**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay For Covered Services

HODGE

**Hodge Company PPO**

**Coverage Period: 06/01/2024 – 05/31/2025**
Coverage for: Single & Family | Plan Type: 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?** | In-Network: **$2,500** person/**$5,000** family per calendar year. Out-of-Network: **$5,000** person/**$10,000** 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. Well-child care, in-network preventive care, in-network independent labs, in-network prosthetic limbs and services subject to 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.<br>Drug card deductibles. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | Health In-Network: **$6,850** person/ **$13,700** family per calendar year. Health Out-Of-Network: **$10,000** person/**$20,000** family per calendar year.The In-Network health and drug card out-of-pocket maximum amounts accumulate together. | 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. |

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **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 health 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 | $25 copay per provider per date of service | 40% coinsurance | Primary Care Practitioners (PCP) are defined as General and Family Practice, Internal Medicine, OB/GYN, Pediatricians, Nurse Practitioners, Certified Nurse Midwives and PAs. |
| | Specialist visit | $50 copay per provider per date of service | 40% coinsurance | Applies to Non-PCP providers. $25 copay per provider per date of service for in-network chiropractic services. Hearing exam are covered according to ACA guidelines. |
| | Preventive care/screening/ immunization | No charge | 40% coinsurance | One preventive exam and one gynecological exam per calendar year. One mammogram per calendar year. Well-child care is covered to age 7. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% coinsurance | 40% coinsurance | For a test in a provider's office or clinic, your cost is included in the cost-share listed above. |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 40% coinsurance | For a test in a provider's office or clinic, your cost is included in the cost-share listed above. |

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

| Common Medical Event | Services You May Need | What You Will Pay In-Network (IN) Provider (You will pay the least) | What You Will Pay Out-of-Network (OON) Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | | | |
| **If you need drugs to treat your illness or condition**<br>More information about **prescription drug coverage** is available at www.medone-rx.com . | Generic Drugs - Tier 1 | $15 copay/prescription (retail)<br>$30 copay/prescription (mail order)<br>Deductible does not apply | | Retail: Covers up to a 30-day supply for the listed copay; a 31 to 60-day supply for 2 copays; and a 61 to 90-day supply for 3 copays. Mail order: Covers up to a 90-day for the listed copay.<br>Medications required as part of PPACA Preventive Care services are covered 100% with no Copay required.<br>If a name brand drug is purchased when a generic is available, you will be responsible for the difference in cost between the name brand and generic drug in addition to the name brand copay. This limitation will not apply if your physician indicates that the name brand must be taken.<br>Specialty drugs are limited to a 30-day supply.<br>Specialty Drugs may have a manufacturer assistance program that covers most of the coinsurance amount. Claim cost incurred by drugs included in the Copay Assist Program will NOT apply toward the annual out of pocket maximum, as most or all of the payment will be paid by the manufacturer copay assistance program. If you have actual out of pocket costs after the manufacture copay assistance program has paid, you will pay no more than your copay when utilizing the manufacturers copay assistance.<br>Certain medications may require you to try a less expensive version of the medication first. This provision will apply to all new employees and anyone taking a new medication for the first time. |
| | Preferred Brand Drugs - Tier 2 | 25% to a maximum copay of $60/prescription (retail);<br>25% to a maximum copay of $120/prescription (mail order). Deductible does not apply. | | |
| | Non-Preferred Brand Drugs - Tier 3 | 25% to a maximum copay of $100/prescription (retail);<br>25% to a maximum copay of $200/prescription (mail order). Deductible does not apply. | | |
| | Specialty Drugs – Tier 4 | 50% (retail or mail order). Deductible does not apply | | |

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| Common Medical Event | Services You May Need | What You Will Pay In-Network (IN) Provider (You will pay the least) | What You Will Pay Out-of-Network (OON) Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 40% coinsurance | ------None------ |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | ------None------ |
| **If you need immediate medical attention** | Emergency room care | $150 copay per facility per date of service for facility and physician(s) combined | $150 copay per facility per date of service for facility and physician(s) combined | For emergency medical conditions treated out-of-network, it is likely you may not be balance billed pursuant to the federal rules developed for implementation of the No Surprises Act. |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | For covered non-emergent situations, out-of-network ambulance services are NOT reimbursed at the in-network level. The member may be balance billed for any out-of-network service as established under the rules developed for implementation of the No Surprises Act. |
| | Urgent care | $75 copay per facility per date of service for facility and physician(s) combined | 40% coinsurance | $25 copay per provider per date of service on services for mental health/substance abuse. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | 40% coinsurance | Transplants are not covered. |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | Transplants are not covered. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Office: $25 copay per provider per date of service<br>Facility: 20% coinsurance | 40% coinsurance | ------None------ |
| | Inpatient services | 20% coinsurance | 40% coinsurance | ------None------ |

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

| Common Medical Event | Services You May Need | What You Will Pay In-Network (IN) Provider (You will pay the least) | What You Will Pay Out-of-Network (OON) Provider (You will pay the most) | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| **If you are pregnant** | Office visits | 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 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 | 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------ |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | 40% coinsurance | ------None------ |
| | Rehabilitation services | Office: $25 PCP/$50 Non-PCP copay per provider per date of service Facility: 20% coinsurance | 40% coinsurance | ------None------ |
| | Habilitation services | Office: $25 PCP/$50 Non-PCP copay per provider per date of service Facility: 20% coinsurance | 40% coinsurance | ------None------ |
| | 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. |
| **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
- Bariatric surgery
- Cosmetic surgery
- Custodial care - in home or facility
- Dental care - Adult
- Dental check-up
- Extended home skilled nursing
- Eye exam
- Glasses
- Hearing aids
- Infertility treatment
- 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
- Chiropractic care
- 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.*

***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 may 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** |

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $2,500 |
| Copayments | $100 |
| Coinsurance | $1,700 |
| *What isn't covered* | |
| **Limits or exclusions** | **$70** |
| **The total Peg would pay is** | **$4,370** |

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

| | |
|---|---|
| The plan's overall deductible | $2,500 |
| Specialist copayment | $50 |
| Hospital(facility) coinsurance | 20% |
| Durable medical equip. 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** |

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $50 |
| Copayments | $400 |
| Coinsurance | $0 |
| *What isn't covered* | |
| **Limits or exclusions** | **$4,300** |
| **The total Joe would pay is** | **$4,750** |

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

| | |
|---|---|
| The plan's overall deductible | $2,500 |
| Specialist copayment | $50 |
| Emergency room copayment | $150 |
| 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** |

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,200 |
| Copayments | $400 |
| Coinsurance | $0 |
| *What isn't covered* | |
| **Limits or exclusions** | **$10** |
| **The total Mia would pay is** | **$1,610** |

*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.