



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, call 866-843-3461 or visit us at www.healthpartners.com. 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 866-843-3461 to request a copy.

| Important Questions | Answers | Why This Matters: |
|----------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>What is the overall deductible?</p> | <p>In-network: \$3,000 Individual/ \$6,000 Family Out-of-network: \$10,000 Individual/ \$20,000 Family</p> | <p>Generally, you must pay all of 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.</p> |
| <p>Are there services covered before you meet your deductible?</p> | <p>Yes, some preventive care services are covered before you meet your deductible.</p> | <p>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 https://www.healthcare.gov/coverage/preventive-care-benefits/.</p> |
| <p>Are there other deductibles for specific services?</p> | <p>There are no other specific deductibles.</p> | <p>You don't have to meet deductibles for specific services.</p> |
| <p>What is the out-of-pocket limit for this plan?</p> | <p>In-network medical/pharmacy: \$6,000 Individual/\$12,000 Family Out-of-network medical/pharmacy: \$30,000 Individual/\$60,000 Family</p> | <p>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.</p> |

| Important Questions | Answers | Why This Matters: |
|------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is not included in the out-of-pocket limit ? | Premium , balance-billed charges (unless balanced billing is prohibited), 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.healthpartnersunitypoint.com/openaccess or call 1-866-843-3461 for a list of in-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 in-network 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.

31 day supply retail / 93 day supply mail order. Formulary insulin covered with no member cost-sharing after a \$25 benefit cap per prescription per month.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, and Other Important Information |
|---------------------------------------------------------------|--------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | Primary Office Visit: 30% coinsurance Convenience Care: 30% coinsurance UnityPoint Health Virtual Care or Virtuwell: 0% coinsurance | Primary Office Visit: 50% coinsurance Convenience Care: 50% coinsurance | None |
| | Specialist visit | 30% coinsurance | 50% coinsurance | None |
| | Preventive care/screening/immunization | No charge | 50% coinsurance | 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) | 30% coinsurance | 50% coinsurance | None |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, and Other Important Information |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | Imaging (CT/PET scans, MRIs) | 30% coinsurance | 50% coinsurance | None |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at healthpartners.com/genericsadvantagerx | Generic drugs | Formulary : 30% coinsurance Non-formulary : 50% coinsurance | Formulary : 50% coinsurance at retail, mail not covered Non-formulary : 50% coinsurance at retail, mail not covered | 31 day supply retail / 93 day supply mail order. Formulary insulin covered with no member cost-sharing after a \$25 benefit cap per prescription per month. Select preventive drugs: Generic: No charge; Brand: \$60 copay. |
| | Formulary brand drugs | 30% coinsurance | 50% coinsurance at retail, mail not covered | |
| | Non-formulary brand drugs | 50% coinsurance | 50% coinsurance at retail, mail not covered | |
| | Specialty drugs | 30% coinsurance | Not covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 30% coinsurance | 50% coinsurance | None |
| | Physician/surgeon fees | 30% coinsurance | 50% coinsurance | None |
| If you need immediate medical attention | Emergency room care | 30% coinsurance | 30% coinsurance | Out-of-network services apply to the in-network deductible. |
| | Emergency medical transportation | 30% coinsurance | 30% coinsurance | Out-of-network services apply to the in-network deductible. |
| | Urgent care | 30% coinsurance | 30% coinsurance | Out-of-Network services apply to the in-network deductible. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 30% coinsurance | 50% coinsurance | None |
| | Physician/surgeon fees | 30% coinsurance | 50% coinsurance | None |
| If you need mental health, behavioral health, or substance abuse needs | Outpatient services | 30% coinsurance | 50% coinsurance | |
| | Inpatient services | 30% coinsurance | 50% coinsurance | None |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, and Other Important Information |
|----------------------------------------------------------------|-------------------------------------------|----------------------------------------------|----------------------------------------------------|-------------------------------------------------------------------------------------------------------|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you are pregnant | Office visits | No charge | 50% coinsurance | Depending on the type of services, a copayment, coinsurance, or deductible may apply. |
| | Childbirth/delivery professional services | 30% coinsurance | 50% coinsurance | None |
| | Childbirth/delivery facility services | 30% coinsurance | 50% coinsurance | None |
| If you need help recovering or have other special health needs | Home health care | 30% coinsurance | 50% coinsurance | None |
| | Rehabilitation services | 30% coinsurance | 50% coinsurance | None |
| | Habilitation services | 30% coinsurance | 50% coinsurance | None |
| | Skilled nursing care | 30% coinsurance | 50% coinsurance | None |
| | Durable medical equipment | 30% coinsurance | 50% coinsurance | None |
| | Hospice services | 30% coinsurance | 50% coinsurance | 15 days per lifetime . |
| If your child needs dental or eye care | Children's eye exam | No charge | 50% coinsurance | None |
| | Children's glasses | 30% coinsurance | Not covered | Limited to one pair of eyeglasses (lenses and frames) or one pair of contact lenses per benefit year. |
| | Children's dental check-up | No charge | No charge | None |

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 | • Long-term care | • Routine foot care |
| • Cosmetic surgery with the exception of port wine stain removal and reconstructive surgery | • Non-emergency care when traveling outside the U.S. | • Weight loss programs |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | |
|----------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|----------------------------|
| • Bariatric surgery | • Dental care (Children) | • Private-duty nursing |
| • Chiropractic care | • Infertility treatment | • Routine eye care (Adult) |

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: Your plan at 1-866-843-3461, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, Iowa Insurance Division at 1-515-281-6348. 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, contact: Your [plan](#) at 1-866-843-3461, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Iowa Insurance Division at 1-515-281-6348.

Does this plan provide [Minimum Essential Coverage](#)? Yes.

[Minimum Essential Coverage](#) generally includes [plan](#), [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 [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](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-398-9119.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-843-3461.

Chinese (中文): 打这电话 1-866-843-3461.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-843-3461.

—————*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*—————

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 | \$3,000 |
| ■ Specialist coinsurance | 30% |
| ■ Hospital (facility) coinsurance | 30% |
| ■ Other coinsurance | 30% |

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 | \$3,000 |
| Copayments | \$0 |
| Coinsurance | \$2,800 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$70 |
| The total Peg would pay is | \$5,870 |

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

| | |
|-----------------------------------------------------------------|---------|
| ■ The plan's overall deductible | \$3,000 |
| ■ Specialist coinsurance | 30% |
| ■ Hospital (facility) coinsurance | 30% |
| ■ Other coinsurance | 30% |

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* | \$1,900 |
| Copayments | \$0 |
| Coinsurance | \$1,000 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$2,920 |

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

| | |
|-----------------------------------------------------------------|---------|
| ■ The plan's overall deductible | \$3,000 |
| ■ Specialist coinsurance | 30% |
| ■ Hospital (facility) coinsurance | 30% |
| ■ Other coinsurance | 30% |

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