

# AllianceSelect<sup>SM</sup>

## Benefit Summary Iowa State Association of Counties Plan 10 - Non-Grandfathered Health Plan



An Independent Licensee of the Blue Cross and Blue Shield Association

Understanding your health benefits is the key to making educated health care decisions. Wellmark offers this summary to help you learn about your health plan coverage and the services that are typically covered or limited.

Your plan allows you to receive care from any health care provider you choose, and when you choose a health care provider who participates in the Alliance Select or BlueCard PPO<sup>®</sup> network, you reduce your out-of-pocket expenses. Need help finding an in-network provider or have specific benefit questions? Visit us and register at [www.wellmark.com](http://www.wellmark.com), refer to your coverage manual or call the Customer Service number on your ID card.

Health Plan Basics	In-Network Benefit	Out-of-Network Benefit
Benefit Period Deductible <i>Amount you pay in a calendar year before benefits are available.</i>	\$1,000 Single \$2,000 Family	
Coinsurance – Office Services <i>Percentage you pay at the time you receive certain office-based services. (Deductible waived.)</i>	20% coinsurance	40% coinsurance after deductible
Coinsurance – Emergency Room <i>Percentage you pay for emergency room and related facility and practitioner services.</i>	20% coinsurance after deductible	Non-Emergency Services: 40% coinsurance after deductible  Emergency Services*: 20% coinsurance after deductible
Coinsurance <i>Percentage of medical expenses you pay after the deductible is met (unless otherwise noted), until you reach your out-of-pocket maximum.</i>	20% coinsurance	40% coinsurance after deductible
Out-of-Pocket Maximum (OPM) <i>Maximum amount you pay for covered services each calendar year. Deductible and coinsurance apply to OPM. Once your OPM is satisfied, most services are covered in-full through the end of the calendar year.</i>	\$2,000 Single \$4,000 Family	
Lifetime Limits on Essential Benefits <i>Essential benefits: a set of health care service categories defined as “essential” by the Affordable Care Act (ACA). Examples of a few ACA defined categories include: emergency services, hospitalization, maternity and newborn care, prescription drugs, and preventive and wellness services.</i>	Unlimited	
Other Allowable Lifetime Limits <i>Maximum amount each covered family member is eligible to receive under this plan, for non-essential covered services, in his/her lifetime.</i>	<b>Infertility</b> – Limited to \$15,000 per lifetime; coinsurance does not apply to out-of-pocket maximum.	
Annual Limits on Essential Benefits	None	
Other Allowable Annual Day/Visit Limits	<b>Nursing Facility Care</b> – Limited to 90 days per benefit period. <b>Hospice Respite</b> – Limited to 15 days inpatient/15 days outpatient per lifetime.	
Care Outside Iowa – BlueCard <sup>®</sup> program	Provides coverage nationwide by using providers of the Blue Cross and/or Blue Shield plan in the area where you receive services. You must use an in-network provider to receive the highest benefit level.	
*Out-of-Network Emergency Services	Covered emergency services for medical conditions that a prudent layperson expects would otherwise result in death, permanent disability, or severe pain will be reimbursed as though services were received from a participating provider. You are responsible for any excess of the provider's billed charge over our settlement amount.	
Covered Benefits <i>When you receive these services, you pay:</i>	In-Network Benefit	Out-of-Network Benefit
Office Services Physician services, X-rays, labs, etc.	20% coinsurance	40% coinsurance after deductible
Independent Lab Services	20% coinsurance after deductible	40% coinsurance after deductible
Chiropractic Care Office Services	20% coinsurance	40% coinsurance after deductible

<b>Covered Benefits</b> <i>When you receive these services, you pay:</i>	<b>In-Network Benefit</b>	<b>Out-of-Network Benefit</b>
<b>Preventive Care Services</b> <ul style="list-style-type: none"> <li>Physical exam (one per benefit period; includes gynecological exam)</li> <li>Immunizations</li> <li>X-ray/labs</li> <li>Mammogram</li> <li>Pap smears</li> <li>Prostate screening</li> <li>Colonoscopies</li> <li>Well-child care</li> <li>Smoking cessation counseling</li> <li>Obesity counseling/screening</li> <li>Child hearing and vision screening</li> </ul>	No cost share	No cost share
<b>Mental Health/Chemical Dependency</b> <ul style="list-style-type: none"> <li>Office visit</li> <li>Outpatient Services</li> <li>Inpatient Services</li> </ul>	20% coinsurance  20% coinsurance after deductible  20% coinsurance after deductible	40% coinsurance after deductible
<b>Maternity Care</b> <ul style="list-style-type: none"> <li>Physician services</li> <li>Facility services</li> </ul>	20% coinsurance after deductible	40% coinsurance after deductible
<b>Contraceptives</b> Injected and implanted contraceptives and contraceptive devices. (oral contraceptives are covered under your drug program, see Prescription Drugs) <ul style="list-style-type: none"> <li>Office services</li> <li>Facility services</li> </ul>	20% coinsurance  20% coinsurance after deductible	40% coinsurance after deductible
<b>Prescription Drugs</b>	Covered under Blue Rx Preferred <sup>SM</sup> prescription drug program. Please refer to your drug plan benefit summary for more information.	
<b>Dental Treatment</b> For accidental injury only, if completed within 12 months of the injury.	20% coinsurance after deductible	40% coinsurance after deductible
<b>Physician Services</b> <ul style="list-style-type: none"> <li>Inpatient facility care</li> <li>Outpatient facility care</li> </ul>	20% coinsurance after deductible	40% coinsurance after deductible
<b>Facility Services</b> (deductible waived for in-network preventive care) <ul style="list-style-type: none"> <li>Inpatient hospital</li> <li>Outpatient hospital</li> <li>Nursing facility</li> </ul>	20% coinsurance after deductible	40% coinsurance after deductible
<b>Ambulance</b>	20% coinsurance after deductible	40% coinsurance after deductible
<b>Emergency Room</b> (if admitted, see Facility Services) <ul style="list-style-type: none"> <li>Facility services</li> <li>Physician services</li> </ul>	20% coinsurance after deductible	<b>Non-Emergency Services:</b> 40% coinsurance after deductible  <b>Emergency Services*:</b> 20% coinsurance after deductible
<b>Home/Durable Medical Equipment</b> (deductible waived for in-network prosthetic limbs)	20% coinsurance after deductible	40% coinsurance after deductible
<b>Home Health Care</b>	20% coinsurance after deductible	40% coinsurance after deductible
<b>Hospice Services</b>	20% coinsurance after deductible	40% coinsurance after deductible

**Important Notes and Disclosures**

This is a general description of coverage. It is not a statement of contract. Actual coverage is subject to terms and conditions specified in the coverage manual you will receive after you enroll and the enrollment regulations in force when the manual becomes effective. Certain exclusions and limitations apply.

Wellmark is not providing any legal advice with regard to compliance with the requirements of the Affordable Care Act ("ACA") and Mental Health Parity and Addiction Equity Act ("MHPAEA"). Regulations and guidance on specific provisions of the ACA and MHPAEA have been and will continue to be provided by the U.S. Department of Health and Human Services ("HHS") and/or other agencies. The information provided reflects Wellmark's understanding of the most current information and is subject to change without further notice. Please note that plan benefits, rates, renewal rate adjustments, and rating impact calculations are subject to change and may be revised during a plan's rating period based on guidance and regulations issued by HHS or other agencies. Wellmark makes no representation as to the impact of plan changes on a plan's grandfathered status or interpretation or implementation of any other provisions of ACA or MHPAEA. Any questions about Wellmark's approach to the ACA or MHPAEA may be referred to your Wellmark account representative. Wellmark will not determine whether coverage is discriminatory or otherwise in violation of Internal Revenue Code Section 105(h). Wellmark also will not provide any testing for compliance with Internal Revenue Code Section 105(h). Wellmark will not be held liable for any penalties or other losses resulting from any employer offering coverage in violation of section 105(h).