Ruan Basic HSA HDHP PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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 Medical coverage, visit www.wellmark.com or call 1-800-524-9242 or for Pharmacy coverage, visit www.express-scripts.com/RuanTransportCorporation or call 1-877-766-3613. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms see the Glossary. You can view the Glossary at <u>www.healthcare.gov/sbc-glossary</u> or call 1-800-211-6773 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$3,300 person/ \$6,600 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 and in- <u>network</u> preventive care 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 <u>www.healthcare.gov/coverage/preventive-care-benefits/</u> .
Are there other <u>deductibles</u> for specific services?	No. There are no other <u>deductible</u> s.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	In- <u>Network</u> : \$4,950 person/ \$9,900 family per calendar year. Out-Of- <u>Network</u> : \$6,600 person/ \$13,200 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 out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan 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 <u>www.wellmark.com</u> or call 1- 800-524-9242 for a list of <u>network</u> <u>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</u> 's <u>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>referra</u> l.



All <u>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> applies.

Common Medical Event	Services You May Need	What You Will Pay In- <u>Network</u> (IN) <u>Provider</u> (You will pay the least)	What You Will Pay Out-of- <u>Network</u> (OON) <u>Provider</u> (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$30 <u>copay</u> per <u>provider</u> per date of service	30% coinsurance	None
	<u>Specialist</u> visit	\$30 <u>copay</u> per <u>provider</u> per date of service	30% coinsurance	Hearing exams are covered according to ACA guidelines.
	Preventive care/screening/ immunization	No charge	30% <u>coinsurance</u>	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 <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	30% <u>coinsurance</u>	For a test in a <u>provider</u> 's office or clinic, your cost is included in the cost-share listed above. In- <u>network</u> independent labs for mental health/substance abuse services are not subject to <u>coinsurance</u> .
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance	For a test in a <u>provider</u> 's office or clinic, your cost is included in the cost-share listed above.
If you need drugs to treat your illness or	Tier 1 Generic	\$20 or 25% whichever is greater	\$20 or 50% whichever is greater	
condition More information about <u>prescription</u> <u>drug coverage</u> is available at <u>www.express-</u> <u>scripts.com</u>	Tier 2 Select Brands	\$35 or 25% whichever is greater	\$35 or 50% whichever is greater	Deductible must be met first unless drugs fall on the Preventive Medications Standard Plus Drug list available at
	Tier 3 Non-Select Brands		\$50 or 50% whichever is greater	www.express-scripts.com 1 copay or coinsurance for 30-day supply
	Specialty drugs	Generic/select brands: \$35 or 25% whichever is greater. Non-select	Not covered	3 copays or coinsurance for 90-day supply (retail or mail) Specialty drugs are covered only when obtained through Accredo.
		brands: \$50 or 25% whichever is greater.		

For more information about limitations and exceptions, see your <u>plan</u> document or call Wellmark at 1-800-211-6773 or Express Scripts at 1-877-766-3613.

Common Medical Event	Services You May Need	What You Will Pay In- <u>Network</u> (IN) <u>Provider</u> (You will pay the least)	What You Will Pay Out-of- <u>Network</u> (OON) <u>Provider</u> (You will pay the most)	Limitations, Exceptions, & Other Important Information	
If you have	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	30% <u>coinsurance</u>	None	
outpatient surgery	Physician/surgeon fees	20% coinsurance	30% coinsurance	None	
If you need immediate medical attention	Emergency room care	\$100 <u>copay</u> and 20% <u>coinsurance</u> per date of service for facility and physician(s) combined	\$100 <u>copay</u> and 20% <u>coinsurance</u> per date of service for facility and physician(s) combined	For <u>emergency medical conditions</u> treated out-of- <u>network</u> , 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	20% <u>coinsurance</u>	20% <u>coinsurance</u>	For covered non-emergent situations, out-of- <u>network</u> ground ambulance services are NOT reimbursed at the ir <u>network</u> level. You may be balance billed for any out-of- <u>network</u> service as established under the rules developed for implementation of the No Surprises Act. Benefits for non-participating ambulance <u>providers</u> are based on actual billed charges.	
	<u>Urgent care</u>	\$30 <u>copay</u> per <u>provider</u> per date of service for facility and physician(s) combined	30% <u>coinsurance</u>	None	
If you have a hospital	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Transplants are limited to Blue Distinction Centers.	
stay	Physician/surgeon fees	20% coinsurance	30% <u>coinsurance</u>	None	
lf you need mental health, behavioral health, or substance	Outpatient services	Office: \$30 <u>copay</u> per <u>provider</u> per date of service Facility: 20% coin	30% <u>coinsurance</u>	None	
abuse services	Inpatient services	20% coinsurance	30% <u>coinsurance</u>	None	

For more information about limitations and exceptions, see your <u>plan</u> document or call Wellmark at 1-800-211-6773 or Express Scripts at 1-877-766-3613.

Common Medical Event	Services You May Need	What You Will Pay In- <u>Network</u> (IN) <u>Provider</u> (You will pay the least)	What You Will Pay Out-of- <u>Network</u> (OON) <u>Provider</u> (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you are pregnant	Office visits	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Cost sharing does not apply for <u>preventive services</u> . For any in- <u>network</u> services that fall outside of routine obstetric care, the office visit benefits shown above may apply.
	Childbirth/delivery professional services	20% coinsurance	30% 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	20% coinsurance	30% coinsurance	None
	Home health care	20% coinsurance	30% coinsurance	None
If you need help recovering or have other special health needs	Rehabilitation services	Office: \$30 <u>copay</u> per <u>provider</u> per date of service Facility: 20% coin	30% coinsurance	None
	Habilitation services	Office: \$30 <u>copay</u> per <u>provider</u> per date of service Facility: 20% coin	30% <u>coinsurance</u>	None
	Skilled nursing care	20% coinsurance	30% coinsurance	None
	Durable medical equipment	20% coinsurance	30% coinsurance	None
	Hospice services	20% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Children's eye exam	Not covered	Not covered	None
If your child needs dental or eye care	Children's glasses	Not covered	Not covered	None
dental of cyc care	Children's dental check-up	Not covered	Not covered	None

For more information about limitations and exceptions, see your <u>plan</u> document or call Wellmark at 1-800-211-6773 or Express Scripts at 1-877-766-3613.

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 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 <u>plan</u> document.)					
 Applied Behavior Analysis therapy Bariatric surgery Chiropractic care Infertility treatment (excludes some services) Most coverage provided outside the U.S. 	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. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the https://www.HealthCare.gov or call 1-800-318-2596.

Your <u>Grievance</u> and <u>Appeals</u> Rights: There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, you can contact: Wellmark at 1-800-211-6773 or Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <u>www.dol.gov/ebsa/healthreform</u>

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 <u>plan</u> 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.

About These Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby (9 months of in- <u>network</u> pre-natal care and a hospital delivery)		Managing Joe's type 2 Diabetes (a years of routine in- <u>network</u> care of a well- controlled condition)		Mia's Simple Fracture (in- <u>network</u> emergency room visit and follow up care)	
 The plan's overall <u>deductible</u> PCP <u>copayment</u> Hospital(facility) <u>coinsurance</u> Other <u>coinsurance</u> 	\$3,300 \$30 20% 20%	 The plan's overall <u>deductible</u> <u>Specialist copayment</u> Hospital(facility) <u>coinsurance</u> Other <u>coinsurance</u> 	\$3,300 \$30 20% 20%	 The plan's overall <u>deductible</u> <u>Specialist copayment</u> Hospital(facility) <u>copay</u> and <u>coins</u> 20% 	\$3,300 \$30 <u>surance</u> \$100 and
This EXAMPLE event includes served Specialist office visits (prenatal care) Childbirth/Delivery Professional Served Childbirth/Delivery Facility Services Diagnostic tests (ultrasounds and block Specialist visit (anesthesia)	ices	This EXAMPLE event includes so Primary care physician office visits disease education) Diagnostic tests (blood work) Prescription drugs Durable medical equipment (gluco	(including	 Other <u>coinsurance</u> This EXAMPLE event includes set Emergency room care (including me supplies) <u>Diagnostic test</u> (x-ray) <u>Durable medical equipment</u> (crutche 	edical
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
Cost Sharing		Cost Sharing		Cost Sharing	
Deductibles	\$3,300	Deductibles	\$1,200	Deductibles	\$2,795
Copayments	\$0	Copayments	\$0	Copayments	\$0
Coinsurance What isn't covered	\$1,500	<u>Coinsurance</u>	\$0	Coinsurance	\$0
What isn't covered		What isn't covered		What isn't covered	
Limits or exclusions	\$70	Limits or exclusions	\$4,300	Limits or exclusions	\$5
The total Peg would pay is	\$4,860	The total Joe would pay is	\$5,550	The total Mia would pay is	\$2,110

The amounts shown in the maternity <u>claim</u> example above are based on amounts using a single per person <u>deductible</u>. Some <u>plans</u> may actually apply a two-person or family <u>deductible</u> to maternity services for the mother and newborn baby.

The <u>plan</u> would be responsible for the other costs of these EXAMPLE covered services.



Wellmark Language Assistance

Discrimination is against the law

Wellmark Blue Cross and Blue Shield complies with applicable state and federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

Wellmark provides:

- Free aids and services to people with disabilities so they may communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as: – Qualified interpreters
 - Information written in other languages

You have the right to get this information and help in your language for free. If you need these services, call 800-524-9242.

ATENCIÓN: Si habla español, los servicios de asistencia de idiomas se encuentran disponibles gratuitamente para usted. Comuníquese al 800-524-9242 o al (TTY: 888-781-4262).

注意:如果您说普通话,我们可免费为您提供语言协助服务。请拨打 800-524-9242 或 (听障专线: 888-781-4262)。

CHÚ Ý: Nếu quý vị nói tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ miễn phí có sẵn cho quý vị. Xin hãy liên hệ 800-524-9242 hoặc (TTY: 888-781-4262).

NAPOMENA: Ako govorite hrvatski, dostupna Vam je besplatna podrška na Vašem jeziku. Kontaktirajte 800-524-9242 ili (tekstualni telefon za osobe oštećena sluha: 888-781-4262).

ACHTUNG: Wenn Sie deutsch sprechen, stehen Ihnen kostenlose sprachliche Assistenzdienste zur Verfügung. Rufnummer: 800-524-9242 oder (TTY: 888-781-4262).

تنبيه: إذا كنت تتحدث اللغة العربية. فإننا نوفر لك خدمات المساعدة اللغوية، المجانية. اتصل بالرقم 800-524-9242 أو (خدمة الهاتف النصي: 888-781-4262).

ສິ່ງຄວນເອົາໃຈໃສ່, ພາສາລາວ ຖ້າທ່ານເວົ້າ: ພວກເຮົາມີບໍລິການຄວາມຊ່ວຍເຫຼືອດ້ານພາສາ ໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ ຫຼື 800-524-9242 ຕິດຕໍ່ທີ່. (TTY: 888-781-4262.)

주의: 한국어 를 사용하시는 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 800-524-9242번 또는 (TTY: 888-781-4262)번으로 연락해 주십시오.

ध्यान रखें : अगर आपकी भाषा हिन्दी है, तो आपके लिए भाषा सहायता सेवाएँ, निःशुल्क उपलब्ध हैं। 800-524-9242 पर संपर्क करें या (TTY: 888-781-4262)।

ATTENTION : si vous parlez français, des services d'assistance dans votre langue sont à votre disposition gratuitement. Appelez le 800 524 9242 (ou la ligne ATS au 888 781 4262).

Geb Acht: Wann du Deitsch schwetze duscht, kannscht du Hilf in dei eegni Schprooch koschdefrei griege. Ruf 800-524-9242 odder (TTY: 888-781-4262) uff.

โปรดุทราบ: หากคุณพูด ไทย เรามีบริการช่วยเหลือด้านภาษาสำหรับคุณโดยไม่คิด ค่าใช้จ่าย ติดต่อ 800-524-9242 หรือ (TTY: 888-781-4262)

PAG-UKULAN NG PANSIN: Kung Tagalog ang wikang ginagamit mo, may makukuha kang mga serbisyong tulong sa wika na walang bayad. Makipag-ugnayan sa 800-524-9242 o (TTY: 888-781-4262).

တါဒုံးသွင်ညါ–နမ္နါကတိၤကညီကိုဂ်.ကျိဂ်တါမးစၤဟာဖ်းတာမၤတဖင်္ဂ.လၢတဘာဉ်လာဘာ့ၤလဲ.အိဉ်လၢနဂိၢိလိၤ.ဆဲးကျိုးဆူ ၈၀၀–၅၂၄–၉၂၄၂မှတမ့်(TTY:၈၈၈–၇၈၁–၄၂၆၂)တက္.

ВНИМАНИЕ! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. Обращайтесь 800-524-9242 (телетайп: 888-781-4262).

सावधान: यदि तपाईं नेपाली बोल्नुहुन्छ भने, तपाईंका लागि नि:शुल्क रूपमा भाषा सहायता सेवाहरू उपलब्ध गराइन्छ । 800-524-9242 वा (TTY: 888-781-4262) मा सम्पर्क गर्नुहोस् ।

HEETINA To a wolwa Fulfulde laabi walliinde dow wolde, naa e njobdi, ene ngoodi ngam maaɗa. Heɓir 800-524-9242 malla (TTY: 888-781-4262).

FUULEFFANNAA: Yo isin Oromiffaa, kan dubbattan taatan, tajaajiloonni gargaarsa afaanii, kaffaltii malee, isiniif ni jiru. 800-524-9242 yookin (TTY: 888-781-4262) quunnamaa.

УВАГА! Якщо ви розмовляєте українською мовою, для вас доступні безкоштовні послуги мовної підтримки. Зателефонуйте за номером 800-524-9242 або (телетайп: 888-781-4262).

Ge': Diné k'ehjí yáníłti'go níká bizaad bee áká' adoowoł, t'áá jiik'é, náhóló. Koji' hólne' 800-524-9242 doodaii' (TTY: 888-781-4262)

Wellmark Blue Cross and Blue Shield of Iowa, Wellmark Health Plan of Iowa, Inc. and Wellmark Blue Cross and Blue Shield of South Dakota are independent licensees of the Blue Cross and Blue Shield Association.