



Linn County 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 1-800-600-4149. 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 1-800-600-4149 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u>?	\$350 person/ \$700 family per calendar 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, in- <u>network</u> <u>preventive care</u> /prosthetic limbs/office visits/independent labs/ <u>urgent care</u> , office and outpatient surgery, in- <u>network</u> ambulance/home health/dme/outpatient for mental health/substance abuse and preadmission tests 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 www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No. There are no other <u>deductibles</u> .	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	\$1,050 person/ \$2,100 family per calendar 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 <u>out-of-pocket limit</u>?	Premiums, <u>balance-billed charges</u> , and health care this <u>plan</u> 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 www.wellmark.com or call 1-800-600-4149 for a list of <u>network 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's 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's</u> 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 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	10% <u>coinsurance</u>	20% <u>coinsurance</u>	Waive cost-share for office surgery and preadmission testing within 7 days of admission.
	<u>Specialist</u> visit	10% <u>coinsurance</u>	20% <u>coinsurance</u>	Waive cost-share for office surgery and preadmission testing within 7 days of admission.
	<u>Preventive care/screening/immunization</u>	No charge	20% <u>coinsurance</u>	One preventive exam and one gynecological exam per calendar year. One mammogram per calendar year. Well-child care is covered to age 7. One medical exam performed for administrative purposes is covered in addition to a preventive exam. 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 <u>plan will pay for</u> .
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u>	20% <u>coinsurance</u>	Waive cost-share for preadmission testing within 7 days of admission. Waive cost-share for in- <u>network</u> outpatient services for mental health/substance abuse.
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	20% <u>coinsurance</u>	For a test in a <u>provider's</u> office or clinic, your cost is included in the cost-share listed above.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.wellmark.com/prescriptions .	Tier 1	30% <u>coinsurance</u>	Not covered	Drugs listed on Wellmark's Blue Rx Complete Drug List 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. 30-day supply for <u>prescription drugs</u> . 90 day prescription maximum (maintenance). 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	30% <u>coinsurance</u>	Not covered	
	Tier 3	30% <u>coinsurance</u>	Not covered	
	Tier 4	30% <u>coinsurance</u>	Not covered	
	Specialty drugs	30% <u>coinsurance</u>	Not covered	

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-600-4149.

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 outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% <u>coinsurance</u>	0% <u>coinsurance</u>	-----None-----
	Physician/surgeon fees	0% <u>coinsurance</u>	0% <u>coinsurance</u>	-----None-----
If you need immediate medical attention	Emergency room care	\$100 <u>copay</u> per date of service followed by <u>deductible</u> and 10% <u>coinsurance</u> for facility and physician(s) combined	\$100 <u>copay</u> per date of service followed by <u>deductible</u> and 10% <u>coinsurance</u> for facility and physician(s) combined	For <u>emergency medical conditions</u> treated out-of-network, you may be balance billed.
	Emergency medical transportation	10% <u>coinsurance</u>	10% <u>coinsurance</u>	For covered non-emergent situations, out-of-network ambulance services are NOT reimbursed at the in-network level. The member may be balance billed for any out-of-network service. Waive cost-share for in-network ambulance services for mental health/substance abuse.
	Urgent care	10% <u>coinsurance</u>	20% <u>coinsurance</u>	Waive cost-share for office surgery and preadmission testing within 7 days of admission.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	20% <u>coinsurance</u>	Non-participating inpatient facilities actual billed charges will be reduced by 25% before <u>plan</u> benefits are applied. Reduction for failure to precertify out-of-network services is 50%.
	Physician/surgeon fees	10% <u>coinsurance</u>	20% <u>coinsurance</u>	-----None-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: 10% <u>coinsurance</u> Facility: 0% <u>coinsurance</u>	20% <u>coinsurance</u>	-----None-----
	Inpatient services	10% <u>coinsurance</u>	20% <u>coinsurance</u>	Non-participating inpatient facilities actual billed charges will be reduced by 25% before <u>plan</u> benefits are applied. Reduction for failure to precertify out-of-network services is 50%.

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-600-4149.

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% <u>coinsurance</u>	20% <u>coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Cost sharing does not apply to certain <u>preventive services</u> .
	Childbirth/delivery professional services	10% <u>coinsurance</u>	20% <u>coinsurance</u>	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% <u>coinsurance</u>	20% <u>coinsurance</u>	-----None-----
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	Waive cost-share for preadmission testing within 7 days of admission. Waive cost-share for in- <u>network</u> outpatient services for mental health/substance abuse. Reduction for failure to precertify is 50% per covered service.
	<u>Rehabilitation services</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	Waive cost-share for in- <u>network</u> outpatient services for mental health/substance abuse.
	<u>Habilitation services</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	Waive cost-share for in- <u>network</u> outpatient services for mental health/substance abuse.
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	Non-participating inpatient facilities actual billed charges will be reduced by 25% before <u>plan</u> benefits are applied. Reduction for failure to precertify out-of- <u>network</u> services is 50%.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	Waive cost-share on in- <u>network</u> services for mental health/substance abuse.
	<u>Hospice services</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	Waive cost-share for in- <u>network</u> outpatient services for mental health/substance abuse. 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 1-800-600-4149.

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.)

- 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
- Weight loss programs

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

- Acupuncture
- Applied Behavior Analysis therapy-covered subject to state mandate through age 18 subject to annual limits
- Bariatric surgery
- Chiropractic care
- Infertility treatment (\$15,000 lifetime maximum)
- 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.

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 1-800-600-4149.

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. _____

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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 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 <u>deductible</u>	\$350
■ PCP <u>coinsurance</u>	10%
■ Hospital(facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	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	\$12,800
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In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$350
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$700
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$1,110

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

■ The plan's overall <u>deductible</u>	\$350
■ <u>Specialist</u> <u>coinsurance</u>	10%
■ Hospital(facility) <u>coinsurance</u>	0%
■ Other <u>coinsurance</u>	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	\$7,400
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In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,000
What isn't covered	
Limits or exclusions	\$200
The total Joe would pay is	\$1,200

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

■ The plan's overall <u>deductible</u>	\$350
■ <u>Specialist</u> <u>coinsurance</u>	10%
■ Hospital(facility) <u>copayment</u>	\$100
■ Other <u>coinsurance</u>	10%

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
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In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$350
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$100
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$550

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.

