


UnityPoint Health Iowa Zip Code Zone 1 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 1-800-546-3939. 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 1-800-546-3939 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u>?	Health: Single / Family Level 1: \$750 / \$1,500 Level 2: \$750 / \$1,500 Level 3: \$1,050 / \$2,100 Level 4: \$1,350 / \$2,700	Generally, you must pay all the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u>?	Yes. Preventive care from in-network <u>providers</u> , physician maternity, ambulance services, home health services, outpatient x-ray and labs, routine hearing exams and health and drug card <u>copayments</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No. There are no other <u>deductibles</u> .	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	Health: Single / Family Level 1: \$3,900 / \$7,800 Level 2: \$3,900 / \$7,800 Level 3: \$4,900 / \$9,300 Level 4: \$6,900 / \$9,900 Drug Card: \$3,900 person/ \$7,800 family per calendar year. The In-Network health and drug card <u>out-of-pocket</u> maximum amounts accumulate together.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>balance-billed charges</u> , and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

Important Questions	Answers	Why this Matters:
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.wellmark.com or call 1-800-546-3939 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an out-of-network <u>provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an out-of-network <u>provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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

Common Medical Event	Services You May Need	What You Will Pay In-Network (IN) Provider (You will pay the least)	What You Will Pay Out-of-Network (OON) Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	Level 1 \$10; Level 2 \$35; Level 3 \$60; Level 4 \$125	Not covered	<u>Copay</u> per <u>provider</u> per date of service (DOS). For this <u>plan</u> you must select a Designated <u>Primary Care Provider</u> (PCP). PCP <u>provider</u> types can be found in the What You Pay section of your <u>plan</u> document. UnityPoint Health Level 1 benefits are those provided by UnityPoint facilities and practitioners or provided by certain practitioners as designated by UnityPoint Health. In- <u>network providers</u> are services received from Wellmark Blue HMO SM <u>network providers</u> .
	<u>Specialist</u> visit	Level 1 \$40; Level 2 \$65; Level 3 \$90; Level 4 \$180	Not covered	<u>Copay</u> per <u>provider</u> per DOS. Applies to Non-PCP <u>providers</u> . \$25 <u>copay</u> per <u>provider</u> per DOS for chiropractic services.
	<u>Preventive care/screening/immunization</u>	No charge	Not covered	One preventive exam and one mammogram per calendar year. One hearing exam is covered as part of <u>preventive care</u> . Waive cost-share for routine hearing exams. 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.

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-546-3939.

Common Medical Event	Services You May Need	What You Will Pay In- <u>Network</u> (IN) <u>Provider</u> (You will pay the least)	What You Will Pay Out-of- <u>Network</u> (OON) <u>Provider</u> (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Coinurance (coin); Level 1 20%; Level 2 25%; Level 3 30%; Level 4 50%	Not covered	For a test in a <u>provider's</u> office or clinic, your cost is included in the cost-share listed above.
	Imaging (CT/PET scans, MRIs)	Coin; Level 1 20%; Level 2 25%; Level 3 30%; Level 4 50%	Not covered	For a test in a <u>provider's</u> office or clinic, your cost is included in the cost-share listed above.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is at www.wellmark.com/prescriptions .	Tier 1	Level 1: \$5 <u>copay</u> per prescription Level 2: \$10 <u>copay</u> per prescription	Not covered	Domestic pharmacy services are those received at UnityPoint Health pharmacy (level 1). In- <u>Network</u> pharmacy services are those received at Wellmark BlueRX SM participating pharmacies (level 2). Refer to your Blue Rx Value Plus Drug List to determine the tier that applies to a covered drug. 1 <u>copay</u> for 30-day supply. 90-day supply, retail: Tier 1 - Level 1 \$15/Level 2 \$30 <u>copay</u> ; Tiers 2 and 3 - Level 1 \$100/Level 2 \$120 <u>copay</u> 90-day supply, mail order through CVS: Tier 1 - \$30 <u>copay</u> ; Tiers 2 and 3 - \$120 <u>copay</u> Erectile dysfunction drugs not covered. <u>Specialty drugs</u> on UPH Specialty Pharmacy Drug List are covered only when filled at UPH Specialty Pharmacy (NPI 101392788). If not available at UPH Specialty Pharmacy, covered when obtained through participating pharmacies. See wellmark.com/prescriptions for information about drugs and drug quantities that require prior authorization by Wellmark to be covered by your plan.
	Tier 2	Level 1: \$35 <u>copay</u> per prescription Level 2: \$40 <u>copay</u> per prescription	Not covered	
	Tier 3	Level 1: \$35 <u>copay</u> per prescription Level 2: \$40 <u>copay</u> per prescription	Not covered	
	Specialty drugs	\$70 <u>copay</u> per prescription	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Coin; Level 1 20%; Level 2 25%; Level 3 30%; Level 4 50%	Not covered	-----None-----
	<u>Physician/surgeon</u> fees	Coin; Level 1 20%; Level 2 25%; Level 3 30%; Level 4 50%	Not covered	-----None-----

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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 need immediate medical attention	<u>Emergency room care</u>	\$300 <u>copay</u>	\$300 <u>copay</u>	<u>Copay</u> applies per visit for facility and physician(s) combined. 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>	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>	Level 1 \$20; Level 2 \$20; Level 3 \$20; Level 4 \$125	Not covered	<u>Copay</u> applies per provider per DOS for facility and physician(s) combined.
If you have a hospital stay	Facility fee (e.g., hospital room)	Coin; Level 1 20%; Level 2 25%; Level 3 30%; Level 4 50%	Not covered	Services for transplants and bariatric surgery are limited to Blue Distinction Centers.
	<u>Physician/surgeon fees</u>	Coin; Level 1 20%; Level 2 25%; Level 3 30%; Level 4 50%	Not covered	-----None-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: \$10 <u>copay</u> per provider per date of service Facility: 20% <u>coinsurance</u>	Not covered	-----None-----
	Inpatient services	20% <u>coinsurance</u>	Not covered	-----None-----

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-546-3939.

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	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 <u>preventive services</u> . For any <u>in-network</u> 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	Coin; Level 1 20%; Level 2 25%; Level 3 30%; Level 4 50%	Not covered	-----None-----

For more information about limitations and exceptions, see your plan document or call Wellmark at 1-800-546-3939.

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>	Apply coin; Level 1 20%; Level 2 25%; Level 3 30%; Level 4 50%	Not covered	-----None-----
	<u>Rehabilitation services</u>	PCP Office: Level 1 \$10; Level 2 \$35; Level 3 \$60; Level 4 \$125 / Facility coin; Level 1 20%; Level 2 25%; Level 3 30%; Level 4 50%	Not covered	<u>Copay</u> applies per <u>provider</u> per DOS. Office Non-PCP: Level 1 \$40; Level 2 \$65; Level 3 \$90; Level 4 \$180.
	<u>Habilitation services</u>	PCP Office: Level 1 \$10; Level 2 \$35; Level 3 \$60; Level 4 \$125 / Facility coin; Level 1 20%; Level 2 25%; Level 3 30%; Level 4 50%	Not covered	<u>Copay</u> applies per <u>provider</u> per DOS. Office Non-PCP: Level 1 \$40; Level 2 \$65; Level 3 \$90; Level 4 \$180.
	<u>Skilled nursing care</u>	Coin; Level 1 20%; Level 2 25%; Level 3 30%; Level 4 50%	Not covered	Limit of 100 days per calendar year.
	<u>Durable medical equipment</u>	Coin; Level 1 20%; Level 2 25%; Level 3 30%; Level 4 50%	Not covered	Orthotics are covered.
	<u>Hospice services</u>	Coin; Level 1 20%; Level 2 25%; Level 3 30%; Level 4 50%	Not covered	Hospice 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 1-800-546-3939.

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
- Long-term care
- Routine eye care - Adult
- Routine foot care
- Some pharmacy drugs are not covered
- 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 (\$10 copay per provider per date of serv)
- Bariatric surgery (limited to Blue Distinction Centers)
- Chiropractic care
- Hearing aids (\$2,500 every 36 months)
- Infertility treatment (\$15,000 LTM)
- Most coverage provided outside the U.S.
- Private-duty nursing - short term intermittent home skilled nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 1-800-546-3939.

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 <u>deductible</u>	\$750
■ PCP <u>copayment</u>	\$10
■ Hospital(facility) <u>coinsurance</u>	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>	\$750
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$1,500
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$2,320

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

■ The plan's overall <u>deductible</u>	\$750
■ <u>Specialist</u> <u>copayment</u>	\$40
■ Hospital(facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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>	\$1,200
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,270

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

■ The plan's overall <u>deductible</u>	\$750
■ <u>Specialist</u> <u>copayment</u>	\$40
■ Hospital(facility) <u>copayment</u>	\$300
■ Other <u>coinsurance</u>	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>	\$750
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$50
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,350

Claim examples calculate as if services are provided by UnityPoint Health.

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.

