supply. 2 copays for 90-day supply (retail and mail order). $0 copay per prescription for over-the-counter drugs. Specialty drugs are covered only when obtained through the CVS Specialty Pharmacy Network.
	Tier 2	$30 copay per prescription	$30 copay per prescription	
	Tier 3	$50 copay per prescription	$50 copay per prescription	
	Tier 4	$50 copay per prescription	$50 copay per prescription	
	Specialty drugs	Generic: Greater of $30 copay per prescription or 0x% coinsurance Preferred: Greater of $50 copay per prescription or 0% coinsurance Non-Preferred: Greater of $100 copay per prescription or 0% coinsurance	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	20% coinsurance	Cost-share is waived for in-network colonoscopy up to $3,500, then coinsurance will apply.
	Physician/surgeon fees	10% coinsurance	20% coinsurance	Cost-share is waived for in-network colonoscopy up to $3,500, then coinsurance will apply.

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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	$100 copay and 10% coinsurance per date of service for facility and physician(s) services combined	$100 copay and 10% coinsurance per date of service for facility and physician(s) services 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.
	Emergency medical transportation	10% coinsurance	10% 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 copay per provider per date of service for facility and physician(s) combined	20% coinsurance	------None------
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	20% coinsurance	Add transplant services benefits here.
	Physician/surgeon fees	10% coinsurance	20% coinsurance	------None------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: $20 copay per provider per date of service Facility: 10% coinsurance	20% coinsurance	------None------
	Inpatient services	10% coinsurance	20% coinsurance	------None------

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-524-9242.

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 are pregnant	Office visits	10% coinsurance	20% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Cost sharing does not apply for preventive services. For any in-network services that fall outside of routine obstetric care, the office visit benefits shown above may apply.
	Childbirth/delivery professional services	10% coinsurance	20% 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	10% coinsurance	20% coinsurance	------None------
If you need help recovering or have other special health needs	Home health care	10% coinsurance	20% coinsurance	------None------
	Rehabilitation services	Office: $20 copay Facility: 10% coinsurance	20% coinsurance	Copay applies per provider per date of service.
	Habilitation services	Office: $20 copay Facility: 10% coinsurance	20% coinsurance	Copay applies per provider per date of service.
	Skilled nursing care	10% coinsurance	20% coinsurance	------None------
	Durable medical equipment	10% coinsurance	20% coinsurance	------None------
	Hospice services	10% coinsurance	20% 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	No charge	20% coinsurance	One routine vision exam per calendar year.
	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.

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
- Bariatric surgery
- Cosmetic surgery
- Custodial care - in home or facility
- Dental care - Adult
- Dental check-up
- Extended home skilled nursing
- Glasses
- Hearing aids
- Long-term care
- 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
- Chiropractic care
- Infertility treatment (excludes some services)
- Most coverage provided outside the U.S.
- Private-duty nursing - short term intermittent home skilled nursing
- Routine eye care - Adult (one vision exam per calendar 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 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: Group name at 1-000-000-0000.

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.

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 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	$750
PCP copayment	$20
Hospital(facility) coinsurance	10%
Other coinsurance	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*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$800
Copayments	$100
Coinsurance	$600
What isn't covered	
Limits or exclusions	**$60**
The total Peg would pay is	**$1,560**

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

The plan's overall deductible	$750
Specialist copayment	$20
Hospital(facility) coinsurance	10%
Other coinsurance	10%

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	$50
Copayments	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	**$20**
The total Joe would pay is	**$1,170**

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

The plan's overall deductible	$750
Specialist copayment	$20
Hospital(facility) copay and coinsurance	$100 and 10%
Other coinsurance	10%

This EXAMPLE event includes services like: Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$800
Copayments	$200
Coinsurance	$100
What isn't covered	
Limits or exclusions	**$0**
The total Mia would pay is	**$1,100**

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.