



Employee Benefits

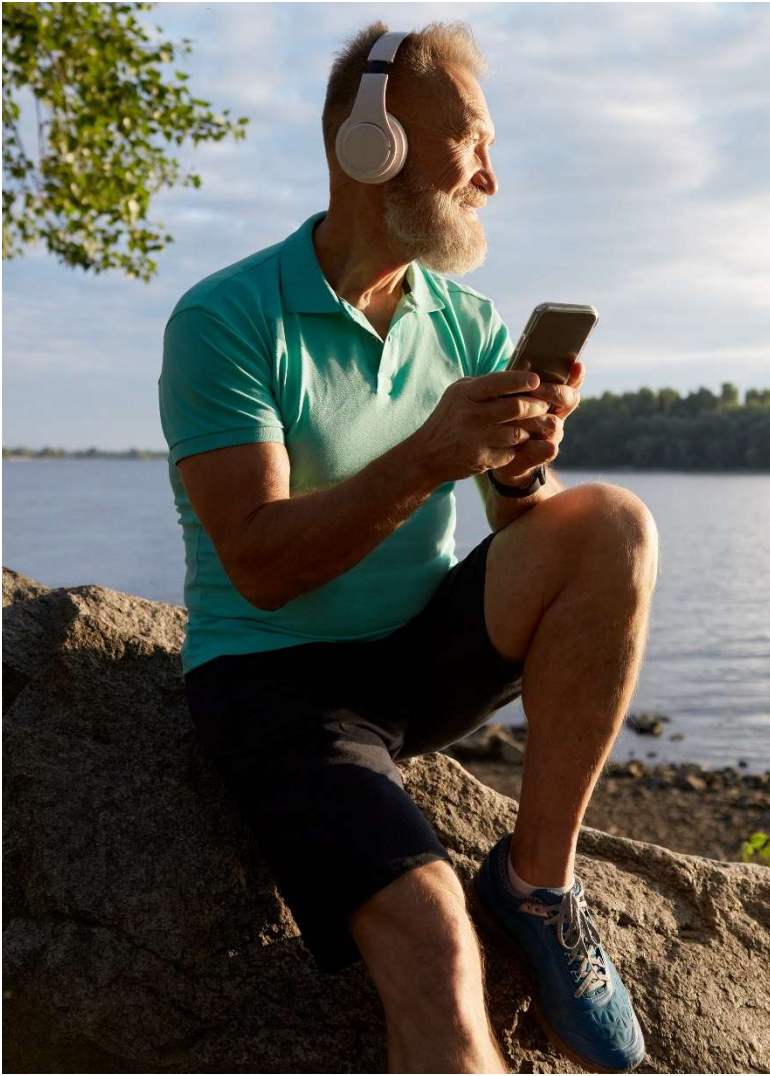


PHYSICIANS' CLINIC
of Iowa, P.C.

2026

Benefit Guide

Non-Shareholder Physician



Welcome to Your Benefits!

This benefit summary describes the benefit plans available to you as an employee of **Physicians' Clinic of Iowa**. The details of these plans are contained in the official plan documents that have been provided to you by your employer, including some insurance contracts. This summary is meant only to cover the highlights of each plan. It does not contain all the details that are included in your summary plan description as described by the Employee Retirement Income Security Act (ERISA).

If there is ever a question about one of these plans, or if there is a conflict between the information in this summary and the formal language of the plan documents, the formal wording in the plan documents will govern. Please note that the benefits described in the summary may be changed at any time and do not represent a contractual obligation on the part of **Physicians' Clinic of Iowa**.

Table of Contents

Welcome!	3	Life Insurance	14
Benefits Eligibility	4	Disability Insurance	15
Choose Your Medical Plan	5	Employee Contributions	16
Medical Plan Comparison	6	How do I Enroll?	17
Pharmacy	7	Benefits Definitions	18-19
Understanding How Your Plan Works	8	Important Contacts	20
Telehealth Benefits	9	Annual Notices	21-38
Health Savings Account (HSA)	10-11	SBC-Plan 1 \$2500 PPO	39-45
Dental Plan	12	SBC-Plan 2 \$2500 HMO	46-52
Vision Plan	13	SBC-Plan 3 \$4000 HDHP	53-60



Welcome!

We are committed to providing competitive benefit programs that are flexible enough to meet your individual needs.

Our comprehensive benefits are carefully designed to give you the tools you need to keep you and your family healthy, provide financial protection in the event of unforeseen circumstances and help you build long-term security for retirement.

Getting the most from your benefits is up to you. You know your family, your goals and your lifestyle best.

This benefits guide was designed to answer some of the basic questions you may have about your benefits. Please take the time to review this guide to make sure you understand the benefits that are available to you and your family and be sure to act before the enrollment deadline.



Benefits Eligibility

You and your eligible family members may participate in the 2026 employee benefits program if you're a Physicians' Clinic of Iowa employee working 20 hours a week or more.



New-Hire Eligibility

New hires can join the plan the first of the month following date of hire.

Your initial enrollment period is within 30 days of employment.

Other opportunities to enroll occur with a change in status (see Qualifying Life Event on page 19) and during the annual Open Enrollment period.

New Hire Benefit elections will be made, or waived, online at www.workforcenow.adp.com during orientation. At that time, you can verify your personal information and make any changes if necessary.

Dependent Eligibility

You can enroll the following dependents in our group benefit plans:

- ❖ Your legal spouse
- ❖ Children up to the age of 26*
- ❖ A child under the age of 26 who is your natural child, stepchild, legally adopted child, or child for whom you have obtained legal guardianship
- ❖ Unmarried children of any age if totally disabled and claimed as dependent on your federal income tax return (documentation of handicapped status must be provided)

Enrolled children lose coverage when they turn 26 and will be mailed COBRA enrollment information.



Choose Your Medical Plan

Your medical plans will be offered through Wellmark Blue Cross Blue Shield. Please review your Summary of Benefits and Coverage (SBC) for additional coverage information and full plan details.

Elections you make will be in effect until December 31, 2026, unless you experience a qualifying life event (see Qualifying Life Event on page 19) .



Understanding Your Plan Options

Plan 1: Alliance Select \$2,500 PPO

This plan has deductible of \$2,500 per individual, and \$5,000 per family. It includes copayments for office visits and prescription drugs. Preventive care is covered at 100%. **This plan has national coverage.**

Plan 2: Blue Access \$2,500 HMO

This plan has deductible of \$2,500 per individual and \$5,000 per family. It includes copayments for office visits and prescription drugs. Preventive care is covered at 100%. **This plan has in-network coverage only.**

Plan 3: Alliance Select \$4000 PPO HDHP

This plan has the same deductible and out-of-pocket maximum amounts of \$4000 individual/\$8000 family. Enrollees pay 100% of the cost (after Wellmark's discount), until they reach \$4000/\$8000, then the plan pays 100%. Preventive care is covered at 100%. This plan is Health Savings Account (HSA) eligible. **This plan has national coverage.**



TAKE ACTION!

Register Online



Download the Mobile App



Alliance Select PPO Network vs Blue Access HMO Network

Your connection to great healthcare is only a click away. Register for an online account at mywellmark.com so you can access time-saving tools, tips for healthy living, choose a doctor, manage your EOBs, and more!

Go to mywellmark.com and click "Register now". Enter your email address and select a password. It is recommended you use a non-employer email address. Follow the prompts to complete your registration.

With the Wellmark mobile app, you've got the tools you need to manage your healthcare all from your smartphone. The mobile app is available in the Apple and Google Play store.

PPO – Plan 1 Alliance Select \$2,500 PPO and Plan 3 Alliance Select \$4,000 HDHP both use the PPO network. You may visit any medical provider you choose, but in-network providers offer the highest level of benefits and lower out-of-pocket costs.

Providers outside the plan's network charge higher rates, so you may be responsible for the difference if a provider's fees are above the Reasonable and Customary (R&C) limits.

HMO – Plan 2 Blue Access \$2,500 HMO uses the HMO network. Members receive benefits by staying within the network; there are no benefits when using out-of-network providers unless the services are for a life or limb threatening emergency.

Members on the HMO plan must select a primary care physician (PCP).

Medical Plan Comparison



Eligibility: Physicians' Clinic of Iowa employees working 20 hours or more

	Plan 1 Wellmark Alliance Select \$2,500 PPO	Plan 2 Wellmark Blue Access \$2,500 HMO*	Plan 3 Wellmark Alliance Select \$4000 High-Deductible Health Plan (HDHP) PPO
MEDICAL BENEFITS IN-NETWORK			
ANNUAL DEDUCTIBLE (Calendar Year)			
Individual	\$2,500	\$2,500	\$4,000
Family	\$5,000	\$5,000	\$8,000
OUT-OF-POCKET (OOP) MAXIMUM (Calendar Year)			
Individual	\$4,000 Medical OOP	\$4,000 Medical OOP	\$4,000 Medical and Rx OOP combined
Family	\$8,000 Medical OOP	\$8,000 Medical OOP	\$8,000 Medical and Rx OOP combined
COINSURANCE			
Preventive Care	Covered at 100%	Covered at 100%	Covered at 100%
Primary Care Physician (PCP) Office Visit	\$25 Copay	\$25 Copay	\$0 after deductible
Specialist Office Visit	\$25 Copay	\$25 Copay	\$0 after deductible
Emergency Room	20% after Deductible	20% after Deductible	\$0 after deductible
Inpatient Hospital	20% after Deductible	20% after Deductible	\$0 after deductible
Outpatient Hospital	20% after Deductible	20% after Deductible	\$0 after deductible
Urgent Care	\$25 Copay	\$25 Copay	\$0 after deductible
Outpatient Surgery	20% after Deductible	20% after Deductible	\$0 after deductible
Lab/X-Ray (Outpatient)	20% after Deductible	20% after Deductible	\$0 after deductible
Mental Health, Behavioral Health, Substance Abuse Office Visit	\$25 Copay	Covered at 100%	\$0 after deductible
Out-of-Network (OON) Co-insurance*	40%*	N/A* (out of network not covered)	0%*

*Important Reminders:

Members enrolled in Plan 2 (\$2,500 Blue Access HMO) must select a Primary Care Physician (PCP). Members should elect their PCP on www.mywellmark.com or by calling Wellmark customer service.

If you go to an out-of-network provider, your cost may be higher, and your provider may ask you to pay the actual charge for your care at the time of your visit.

Prescription Drug Coverage



CVS Caremark



	Plan 1 Wellmark Alliance Select \$2500 PPO	Plan 2 Wellmark Blue Access \$2500 HMO	Plan 3 Wellmark Alliance Select \$4000 High-Deductible Health Plan (HDHP) PPO	
Prescription Drug Coverage				
Retail 30-day supply	Tier 1	\$10 Copay	\$10 Copay	\$0 after deductible
	Tier 2	\$35 Copay	\$35 Copay	\$0 after deductible
	Tier 3	\$75 Copay	\$75 Copay	\$0 after deductible
	Tier 4	\$150 Copay	\$150 Copay	\$0 after deductible
Specialty Drugs (on Prudent Rx Drug List)				
(Covered only when obtained through Specialty Pharmacy Program). If you choose to opt-in to the PrudentRx program: If you choose to opt-out of the PrudentRx program: *The 30% coinsurance does not count towards out-of-pocket maximum	\$0 30%*	\$0 30%*	\$0 after deductible \$0 after deductible	
Specialty Drugs (not on Prudent Rx Drug List) (Covered only when obtained through Specialty Pharmacy Program).	\$100	\$100	\$0 after deductible	
Prescription Drug Out-of-Pocket Maximum (OOP)				
Individual	\$2,250 Rx OOP Separate from Medical OOP	\$2,250 Rx OOP Separate from Medical OOP	\$4,000 Medical and Rx combined	
Family	\$4,500 Rx OOP Separate from Medical OOP	\$4,500 Rx OOP Separate from Medical OOP	\$8,000 Medical and Rx combined	



Understanding How Your Plan Works

1

YOUR FAMILY

visits your provider (doctor/hospital) and shows their medical insurance card

2

YOUR DOCTOR OR PROVIDER

will bill your medical carrier

3

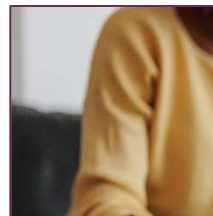
YOUR MEDICAL CARRIER

will process your claim, notify your provider, and send a Claims Summary to you and your provider

4

EXPLANATION OF BENEFITS (EOB)

You are responsible to pay the amount due to your provider as shown on your EOB



Telehealth Benefits

With telehealth, you can schedule a virtual appointment with board-certified doctors and pediatricians who can diagnose, treat and prescribe most medications for minor medical conditions, such as:

- Acne
- Allergies
- Asthma
- Bronchitis
- Cold and flu
- Constipation
- Earaches
- Fever
- Headaches
- Infections
- Insect bites
- Joint aches
- Nausea
- Pink eye
- Rashes
- Respiratory infections
- Shingles
- Sinus infections
- Skin infections
- Sore throats
- Urinary tract infections

We've all been there—it's the middle of the night and you have a sick child or maybe you are trying to get an appointment with your primary care provider, but the first appointment isn't for two weeks. Good news... there's an easier way! Telehealth is a convenient option for scheduling virtual doctor visits from your own home. With telehealth, you don't have to drive to the doctor's office or sit in a waiting room when you're sick—you can see your doctor from the comfort of your own bed or sofa.

- See a board-certified, licensed, telehealth trained doctor on your schedule with on-demand virtual visits 24/7, including holidays.
- Get treated for more than 80 common conditions including colds, flu, allergies and more.
- Get a prescription or short-term refill of any existing prescription sent to a pharmacy nearby, in less time than your usual doctor visit.
- Avoid costly copays and deductibles of the ER and urgent care clinic.

To access telehealth benefits please , download the Doctor on Demand app, or visit [DoctorOnDemand.com](https://www.DoctorOnDemand.com).
(You will need your Wellmark ID card available to create your Doctor on Demand account).



Health Savings Account (HSA)



What is a Health Savings Account?

A Health Savings Account (HSA) is a way for you to save pre-tax dollars that can be used to pay for qualified healthcare expenses like deductibles, copays, coinsurance, prescriptions, vision and dental expenses. High-deductible health plans have lower premiums and may result in lower annual medical costs. These plans offer several advantages to reward you for taking an active role in your healthcare spending.



Lower Paycheck Costs

Allowing you to keep more control of your money



Tax-Advantaged Savings Account

Enrolling in and contributing to a Health Savings Account (HSA) helps you pay your deductible and out-of-pocket costs



Comparable Benefits

These plans use the same networks that other plans offer, and in-network preventive care is still covered at 100%

Who is Eligible for an HSA?

Must be enrolled in a high-deductible health plan

Cannot be covered by any other medical plan that is not a qualified HDHP. This includes a spouse's medical coverage unless it's also a qualified HDHP

Cannot be enrolled in Medicare, including Parts A or B, Medicaid or Tricare

Cannot be claimed as a dependent on another person's tax return

Cannot be a veteran who has received treatment, other than preventive care, through the Department of Veterans Affairs within the past three months

For a list of eligible expenses, see IRS Publication 502, available at www.irs.gov.

Health Savings Account (HSA)

Continued

HSAs and Your Taxes

All withdrawals from your HSA are tax-free, as long as you use the money to pay for eligible health care expenses. In addition, all the money in the account is yours and will never be forfeited. It rolls over from year to year, and you can take it with you if you leave the company or retire. After age 65, you can withdraw funds for any reason without a tax penalty — you pay ordinary income tax only if the withdrawal isn't for eligible health care expenses.

How Much Can I Contribute?

Employee only coverage per calendar year:

\$4,400

Employee plus dependents coverage:

\$8,750

Anyone 55+ can make an additional annual catch-up contribution of

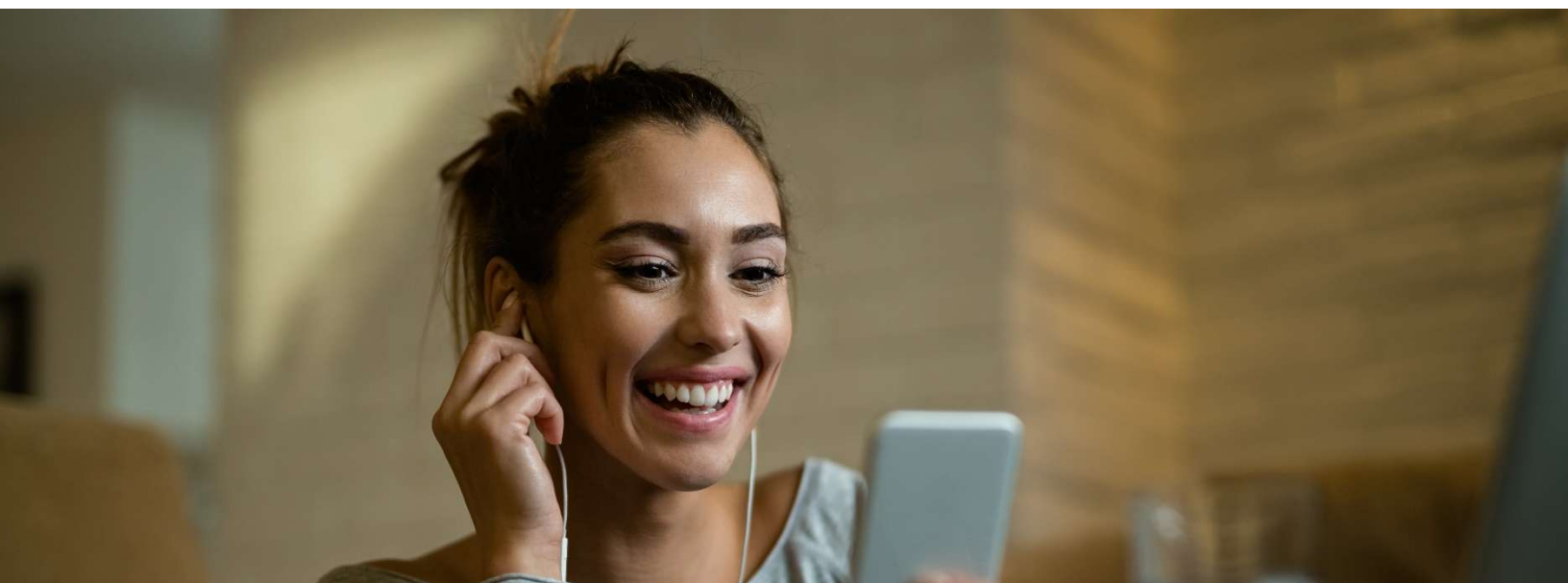
\$1,000



Dental Plan

In addition to protecting your smile, dental insurance helps pay for dental care and includes regular checkups, cleanings and x-rays. Receiving regular dental care can protect you and your family from the high cost of dental disease and surgery. Dental coverage is offered for basic and major services. The dental plan also includes 100% coverage for preventive care. You and your eligible dependents may enroll in the dental coverage administered by **Delta Dental of Iowa**.

Plan Features	Delta Dental PPO Network	Delta Dental Premier Network / Non-Participating
Annual Deductible		
Individual	\$15	\$25
Family	\$30	\$50
Annual Maximum		
Per covered individual		\$1,000
Preventive Care		
Routine check-ups, cleanings, x-rays, fluoride, sealants, space maintainers	Deductible waived; Covered at 100%	Deductible waived; Covered at 100%
Basic Services		
Cavity repair, tooth extractions, general anesthesia, routine oral surgery, emergency care	10% after deductible	20% after deductible
Major Services		
Root canals, periodontics, perio maintenance therapy	20% after deductible	20% after deductible
Crowns, bridges, dentures, implants	50% after deductible	50% after deductible
Orthodontia Services		
Appliances and service for children under age 19		50% coinsurance
Orthodontia Maximum (per child, per lifetime)		\$1,000



Vision Plan

VSP

Driving to work, reading a news article and watching TV are all activities you likely perform every day. Your ability to do all of these activities, though, depends on your vision and eye health. Vision insurance can help you maintain your vision as well as detect various health problems.

Your vision insurance is provided by **VSP** and entitles you to specific eye care benefits. Our policy covers routine eye exams and other procedures and provides specified dollar amounts or discounts for the purchase of eyeglasses and contact lenses.

In Network	
Well Vision Eye Exam	\$20 copay
Lenses	
Single Vision Lenses	\$20
Standard Lined Bifocal Lenses	\$20
Standard Trifocal Lenses	\$20
Standard Progressive Lenses	\$20
Elective Contacts (in lieu of glasses)	
Lens Allowance	\$130 Allowance
Lens Fitting and Evaluation	Up to \$60
Frames	
Most brands	\$130 Allowance
Featured Frame Brands	\$150 Allowance; 20% savings on amount over allowance
Frames purchased at Costco	\$70 allowance
Frequency of Services	
Vision Exam, Lenses (traditional or contact), & Frames	Every Calendar Year
Additional Plan Details	
Laser Vision Correction	Average 15% off regular price (not promotional prices); Discounts only available from contracted facilities
Waiting period	There are no waiting periods. If you see an in-network provider, there are no prior authorizations or claim form necessary
ID Cards	Not required. Your network provider will be able to look up your benefits. You may print one from the app or website if you prefer
Out-of-Network Providers	If you see a non-network provider, you will need to contact VSP Member Services to determine process for reimbursement

Life Insurance

Basic Life & Accidental Death & Dismemberment (AD&D)

The Basic Life and AD&D plan provides a benefit in the event of your death, dismemberment or paralysis. This benefit is sponsored by Physicians' Clinic of Iowa and is for regular, full-time employees working a minimum of 32 hours per week. If you are eligible, you will automatically be enrolled at no cost to you.

Supplemental Life Insurance

You may purchase additional life insurance at group rates:

- Available in increments of \$10,000 up to \$500,000, not to exceed 5x earnings
- You pay the full cost of this plan, and the amount deducted depends on the age of the associate and the amount of coverage elected
- **IMPORTANT:** If you do not elect this coverage when first becoming eligible or an election over \$300,000 (if under age 60) or \$100,000 (if age 60 or over) is made, you are subject to medical underwriting by the carrier.

Life Insurance for Spouses & Dependents

When you enroll yourself for supplemental life insurance, you may also purchase dependent life insurance at group rates:

- Spousal life is available in increments of \$5,000 up to a max of \$250,000, not to exceed 50% of the employee's elected amount
- Can elect up to \$50,000 without medical underwriting as a new hire
- Child life is available from birth to age 20 (26 if full-time student): \$10,000
 - Children are not subject to medical underwriting
 - The cost remains the same regardless of the number of children you have
 - If your child is no longer eligible, contact Lori Kelchen in HR to cancel their coverage.

TAKE ACTION!

Don't forget to designate a beneficiary!

Note: Upon loss of eligibility or termination of employment, you and/or your dependents may elect to continue your employer-sponsored Basic or Voluntary Term Life Insurance coverage by either porting or converting it.

If you can continue your life insurance policy, you can port it, which means continuing the same type of policy, or you can convert it, which means change it to a new type of individual policy. Remember, no matter which option you choose, you become responsible for the premiums.

GUARANTEED ISSUE AND EVIDENCE OF INSURABILITY

Employees and spouses who elect Voluntary Life and AD&D coverage when they are first eligible can elect up to the Guaranteed Issue (GI) amount without Evidence of Insurability (EOI). If the amount requested is more than GI, you will need to provide EOI before the amount over GI becomes effective.

IMPUTED INCOME

Under current tax laws, imputed income is the value of your Basic Life insurance that exceeds \$50,000 is subject to federal income, Social Security and state income taxes, if applicable. This imputed income amount will be included in your paycheck and shown on your W-2 statement.

Disability Insurance



At Physicians' Clinic of Iowa, we want to do everything we can to protect you and your family. That's why Physicians' Clinic of Iowa pays for the full cost of long-term disability insurance—meaning that you owe nothing out of pocket.

Physicians' Clinic of Iowa employees working 32+ hours per week are eligible for long-term disability coverage. In the event that you become disabled from a non-work-related injury or sickness, disability income benefits will provide a partial replacement of lost income.

Long-Term Disability (LTD)

In the event you become disabled, long term disability income benefits are provided as a source of income.

Eligibility begins on the first of the month following or coinciding with hire date.

Benefits begin after a 90-day elimination period. Benefits are paid at 60% of gross earnings, up to a maximum monthly benefit of \$10,000.

Coverage for total disability continues until you recover or reach your Social Security Normal Retirement Age (SSNRA), whichever is sooner

EMPLOYEE CONTRIBUTIONS

Medical Plan 1:		Per Pay Period (24)	Per Pay Period (24)	Per Pay Period (24)
Wellmark Alliance Select \$2500 PPO				
Hours Hired to Work:		20-29 Hours	30-39 Hours	40+ Hours
Employee		\$299.42	\$171.43	\$105.22
Employee & Spouse		\$672.77	\$441.47	\$321.83
Employee & Child (ren)		\$621.85	\$408.05	\$297.47
Family		\$1,008.07	\$661.50	\$482.23
Medical Plan 2:		Per Pay Period (24)	Per Pay Period (24)	Per Pay Period (24)
Wellmark Blue Access \$2500 HMO				
Hours Hired to Work:		20-29 Hours	30-39 Hours	40+ Hours
Employee		\$253.57	\$120.14	\$51.12
Employee & Spouse		\$607.26	\$379.54	\$261.75
Employee & Child (ren)		\$561.30	\$350.81	\$241.94
Family		\$909.91	\$568.69	\$392.20
Medical Plan 3:		Per Pay Period (24)	Per Pay Period (24)	Per Pay Period (24)
Wellmark Alliance Select \$4000 HDHP PPO				
Hours Hired to Work:		20-29 Hours	30-39 Hours	40+ Hours
Employee		\$226.83	\$94.80	\$26.50
Employee & Spouse		\$550.20	\$324.14	\$207.21
Employee & Child (ren)		\$508.56	\$299.61	\$191.53
Family		\$824.40	\$485.68	\$310.48

- Premiums listed are subsidized rates that some non-shareholder physicians may be eligible for per the terms of their employment agreements. Shareholder physicians are responsible for 100% of the insurance premiums (full premiums available upon request).
- Non-shareholder physicians scheduled to become shareholder physicians in 2026 will see an increase in their premium deduction.

Dental		Per Pay Period (24)	Per Pay Period (24)	Per Pay Period (24)
Hours Hired to Work:		20-29 Hours	30-39 Hours	40+ Hours
Employee		\$7.14	\$2.43	\$0.00
Family		\$38.80	\$33.31	\$30.47
Waived Medical		\$21.74	\$7.41	\$0.00

Vision	Per Pay Period (24)
Hours Hired to Work:	All Eligible Employees working 20-40+ Hours
Employee	\$4.34
Employee & Spouse	\$6.95
Employee & Child (ren)	\$7.10
Family	\$11.44



How Do I Enroll?



New Hire Enrollment:

1. Log In

If you are a new hire, you will make your benefit elections online at www.workforcenow.adp.com during orientation. At that time, you can verify your personal information and make any changes if necessary.

2. Choose Your Plan

3. Enroll

Based off of the best value plan for your needs, enroll in your benefits.

Reminder



- Benefits are not able to be changed mid-year unless you experience a qualifying life event
- Enrollment must be completed within 30 days of your qualifying life event
- Make sure you hit 'submit' to save your elections before closing the window

BENEFITS DEFINITIONS

Coinsurance

Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service. You generally pay coinsurance plus any deductibles you owe. (For example, if the health insurance or plan's allowed amount for an office visit is \$100 and you've met your deductible, your coinsurance payment of 20% would be \$20. The health insurance or plan pays the rest of the allowed amount.)

Copayment

A fixed amount (for example, \$25) you pay for a covered health care service, usually when you receive the service (sometimes called "copay"). The amount can vary by the type of covered health care service.

Deductible

An amount you could owe during a coverage period (usually one year) for covered health care services before your plan begins to pay. An overall deductible applies to all or almost all covered items and services. (For example, if your deductible is \$2500, your plan won't pay anything until you've met your \$2500 deductible for covered health care services subject to the deductible.)

Each family member has an individual deductible in addition to the overall family deductible. This means that, if an individual in the family reaches his or her deductible before the family deductible is reached, his or her services will be paid by the insurance company.

High-Deductible Health Plan (HDHP)

A type of health plan that has lower monthly premiums, but higher deductibles and out-of-pocket limits, than a traditional health plan. HDHPs are often coupled with an HSA (Health Savings Account)

Network

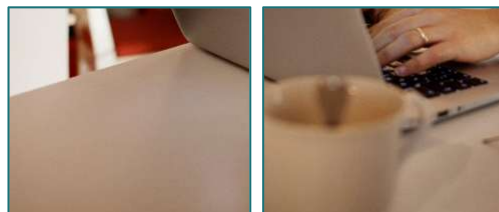
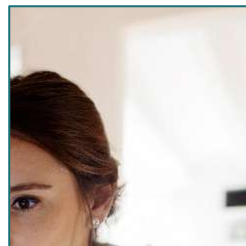
The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Network Provider

A provider who has a contract with your health insurer or plan who has agreed to provide services to members of a plan. You will pay less if you see a provider in the network. Also called "preferred provider" or "participating provider."

Out-of-Network Provider

A provider who doesn't have a contract with your plan to provide services. If your plan covers out-of-network services, you'll usually pay more to see an out-of-network provider than a preferred provider. Your policy will explain what those costs may be. May also be called "non-preferred" or "non-participating" instead of "out-of-network provider."



BENEFITS DEFINITIONS (CONT.)

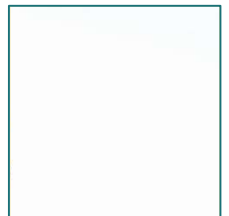
Out-of-Pocket Maximum

The most you could pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit, the plan will usually pay 100% of the allowed amount. This limit helps you plan for health care costs. This limit never includes your premium, balance-billed charges or health care your plan doesn't cover. Some plans don't count all of your copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit.



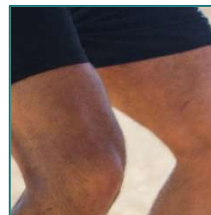
Premium

The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly, or yearly.



Provider

An individual or facility that provides health care services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. The plan may require the provider to be licensed, certified, or accredited as required by state law.

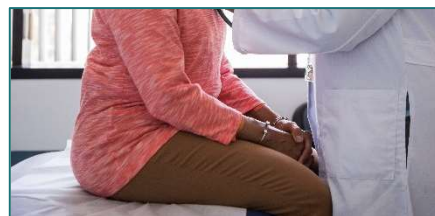


Qualifying Life Event

A significant change in your life which allows an individual to make mid-year changes to their insurance elections outside of regular annual enrollment periods. Examples of qualifying events are listed below:

- Getting married or divorced
- Having or adopting a baby or child
- Becoming eligible for new coverage (Medicare or Medicaid, new eligibility through your employer or your spouse's employer)
- Losing other health coverage

If you need to make a mid-year change due to a qualifying life event, you must submit the required documentation WITHIN 30 DAYS of the qualifying life change event.



IMPORTANT CONTACTS

Coverage	Carrier / Contact	Phone	Website
Medical	Wellmark Blue Cross Blue Shield	800-524-9242 (Customer Service) 844-842-3935 BeWell 24/7	www.wellmark.com
Dental	Delta Dental	800-544-0718 Email: claims@deltadentalia.com	www.deltadentalia.com
Vision	VSP	800 877-7195	www.vsp.com
Basic Life and Supplemental Life	Reliance Standard	800-351-7500	www.reliancestandard.com
Identity Theft/Legal Services	Legal Shield	Alan Jessen 319-415-1759 Email: amjessen@cfu.net	https://www.midwest.lsenrollment.com/ls-plans-2/24PP1695
Human Resources	Lori Kelchen Kendra Herdliska	319-247-3018 319-247-3004	Email: lkelchen@pcofiowa.com Email: kherdliska@pcofiowa.com

Annual Notices

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed on the following page, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office, dial **1-877-KIDS NOW**, or visit www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2025. Contact your State for more information on eligibility.

To see if any other states have added a premium assistance program since July 31, 2025 or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, ext. 61565

STATE	WEBSITE/EMAIL	PHONE
Alabama Medicaid	myalhipp.com	855-692-5447
Alaska Medicaid	Premium Payment Program: myakhipp.com Medicaid Eligibility: health.alaska.gov/dpa Email: customerservice@myakhipp.com	866-251-4861
Arkansas Medicaid	http://myarhipp.com/	855-MyARHIPP (855-692-7447)

Annual Notices

California Medicaid	dhcs.ca.gov/hipp Email: hipp@dhcs.ca.gov	916-445-8322 916-440-5676 (fax)
Colorado Medicaid and CHIP	Medicaid: healthfirstcolorado.com CHIP: hcpf.colorado.gov/child-health-plan-plus HIBI: mycohibi.com	800-221-3943 Relay 711 800-359-1991 Relay 711 855-692-6442
Florida Medicaid	flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html	877-357-3268
Georgia Medicaid	HIPP: medicaid.georgia.gov/health-insurance-premium-payment-program-hipp CHIPRA: medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra	678-564-1162, press 1 678-564-1162, press 2
Indiana Medicaid	HIPP: https://www.in.gov/fssa/dfr/ All other Medicaid: in.gov/medicaid	800-403-0864 800-457-4584
Iowa Medicaid and CHIP	Medicaid: hhs.iowa.gov/programs/welcome-iowa-medicaid CHIP: hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki HIPP: hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp	800-338-8366 800-257-8563 888-346-9562
Kansas Medicaid	kancare.ks.gov	800-792-4884 HIPP: 800-967-4660
Kentucky Medicaid and CHIP	KI-HIPP: chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx KI-HIPP Email: KIHIPPPROGRAM@ky.gov KCHIP: kynect.ky.gov Medicaid: chfs.ky.gov/agencies/dms	KI-HIPP: 855-459-6328 KCHIP: 877-524-4718
Louisiana Medicaid	ldh.la.gov/healthy-louisiana or www.ldh.la.gov/lahipp	Medicaid: 888-342-6207 LaHIPP: 855-618-5488
Maine Medicaid	Enrollment: mymaineconnection.gov/benefits Private health insurance premium: maine.gov/dhhs/ofi/applications-forms	Enroll: 800-442-6003 Private HIP: 800-977-6740 TTY/Relay: 711
Massachusetts Medicaid and CHIP	mass.gov/masshealth/pa Email: masspremassistance@accenture.com	800-862-4840 TTY/Relay: 711
Minnesota Medicaid	mn.gov/dhs/health-care-coverage	800-657-3672
Missouri Medicaid	dss.mo.gov/mhd/participants/pages/hipp.htm	573-751-2005
Montana Medicaid	HIPP: dphhs.mt.gov/MontanaHealthcarePrograms/HIPP HIPP Email: HSHIPPProgram@mt.gov	800-694-3084
Nebraska Medicaid	ACCESSNebraska.ne.gov	855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
Nevada Medicaid	Medicaid: dhcfnv.gov	800-992-0900
New Hampshire Medicaid	dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov	603-271-5218 or 800-852-3345, ext. 15218
New Jersey Medicaid and CHIP	Medicaid: state.nj.gov/humanservices/dmahs/clients/medicaid CHIP: njfamilycare.org/index.html	Medicaid: 800-356-1561 CHIP Premium Assist: 609-631-2392 CHIP: 800-701-0710 TTY/Relay: 711
New York Medicaid	health.ny.gov/health_care/medicaid	800-541-2831
North Carolina Medicaid	medicaid.ncdhhs.gov	919-855-4100
North Dakota Medicaid	hhs.nd.gov/healthcare	844-854-4825
Oklahoma Medicaid and CHIP	insureoklahoma.org	888-365-3742
Oregon Medicaid	healthcare.oregon.gov/Pages/index.aspx	800-699-9075

Annual Notices

Pennsylvania Medicaid and CHIP	Medicaid: pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html CHIP: dhs.pa.gov/CHIP/Pages/CHIP.aspx	Medicaid: 800-692-7462 CHIP: 800-986-KIDS (5437)
Rhode Island Medicaid and CHIP	cohhs.ri.gov	855-697-4347 or 401-462-0311 (Direct RIte)
South Carolina Medicaid	scdhhs.gov	888-549-0820
South Dakota Medicaid	dss.sd.gov	888-828-0059
Texas Medicaid	hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program	800-440-0493
Utah Medicaid and CHIP	UPP: medicaid.utah.gov/upp/ UPP Email: upp@utah.gov Adult Expansion: medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program: medicaid.utah.gov/buyout-program/ CHIP: chip.utah.gov	UPP: 877-222-2542
Vermont Medicaid	dvha.vermont.gov/members/medicaid/hipp-program	800-250-8427
Virginia Medicaid and CHIP	coverva.dmas.virginia.gov/learn/premium-assistance/famis-select coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs	Medicaid/CHIP: 800-432-5924
Washington Medicaid	hca.wa.gov	800-562-3022
West Virginia Medicaid and CHIP	dhhr.wv.gov/bms/ mywvhipp.com/	Medicaid: 304-558-1700 CHIP: 855-699-8447
Wisconsin Medicaid and CHIP	dhs.wisconsin.gov/badgercareplus/p-10095.htm	800-362-3002
Wyoming Medicaid	health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility	800-251-1269

Annual Notices

Medicare Part D Notice of Creditable Prescription Drug Coverage

IMPORTANT NOTICE FROM PHYSICIANS' CLINIC OF IOWA, PC ABOUT YOUR PRESCRIPTION DRUG COVERAGE & MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Physicians' Clinic of Iowa, PC and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Physicians' Clinic of Iowa, PC has determined that the prescription drug coverage offered by the Physicians' Clinic of Iowa, PC plan is, on average for all plan participants, **IS** expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is **Creditable Coverage**, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Physicians' Clinic of Iowa, PC coverage will be affected. If you do decide to join a Medicare drug plan and drop your Physicians' Clinic of Iowa, PC coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

Effective 1/1/2026, the HDHP through PCI will no longer be considered creditable for Medicare Part D. Depending upon how long you are without creditable prescription drug coverage, you may pay a penalty to join a Medicare drug plan when you do join. Starting with the end of the last month that you were eligible to join a Medicare drug plan but didn't join, and you

Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, and you go at least 63 consecutive days without creditable prescription drug coverage, your monthly premium may go up at least 1% of the base Medicare beneficiary premium per month, for every month that you did not have creditable coverage.

For example, if you are without creditable drug coverage for nineteen months, your premium may consistently be at least 19% higher than the base Medicare beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October annual enrollment to join the Medicare prescription drug plan.

Notice of Creditable Coverage continued on the next page.

Annual Notices

Medicare Part D Notice of Creditable Prescription Drug Coverage

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Physicians' Clinic of Iowa, PC changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare Prescription drug coverage:

- Visit www.medicare.gov.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this creditable coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: October 11, 2025

Name of Entity/Sender: Physicians' Clinic of Iowa, PC

Contact/Office: Lori Kelchen

Address: 202 10th Street SE, Cedar Rapids, IA 52403

Phone Number: (319) 247-3018

Annual Notices

Medicare Part D Notice of Non-Creditable Prescription Drug Coverage

IMPORTANT NOTICE FROM PHYSICIANS' CLINIC OF IOWA, PC ABOUT YOUR PRESCRIPTION DRUG COVERAGE & MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Physicians' Clinic of Iowa, PC and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are several important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Effective 1/1/2026, Physicians' Clinic of Iowa, PC has determined that the prescription drug coverage offered by the Physicians' Clinic of Iowa, PC **High-Deductible Health Plan (HDHP)** is, on average for all plan participants, **NOT** expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, this plan is considered **Non-Creditable Coverage**.
3. This is important, because you will likely pay less for your drug costs if you join a Medicare drug plan, than if you have prescription coverage under PCI's HDHP. This is also important because it may mean that you may pay a higher premium (penalty) if you do not join a Medicare drug plan when you first become eligible.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however, you may also pay a higher premium (a penalty) because you did not have creditable coverage

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

Effective 1/1/2026, the HDHP through PCI will no longer be considered creditable for Medicare Part D. Depending upon how long you are without creditable prescription drug coverage, you may pay a penalty to join a Medicare drug plan when you do join. Starting with the end of the last month that you were eligible to join a Medicare drug plan but didn't join, and you

Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, and you go at least 63 consecutive days without creditable prescription drug coverage, your monthly premium may go up at least 1% of the base Medicare beneficiary premium per month, for every month that you did not have creditable coverage.

For example, if you are without creditable drug coverage for nineteen months, your premium may consistently be at least 19% higher than the base Medicare beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October annual enrollment to join the Medicare prescription drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Physicians' Clinic of Iowa, PC coverage may be affected. If you do decide to join a Medicare drug plan and drop your Physicians' Clinic of Iowa, PC coverage, be aware that you and your dependents may not be able to get this coverage back.

You should also know that if you drop or lose your current Physicians' Clinic of Iowa, PC coverage and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

Notice of Non-Creditable Coverage continued on the next page.

Annual Notices

Medicare Part D Notice of Non-Creditable Prescription Drug Coverage

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Physicians' Clinic of Iowa, PC changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare Prescription drug coverage:

- Visit www.medicare.gov.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this creditable coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: October 11, 2025

Name of Entity/Sender: Physicians' Clinic of Iowa, PC

Contact/Office: Lori Kelchen

Address: 202 10th Street SE, Cedar Rapids, IA 52403

Phone Number: (319) 247-3018

Annual Notices

COBRA RIGHTS NOTICE

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. ***This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.*** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;

- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse. Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When Is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Physicians' Clinic of Iowa, PC – Lori Kelchen

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Annual Notices

HOW IS COBRA CONTINUATION COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability Extension of 18-Month Period of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

IF YOU HAVE QUESTIONS

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

PLAN CONTACT INFORMATION

Date: January 1, 2026

Name of Entity/Sender: Physicians' Clinic of Iowa, PC

Contact/Office: Lori Kelchen

Address: 202 10th Street SE, Cedar Rapids, IA 52403

Phone Number: (319) 247-3018

Annual Notices

60-DAY SPECIAL ENROLLMENT PERIOD

In addition to the qualifying events listed in the enrollment guide, you and your dependents will have a special 60-day period to elect or discontinue coverage if:

- You or your dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- You or your dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you decline enrollment in medical coverage for yourself or your dependents (including your spouse) because of other health insurance coverage, you may be able to enroll yourself or your dependents in Physicians' Clinic of Iowa, PC medical coverage if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment no more than 30 days after your or your dependent's other coverage ends (or after the employer stops contributing to the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you can enroll yourself and your dependents in Physicians' Clinic of Iowa, PC medical coverage as long as you request enrollment by contacting the benefits manager no more than 30 days after the marriage, birth, adoption or placement for adoption. For more information, contact Physicians' Clinic of Iowa, PC – Lori Kelchen (319)247-3018 lkelchen@pcofiowa.com

202 10th Street SE, Cedar Rapids, IA 52403.

CONTINUATION REQUIRED BY FEDERAL LAW FOR YOU AND YOUR DEPENDENT

The Continuation Required by Federal Law does not apply to any benefits for loss of life, dismemberment or loss of income. Federal law enables you or your Dependent to continue health insurance if coverage would cease due to a reduction of your work hours or your termination of employment (other than your gross misconduct). Federal law also enables your Dependents to continue health insurance if their coverage ceases due to your death, divorce or legal separation, or with respect to a Dependent child, failure to continue to qualify as a Dependent. Continuation must be elected in accordance with the rules of your Employer's group health plan(s) and is subject to federal law, regulations and interpretations.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Physician's Clinic of Iowa, PC, in accordance with the HIPAA, protects your Protected Health Information (PHI). PCI will only discuss your PHI with medical providers and third-party administrators when necessary to administer the plan that provides you your medical, dental, and vision benefits or as mandated by law. A copy of the Notice of Privacy Practices is available upon request in the Human Resources Department.

NEWBORN & MOTHERS HEALTH PROTECTION NOTICE

For maternity hospital stays, in accordance with federal law, the Plan does not restrict benefits, for any hospital length of stay in connection with childbirth for the mother or newborn child, to less than 48 hours following a vaginal delivery or less than 96 hours following a Cesarean delivery.

However, federal law generally does not prevent the mother's or newborn's attending care provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). The plan cannot require a provider to prescribe a length of stay any shorter than 48 hours (or 96 hours following a Cesarean delivery).

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultations with the attending physician and the patient, for:

- All states of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of the mastectomy, including lymphedema

These benefits will be provided subject to the same deductibles, copays and coinsurance applicable to other medical and surgical benefits provided under your medical plan. For more information on WHCRA benefits, contact Lori Kelchen at (319) 247-3018 or lkelchen@pcofiowa.com

MENTAL HEALTH PARITY ACT

According to the Mental Health Parity Act of 1996, the lifetime maximum and annual maximum dollar limits for mental health benefits under the medical plan are equal to the lifetime maximum and annual maximum dollar limits for medical and surgical benefits under this plan. However, mental health benefits may be limited to a maximum number of treatment days per year or series per lifetime.

Annual Notices

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

PART A: GENERAL INFORMATION

Since key parts of the health care law took effect in 2014, there is another way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away. Typically, you can enroll in a Marketplace health plan during the Marketplace's annual Open Enrollment period or if you experience a qualifying life event.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan.

However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.12% for plans that start in 2023 of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution — as well as your employee contribution to employer-offered coverage — is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Physicians' Clinic of Iowa, PC, Lori Kelchen — lkelchen@pcofiowa.com (319) 247-3018

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit [HealthCare.gov](https://www.healthcare.gov) for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

Annual Notices

PART B: INFORMATION ABOUT HEALTH COVERAGE OFFERED BY YOUR EMPLOYER

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

Employer Name: Physician's Clinic of Iowa, PC	Tax ID #:
Address: 202 10 th Street SE	Phone #: 319-247-3018
City: Cedar Rapids	State/Zip: Iowa 52403
Contact Person: Lori Kelchen	Email address: lkelchen@pcofiowa.com

Here is some basic information about health coverage offered by this employer:

As your employer, we offer a health plan to some employees.

Eligible employees are:

- Full-Time Employees
- Regular Part Time Employees working 20 hours

With respect to dependents, we do offer coverage.

Eligible dependents are:

- Legal Spouse or common law spouse/and/or/his/her children, where applicable by law
- Your children who are your natural children, stepchildren, adopted children or children for whom you have legal custody (age restrictions apply)
- Disabled children aged 20 or older who meet certain criteria

This coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

****Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace.**

The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, www.healthcare.gov will guide you through the process.

Annual Notices

Physicians' Clinic of Iowa, PC Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective date: 2/16/2026

OUR PLEDGE TO YOU

This notice is intended to inform you of the privacy practices followed by Physicians' Clinic of Iowa, PC (the Plan) and the Plan's legal obligations regarding your protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The notice also explains the privacy rights you and your family members have as participants of the Plan.

The Plan often needs access to your protected health information in order to provide payment for health services and perform plan administrative functions. We want to assure the participants covered under the Plan that we comply with federal privacy laws and respect your right to privacy. Physicians' Clinic of Iowa, PC requires all members of our workforce and third parties that are provided access to protected health information to comply with the privacy practices outlined below.

PROTECTED HEALTH INFORMATION

Your protected health information is protected by the HIPAA Privacy Rule. Generally, protected health information is information that identifies an individual created or received by a health care provider, health plan or an employer on behalf of a group health plan that relates to physical or mental health conditions, provision of health care, or payment for health care, whether past, present or future.

HOW WE MAY USE YOUR PROTECTED HEALTH INFORMATION

Under the HIPAA Privacy Rule, we may use or disclose your protected health information for certain purposes without your permission. This section describes the ways we can use and disclose your protected health information.

Payment. We use or disclose your protected health information without your written authorization in order to determine eligibility for benefits, seek reimbursement from a third party, or coordinate benefits with another health plan under which you are covered. For example, a health care provider that provided treatment to you will provide us with your health information. We use that information in order to determine whether those services are eligible for payment under our group health plan.

Health Care Operations. We use and disclose your protected health information in order to perform plan administration functions such as quality assurance activities, resolution of internal grievances, and evaluating plan performance. For example, we review claims experience in order to understand participant utilization and to make plan design changes that are intended to control health care costs.

However, we are prohibited from using or disclosing protected health information that is genetic information for our underwriting purposes.

Treatment. Although the law allows use and disclosure of your protected health information for purposes of treatment, as a health plan we generally do not need to disclose your information for treatment purposes. Your physician or health care provider is required to provide you with an explanation of how they use and share your health information for purposes of treatment, payment, and health care operations.

As Permitted or Required by Law. We may also use or disclose your protected health information without your written authorization for other reasons as *permitted* by law. We are *permitted* by law to share information, subject to certain requirements, in order to communicate information on health-related benefits or services that may be of interest to you, respond to a court order, or provide information to further public health activities (e.g., preventing the spread of disease) without your written authorization. We are also permitted to share protected health information during a corporate restructuring such as a merger, sale, or acquisition. We will also disclose health information about you when *required* by law, for example, in order to prevent serious harm to you or others.

Pursuant to Your Authorization. When required by law, we will ask for your written authorization before using or disclosing your protected health information. Uses and disclosures not described in this notice will only be made with your written authorization. Subject to some limited exceptions, your written authorization is required for the sale of protected health information and for the use or disclosure of protected health information for marketing purposes. If you choose to sign an authorization to disclose information, you can later revoke that authorization to prevent any future uses or disclosures.

A Note about Substance Use Disorder Records. We are prohibited by federal law (42 CFR Part 2) from using or disclosing certain information about a member's substance use disorders for any purpose, unless the member consents to the uses and disclosures. We cannot use or disclose information about a member's treatment for substance use disorders (or provide testimony based on such information) for any civil, criminal, administrative, or legislative proceedings against the member. Any such disclosure is permitted only with the member's consent or a special type of court order, for which the member must have notice and an opportunity to object.

To Business Associates. We may enter into contracts with entities known as Business Associates that provide services to or perform functions on behalf of the Plan. We may disclose protected health information to Business Associates once they have agreed in writing to safeguard the protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims. Business Associates are also required by law to protect protected health information.

To the Plan Sponsor. We may disclose protected health information to certain employees of Physicians' Clinic of Iowa, PC for the purpose of administering the Plan. These employees will use or disclose the protected health information only as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized additional disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Annual Notices

YOUR RIGHTS

Right to Inspect and Copy. In most cases, you have the right to inspect and copy the protected health information we maintain about you. If you request copies, we will charge you a reasonable fee to cover the costs of copying, mailing, or other expenses associated with your request. Your request to inspect or review your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to inspect and copy your health information. To the extent your information is held in an electronic health record, you may be able to receive the information in an electronic format.

Right to Amend. If you believe that information within your records is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information. Your request to amend your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to amend your health information. If we deny your request, you may file a statement of disagreement with us for inclusion in any future disclosures of the disputed information.

Right to an Accounting of Disclosures. You have the right to request an accounting of certain disclosures of your protected health information made by the Plan. This accounting covers disclosures made during the six (6) years prior to your request, excluding disclosures for treatment, payment, or health care operations, disclosures made to you, disclosures pursuant to your authorization, and certain other exceptions permitted by law. Changes in law may affect this right, and the Plan will update this Notice as necessary. To request an accounting, contact the Plan's Privacy Officer at the address listed at the end of this Notice. You may request one accounting free of charge within a 12-month period. For additional requests in the same period, we may charge a reasonable, cost-based fee after notifying you and providing an opportunity to withdraw or modify your request.

Right to Request Restrictions. You have the right to request that we not use or disclose information for treatment, payment, or other administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. You also have the right to request that we limit the protected health information that we disclose to someone involved in your care or the payment for your care, such as a family member or friend. Your request for restrictions must be submitted in writing to the person listed below. We will consider your request, but in most cases are not legally obligated to agree to those restrictions.

If you pay for a service or health care item out-of-pocket in full, you may request that your health care provider not disclose protected health information related to that service or item to your health plan for purposes of payment or health care operations.

Right to Request Confidential Communications. You have the right to receive confidential communications containing your health information. Your request for restrictions must be submitted in writing to the person listed below. We are required to accommodate reasonable requests. For example, you may ask that we contact you at your place of employment or send communications regarding treatment to an alternate address.

Right to be Notified of a Breach. You have the right to be notified in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information. Notice of any such breach will be made in accordance with federal requirements.

Right to Receive a Paper Copy of this Notice. If you have agreed to accept this notice electronically, you also have a right to obtain a paper copy of this notice from us upon request. To obtain a paper copy of this notice, please contact the person listed below.

OUR LEGAL RESPONSIBILITIES

We are required by law to maintain the privacy of your protected health information, provide you with this notice about our legal duties and privacy practices with respect to protected health information and notify affected individuals following a breach of unsecured protected health information.

We will comply with State or other laws that impose more stringent limitations on our use or disclosure of members' Information.

Information that we disclose pursuant to this Notice may be subject to redisclosure by the recipient and may no longer be protected by federal privacy regulations.

CHANGES TO THIS NOTICE

We may change our policies at any time and reserve the right to make the change effective for all protective health information that we maintain. In the event that we make a significant change in our policies, we will provide you with a revised copy of this notice. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

CONTACTS

If you have any questions or complaints, please contact:

Lori Kelchen
Physicians' Clinic of Iowa, PC
202 10th Street SE
Cedar Rapids, IA 52403
(319) 247-3018
lkelchen@pcofiowa.com

COMPLAINTS

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed above. You also may send a written complaint to the U.S. Department of Health and Human Services - Office for Civil Rights at 200 Independence Avenue, S.W., Washington, D.C. 20201, by calling 1-877-696-6775, or by visiting www.hhs.gov/ocr

You will not be penalized or retaliated against for filing a complaint with the Office of Civil Rights or with us.



PRIVACY PRACTICES NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

**PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.**

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your medical information and to notify you if there is a breach of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your medical information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect December 23, 2024, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all medical information that we maintain, including medical information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and post the new notice on our website. We will provide a copy of the new notice (or information about the changes to our privacy practices and how to obtain the new notice) in our next annual mailing to health plan contract holders.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Organizations Covered by this Notice

This notice applies to the privacy practices of the group health plans, health insurers and HMO listed below. These organizations are each participants in an organized health care arrangement. As such, we may share your medical information and the medical information of others we service with each other as needed for the payment activities or health care operations relating to our organized health care arrangement. We also may disclose your medical information to a business associate to assist us in these activities. Our business associates are required to comply with federal Privacy Rules and this Privacy Practices Notice.

- Wellmark, Inc., doing business as Wellmark Blue Cross and Blue Shield of Iowa
- Wellmark of South Dakota, Inc., doing business as Wellmark Blue Cross and Blue Shield of South Dakota
- Wellmark Health Plan of Iowa, Inc.
- Wellmark Synergy Health, Inc.
- Wellmark Value Health Plan, Inc.
- Wellmark, Inc. Employee Health Care Plan
- Wellmark, Inc. Retiree Health and Life Plan
- Wellmark, Inc. Employee Assistance Program

Uses and Disclosures of Medical Information

We use and disclose medical information about you for treatment, payment, and health care operations. For example:

Treatment: We may use or disclose a member's medical information to help treat a patient. For example, we may disclose a list of prescriptions you have filled to a physician in order to provide treatment to you.

Payment: We may use and disclose your medical information to pay claims from physicians, hospitals and other providers for services delivered to you that are covered by your health plan, to determine your eligibility for benefits, to coordinate benefits, to examine medical necessity, to obtain premiums, to issue explanations of benefits to the person enrolled in the health plan in which you participate, and the like. We may disclose your medical information to

a health care provider or entity subject to the federal Privacy Rules so they can obtain payment or engage in similar payment activities.

Health Care Operations: may use and disclose your medical information in connection with our health care operations. Health care operations include:

- Rating our risk and determining our premiums for your health plan;
- Quality assessment and improvement activities;
- Reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities;
- Medical review, legal services, and auditing, including fraud and abuse detection and compliance;
- Business planning and development; and
- Business management and general administrative activities, including management activities relating to privacy, customer service, resolution of internal grievances, and creating de-identified information or a limited data set.

We may disclose your medical information to another entity that has a relationship with you and is subject to the federal Privacy Rules, for their health care operations relating to quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, or detecting or preventing health care fraud and abuse.

On Your Authorization: You may give us written authorization to use your medical information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot sell your medical information and we cannot use or disclose your medical information for any reason that is not described in this notice. We also need your authorization to market products or services to you, except that we may use your medical information to contact you with information about health-related benefits and services or about treatment alternatives that may be of interest to you. We also may use or disclose your medical information to encourage you to purchase or use a product or service by face-to-face communication or to provide you with promotional gifts.

To Your Family and Friends: We may disclose your medical information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care. We may use or disclose an individual's name, location, and general condition or death to notify, or assist in the notification of (including identifying or locating), a person involved in the individual's care.

Before we disclose your medical information to a person involved in your health care or payment for your health care, we will provide you with an opportunity to object to such uses or disclosures. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest.

Your Employer or Organization Sponsoring Your Group Health Plan: If you are a member of a group health plan, we may disclose your medical information and the medical information of others enrolled in your group health plan to the employer or other organization that sponsors your group health plan to permit the plan sponsor to perform plan administration functions. Please see your group health plan document for a full explanation of the uses and disclosures that the plan sponsor may make of your medical information in providing plan administration.

We may also disclose enrollment data and summary information about the members in your group health plan to the plan sponsor to use to obtain premium bids for the health insurance coverage offered through your group health plan or to decide whether to modify, amend or terminate your group health plan. The summary information we may disclose summarizes claims history, claims expenses, or types of claims experienced by the members in your group health plan. The summary information will be stripped of demographic information about the members in the group health plan, but the plan sponsor may still be able to identify you or other members in your group health plan from the summary information.

Underwriting: We may receive your medical information for underwriting, premium rating or other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits. Wellmark is prohibited from using or disclosing your genetic information for underwriting purposes. We will not use or further disclose this medical information for any other purpose, except as required by law, unless the contract of health insurance or health benefits is placed with us. In that case, our use and disclosure of your medical information will only be as described in this notice.

Disaster Relief: We may use or disclose your medical information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Public Benefit: We may use or disclose our members' medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- As required by law;
- For public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury;
- To report adult abuse, neglect, or domestic violence;
- To health oversight agencies;
- In response to court and administrative orders and other lawful processes;
- To law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
- To coroners, medical examiners, and funeral directors;
- To organ procurement organizations;
- To avert a serious threat to health or safety;
- In connection with certain research activities;
- To the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- To correctional institutions regarding inmates; and
- As authorized by state worker's compensation laws.

Once we disclose information to a third party other than a health care provider, health plan, or other person subject to the federal Privacy Rules, the information may no longer be protected by federal Privacy Rules and the recipient may use or redisclose that information for other purposes.

Individual Rights

Access: You have the right to look at or get copies of your medical information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your medical information. You may obtain a form to request access by using the contact information listed at the end of this notice. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you a reasonable, cost-based fee for copying your medical information and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your medical information in that format. If you prefer, we will prepare a summary or an explanation of your medical information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your medical information for purposes other than treatment, payment, health care operations, as authorized by you, and for certain other purposes, for up to six (6) years after the record is created. We will provide you with the date on which we made the disclosure, the name of the person or entity to whom we disclosed your medical information, a description of the medical information we disclosed, the reason for the disclosure, and certain other information. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement to additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing.

Confidential Communication: You have the right to request that we communicate with you about your medical information by alternative means or to alternative locations if you believe our current mode of communication could endanger you. You must make your request in writing, and you must state that the information could endanger you if it is not communicated in confidence as you request. We must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to collect premiums and pay claims under your health plan, including issuance of explanations of benefits to the contract holder of the health plan in which you participate.

An explanation of benefits issued to the contract holder for health care that you received for which you did not request confidential communications or about the contract holder or others covered by the health plan in which you participate may contain sufficient information to reveal that you obtained healthcare for which we paid, even though you requested that we communicate with you about that health care in confidence.

Amendment: You have the right to request that we amend your medical information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended and the originator remains available or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you want to amend. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

Other Limitations on Our Uses and Disclosures of Medical Information

We are prohibited by federal law from using or disclosing certain information about a member's substance use disorders for any purpose, unless the member consents to the uses and disclosures. In most cases, the member will give us consent through the treating provider. We cannot use or disclose information about a member's treatment for substance use disorders (or provide testimony based on such information) for any civil, criminal, administrative, or legislative proceedings against the member. Any such disclosure is permitted only with the member's consent or a special type of court order, for which the member must have notice and an opportunity to object, as well as a subpoena, court order, or similar legal mandate.

We will comply with State or other laws that impose more stringent limitations on our use or disclosure of members' Medical Information than the federal Privacy Rules.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information or your other rights described in this Notice, you may complain to us using the contact information listed at the end of this notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Office: **Mailing Address:** Wellmark, Inc.
Privacy Office, Station 5W590
1331 Grand Avenue
Des Moines IA 50309-2901

Telephone:
877-610-6395 Outside Des Moines Area
515-376-5850 Des Moines Local Area
Email: privacyoffice@wellmark.com
Web Site: www.wellmark.com




Physicians Clinic of Iowa 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 1-800-524-9242 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$2,500 person/ \$5,000 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 preventive care, in-network independent labs, outpatient MRI and CT scans, colonoscopies and services subject to health and drug card copayments are covered before you meet your deductible.	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?	No. There are no other deductibles.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Health: \$4,000 person/ \$8,000 family per calendar year. Drug Card: \$2,250 person/ \$4,500 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, 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 <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 <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-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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$25 <u>copay</u> per date of service	40% <u>coinsurance</u>	Doctor on Demand contracted telehealth services are covered.
	<u>Specialist</u> visit	\$25 <u>copay</u> per date of service	40% <u>coinsurance</u>	Hearing exams are covered according to ACA guidelines.
	<u>Preventive care</u> / <u>screening</u> / <u>immunization</u>	No charge	40% <u>coinsurance</u>	One preventive exam and 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 <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <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. <u>In-network</u> independent labs for mental health/chemical dependency services are not subject to <u>coinsurance</u> .
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <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.

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
<p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at www.wellmark.com/prescriptions.</p>	Tier 1	\$10 <u>copay</u> per prescription	\$10 <u>copay</u> per prescription	<p>Refer to your Blue Rx Complete Drug List to determine the tier that applies to a covered drug.</p> <p>For out-of-network <u>prescription drugs</u>, you may be balance billed.</p> <p>1 <u>copay</u> for 30-day supply. 2 <u>copays</u> for 90-day supply (retail and mail order).</p> <p><u>Specialty drugs</u> are covered only when obtained through the <u>Specialty Pharmacy Network</u>.</p> <p><u>Specialty drugs</u> on the PrudentRx drug list (found at Wellmark.com) will have 30% <u>coinsurance</u>. If you enroll with PrudentRx, you will have \$0 member cost-share for drugs on the PrudentRx drug list.</p> <p>See wellmark.com/prescriptions for information about drugs and drug quantities that require prior authorization by Wellmark to be covered by your plan.</p>
	Tier 2	\$35 <u>copay</u> per prescription	\$35 <u>copay</u> per prescription	
	Tier 3	\$75 <u>copay</u> per prescription	\$75 <u>copay</u> per prescription	
	Tier 4	\$150 <u>copay</u> per prescription	\$150 <u>copay</u> per prescription	
	Specialty drugs	\$100 <u>copay</u> per prescription	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Waive cost-share for colonoscopies.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Waive cost-share for colonoscopies.

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 immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	For <u>emergency medical conditions</u> 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.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Benefits for non-participating ambulance providers are based on actual billed charges. For covered non-emergent situations, OON ground ambulance services are NOT reimbursed at the IN 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.
	<u>Urgent care</u>	\$25 <u>copay</u> per date of service for facility and physician(s) combined	40% <u>coinsurance</u>	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----
	<u>Physician/surgeon fees</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: \$25 <u>copay</u> per date of service Facility: 20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----None-----
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	-----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	20% coinsurance	40% coinsurance	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 <u>in-network services</u> that fall outside of routine obstetric care, the office visit benefits shown above may apply.
	Childbirth/delivery professional services	20% coinsurance	40% 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	40% coinsurance	-----None-----
	Home health care	20% coinsurance	40% coinsurance	-----None-----
	Rehabilitation services	Office: \$25 copay per date of service Facility: 20% coinsurance	40% coinsurance	-----None-----
	Habilitation services	Office: \$25 copay per date of service Facility: 20% coinsurance	40% coinsurance	-----None-----
If you need help recovering or have other special health needs	Skilled nursing care	20% coinsurance	40% coinsurance	-----None-----
	Durable medical equipment	20% coinsurance	40% coinsurance	-----None-----
	Hospice services	20% coinsurance	40% coinsurance	Hospice respite care is limited to 15 inpatient and 15 outpatient days per lifetime.
	Children's eye exam	Not covered	Not covered	-----None-----
	Children's glasses	Not covered	Not covered	-----None-----
If your child needs dental or eye care	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
- 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.)

- Applied Behavior Analysis therapy
- Bariatric surgery
- Chiropractic care
- Infertility treatment (excludes some services)
- 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 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 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: Wellmark at 1-800-524-9242 or Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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.

Wellmark Blue Cross and Blue Shield of Iowa is an independent licensee of the Blue Cross and Blue Shield Association.

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 \$2,500
- PCP copayment \$25
- Hospital(facility) coinsurance 20%
- Other coinsurance 20%

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
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In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$2,500
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$1,400
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$4,060

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

- The plan's overall deductible \$2,500
- Specialist copayment \$25
- Hospital(facility) coinsurance 20%
- Other coinsurance 20%

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
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In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$50
<u>Copayments</u>	\$1,300
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,370

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

- The plan's overall deductible \$2,500
- Specialist copayment \$25
- Hospital(facility) coinsurance 20%
- Other coinsurance 20%

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	\$2,800
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In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,900
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,000

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.



Physicians Clinic of Iowa Blue HMO



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 1-800-524-9242 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$2,500 person/ \$5,000 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. Independent labs, physician maternity care, preventive care from in-network providers, outpatient MRI and CT scans, colonoscopies and services subject to health and drug card copayments are covered before you meet your deductible.	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?	No. There are no other deductibles.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Health: \$4,000 person/ \$8,000 family per calendar year. Drug Card: \$2,250 person/ \$4,500 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, 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 <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 <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-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 <u>health care provider's office</u> or <u>clinic</u>	Primary care visit to treat an injury or illness	\$25 <u>copay</u> per <u>provider</u> per date of <u>service</u>	Not covered	Doctor on Demand contracted telehealth services are covered. For this <u>plan</u> you must select a Designated Primary Care Provider (PCP). PCP <u>provider types</u> can be found in the What You Pay section of your <u>plan</u> document.
	<u>Specialist</u> visit	\$25 <u>copay</u> per <u>provider</u> per date of <u>service</u>	Not covered	Applies to Non-PCP <u>providers</u> . Hearing exams are covered according to ACA guidelines.
	<u>Preventive care</u> / <u>screening</u> / <u>immunization</u>	No charge	Not covered	One preventive exam and 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 <u>test</u>	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	Not covered	For a test in a <u>provider's</u> office or clinic, your cost is included in the cost-share listed above. In- <u>network</u> independent labs for mental health/chemical dependency services are not subject to <u>coinsurance</u> .
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	Not covered	For a test in a <u>provider's</u> 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
<p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at www.wellmark.com/prescriptions.</p>	Tier 1	\$10 <u>copay</u> per prescription	\$10 <u>copay</u> per prescription	<p>Refer to your Blue Rx Complete Drug List to determine the tier that applies to a covered drug.</p> <p>For out-of-network <u>prescription drugs</u>, you may be balance billed.</p> <p>1 <u>copay</u> for 30-day supply. 2 <u>copays</u> for 90-day supply (retail and mail order).</p> <p><u>Specialty drugs</u> are covered only when obtained through the <u>Specialty Pharmacy Network</u>.</p> <p><u>Specialty drugs</u> on the PrudentRx drug list (found at Wellmark.com) will have 30% <u>coinsurance</u>. If you enroll with PrudentRx, you will have \$0 member cost-share for drugs on the PrudentRx drug list.</p> <p>See wellmark.com/prescriptions for information about drugs and drug quantities that require prior authorization by Wellmark to be covered by your plan.</p>
	Tier 2	\$35 <u>copay</u> per prescription	\$35 <u>copay</u> per prescription	
	Tier 3	\$75 <u>copay</u> per prescription	\$75 <u>copay</u> per prescription	
	Tier 4	\$150 <u>copay</u> per prescription	\$150 <u>copay</u> per prescription	
	Specialty drugs	\$100 <u>copay</u> per prescription	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	Not covered	Waive cost-share for colonoscopies.
	Physician/surgeon fees	20% <u>coinsurance</u>	Not covered	Waive cost-share for colonoscopies.

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 immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	For <u>emergency medical conditions</u> 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.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Benefits for non-participating ambulance providers are based on actual billed charges. 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.
	<u>Urgent care</u>	\$25 <u>copay</u>	Not covered	Copay applies per date of service for facility and physician(s) combined.
	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	Not covered	-----None-----
If you have a hospital stay	Physician/surgeon fees	20% <u>coinsurance</u>	Not covered	-----None-----
	Outpatient services	Office: 0% <u>coinsurance</u> Facility: 20% <u>coinsurance</u>	Not covered	-----None-----
	Inpatient services	20% <u>coinsurance</u>	Not covered	-----None-----
If you are pregnant	Office visits	No charge	Not covered	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	No charge	Not covered	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% <u>coinsurance</u>	Not covered	-----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	
<p>If you need help recovering or have other special health needs</p>	<u>Home health care</u>	20% coinsurance	Not covered	-----None-----	
	<u>Rehabilitation services</u>	Office: \$25 copay per provider per date of service Facility: 20% coinsurance	Not covered	-----None-----	
	<u>Habilitation services</u>	Office: \$25 copay per provider per date of service Facility: 20% coinsurance	Not covered	-----None-----	
	<u>Skilled nursing care</u>	20% coinsurance	Not covered	-----None-----	
	<u>Durable medical equipment</u>	20% coinsurance	Not covered	-----None-----	
	<u>Hospice services</u>	20% coinsurance	Not covered	Hospice respite care is limited to 15 inpatient and 15 outpatient days per lifetime.	
	<p>If your child needs dental or eye care</p>	Children's eye exam	0% coinsurance	Not covered	One routine vision exam per calendar year. Must be performed by an in-network provider.
		Children's glasses	Not covered	Not covered	-----None-----
		Children's dental check-up	Not covered	Not covered	-----None-----

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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
- Cosmetic surgery
- Custodial care - in home or facility
- Dental care - Adult
- Dental check-up
- Extended home skilled nursing
- Glasses
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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
- Bariatric surgery
- Chiropractic care
- Infertility treatment (excludes some services)
- 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 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 Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

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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.

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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 deductible \$2,500
- PCP copayment \$25
- Hospital(facility) coinsurance 20%
- Other no charge No Charge

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
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In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$2,500
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$1,200
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,770

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

- The plan's overall deductible \$2,500
- Specialist copayment \$25
- Hospital(facility) coinsurance 20%
- Other coinsurance 20%

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
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In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$50
<u>Copayments</u>	\$1,300
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,370

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

- The plan's overall deductible \$2,500
- Specialist copayment \$25
- Hospital(facility) coinsurance 20%
- Other coinsurance 20%

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	\$2,800
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In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,900
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,000

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.



Physicians Clinic of Iowa HDHP 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 1-800-524-9242 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$4,000 person/\$8,000 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, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. In-network preventive care is covered before you meet your deductible.	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?	No. There are no other deductibles.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	\$4,000 person/\$8,000 family per calendar year.	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, the overall family out-of-pocket limit must be 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 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.
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	0% coinsurance	0% coinsurance	Doctor on Demand contracted telehealth services are covered.
	Specialist visit	0% coinsurance	0% coinsurance	Hearing exams are covered according to ACA guidelines.
	Preventive care/screening/immunization	No charge	0% coinsurance	One preventive exam and 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.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	0% coinsurance	-----None-----
	Imaging (CT/PET scans, MRIs)	0% coinsurance	0% 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
<p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at www.wellmark.com/prescriptions.</p>	Tier 1	0% <u>coinsurance</u>	0% <u>coinsurance</u>	<p>Refer to your Blue Rx Complete Drug List to determine the tier that applies to a covered drug.</p> <p>You pay the discounted cost of your <u>prescription drugs</u> until your overall <u>deductible</u> is met. For out-of-network <u>prescription drugs</u>, you may be balance billed.</p> <p>30-day supply for <u>prescription drugs</u>. 90-day prescription maximum.</p> <p><u>Specialty drugs</u> are covered only when obtained through the <u>Specialty Pharmacy Network</u>.</p> <p><u>Specialty drugs</u> on the PrudentRx drug list (found at Wellmark.com) will have 30% <u>coinsurance</u>. If you enroll with PrudentRx, you will have \$0 member cost-share for drugs on the PrudentRx drug list once your <u>deductible</u> is met.</p> <p>See wellmark.com/prescriptions for information about drugs and drug quantities that require prior authorization by Wellmark to be covered by your plan.</p>
	Tier 2	0% <u>coinsurance</u>	0% <u>coinsurance</u>	
	Tier 3	0% <u>coinsurance</u>	0% <u>coinsurance</u>	
	Tier 4	0% <u>coinsurance</u>	0% <u>coinsurance</u>	
	Specialty drugs	0% <u>coinsurance</u>	Not covered	
<p>If you have outpatient surgery</p>	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-----

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 immediate medical attention	<u>Emergency room care</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	For <u>emergency medical conditions</u> 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.
	<u>Emergency medical transportation</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	Benefits for non-participating ambulance <u>providers</u> are based on actual billed charges. For covered non-emergent situations, OON ground ambulance services are NOT reimbursed at the IN 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.
	<u>Urgent care</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	0% <u>coinsurance</u>	0% <u>coinsurance</u>	-----None-----
	Physician/surgeon fees	0% <u>coinsurance</u>	0% <u>coinsurance</u>	-----None-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% <u>coinsurance</u>	0% <u>coinsurance</u>	-----None-----
	Inpatient services	0% <u>coinsurance</u>	0% <u>coinsurance</u>	-----None-----
	Office visits	0% <u>coinsurance</u>	0% <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> .
If you are pregnant	Childbirth/delivery professional services	0% <u>coinsurance</u>	0% <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	0% <u>coinsurance</u>	0% <u>coinsurance</u>	-----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 need help recovering or have other special health needs	<u>Home health care</u>	0% coinsurance	0% coinsurance	None-----
	<u>Rehabilitation services</u>	0% coinsurance	0% coinsurance	None-----
	<u>Habilitation services</u>	0% coinsurance	0% coinsurance	None-----
	<u>Skilled nursing care</u>	0% coinsurance	0% coinsurance	None-----
	<u>Durable medical equipment</u>	0% coinsurance	0% coinsurance	None-----
	<u>Hospice services</u>	0% coinsurance	0% 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	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 1-800-524-9242.

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
- 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.)

- Applied Behavior Analysis therapy
- Bariatric surgery
- Chiropractic care
- Infertility treatment (excludes some services)
- 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 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 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: Wellmark at 1-800-524-9242 or Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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.

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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 deductible \$4,000
- PCP coinsurance 0%
- Hospital(facility) coinsurance 0%
- Other coinsurance 0%

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	
<u>Deductibles</u>	\$4,000
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$4,060

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

- The plan's overall deductible \$4,000
- Specialist coinsurance 0%
- Hospital(facility) coinsurance 0%
- Other coinsurance 0%

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	
<u>Deductibles</u>	\$4,000
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$4,020

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

- The plan's overall deductible \$4,000
- Specialist coinsurance 0%
- Hospital(facility) coinsurance 0%
- Other coinsurance 0%

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 \$2,800

In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$2,800
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,800

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.



PHYSICIANS' CLINIC
of Iowa, P.C.

