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 515-243-3246. 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.dol.gov/ebsa/healthreform.com or call 515-243-3246 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: **$750** per person/ **$1,500** per family; Non-Network: **$1,500** per person/ **$3,000** per family	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.
Are there services covered before you meet your deductible?	Yes. Network preventive care, dental and vision services, hearing aid benefits and LiveHealth Online services 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 https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this Plan?	Network: **$2,750** per person/ **$5,500** per family; Non-Network: **$5,500** per person/ **$11,000** per family Prescription Drugs: **$3,850** per person/**$7,700** per family	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 limit until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, dental and vision services, hearing aids, and health care this Plan does not 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.ualocal33.org or call 515-243-3246 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 a non-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 a non-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		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-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	20% coinsurance	30% coinsurance	You may also use LiveHealth Online for minor illnesses free of charge. If you use any other telehealth provider service, the non-network provider deductible and coinsurance applies.
	Specialist visit	20% coinsurance	30% coinsurance	None
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	30% coinsurance	Office visits are not covered from a non-network provider. You may have to pay for services that are not 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	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.savrx.com.	Generic drugs	20% coinsurance	20% coinsurance	Prescription drugs are not covered if prescription drug card is not shown at time of purchase. No charge for ACA-required generic preventive drugs such as FDA-approved contraceptives (or brand name drugs if a generic is medically inappropriate).
	Brand drugs	20% coinsurance; if a brand drug is purchased when a generic is available; you pay 20% coinsurance and the difference in cost between the brand and the generic.	20% coinsurance; if a brand drug is purchased when a generic is available; you pay 20% coinsurance and the difference in cost between the brand and the generic.	
	Specialty drugs	20% coinsurance	20% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance	None
	Physician/surgeon fees	20% coinsurance	30% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$100 copayment, and 20% coinsurance	$100 copayment, and 20% coinsurance	$100 copayment waived if you are admitted to the hospital within 24 hours.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Transportation to nearest appropriate facility for care of an emergency medical condition.
	Urgent care	20% coinsurance	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered unless due to emergency; $100 copayment and 20% coinsurance in case of emergency.	Non-network inpatient hospital stays are not covered unless due to emergency. You must pay 100% of charges for these stays.
	Physician/surgeon fees	20% coinsurance		
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	30% coinsurance	Therapists and psychologists obtained from LiveHealth Online services are provided free of charge. If any other telehealth provider service is used, the non-network provider deductible and coinsurance applies.
	Inpatient services	20% coinsurance	Not covered unless due to emergency; $100 copayment and 20% coinsurance in case of emergency.	Non-network inpatient hospital stays are not covered unless due to emergency. You must pay 100% of charges for these non-emergency stays.
If you are pregnant	Office visits	20% coinsurance	30% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound). Prenatal care (other than ACA-required preventive screenings) is not covered for dependent children. Delivery and other related inpatient charges are not covered for dependent children.
	Childbirth/delivery professional services	20% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	30% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	30% coinsurance	None
	Rehabilitation services	20% coinsurance	Outpatient: 30% coinsurance. Inpatient not covered unless due to emergency; $100 copayment and 20% coinsurance in case of emergency.	Physical, speech and occupational therapy coverage is limited to 20 combined visits per person per calendar year. You must pay 100% of charges for non-network inpatient stays if not due to emergency.
	Habilitation services	20% coinsurance	Outpatient: 30% coinsurance. Inpatient not covered unless due to emergency; $100 copayment and 20% coinsurance in case of emergency.	You must pay 100% of charges for non-network inpatient stays if not due to emergency.
	Skilled nursing care	20% coinsurance	Outpatient: 30% coinsurance. Inpatient not covered unless due to emergency; $100 copayment and 20% coinsurance in case of emergency.	You must pay 100% of charges for non-network inpatient stays if not due to emergency.
	Durable medical equipment	20% coinsurance	30% coinsurance	Purchase price or maintenance expenses paid only once per item.
	Hospice services	20% coinsurance	Outpatient: 30% coinsurance. Inpatient not covered unless due to emergency; $100 copayment and 20% coinsurance in case of emergency.	Person must be diagnosed with having a life expectancy of six months or less. Coverage limited to a maximum of 210 days. You must pay 100% of charges for non-network inpatient stays if not due to emergency.
If your child needs dental or eye care	Children's eye exam	No charge up to $150 limit. Deductible does not apply.	No charge up to $150 limit. Deductible does not apply.	$150 calendar year maximum per person for eye exam and glasses combined. Coverage can be declined. $1,000 maximum per person per calendar year for expenses paid under the member's HRA.
	Children's glasses			
	Children's dental check-up	No charge Deductible does not apply.	No charge. Deductible does not apply.	Limited to one check-up every 6 months. $1,000 maximum per person per calendar year does not apply to individuals under age 19.Coverage can be declined.

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	• Infertility treatment • Long-term care	• Non-emergency care when traveling outside the United States • Private-duty nursing

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your Plan document.)		
• Chiropractic care (reimbursable up to $1,000 through member's HRA; otherwise, not covered) • Cosmetic surgery (only for reconstruction after a mastectomy) • Dental care (Adult) (One exam every 6 months; $1,000 per person calendar year maximum; coverage can be declined)	• Hearing aids ($350 maximum per ear per person per four-year period) • Routine eye care (Adult) ($150 calendar year maximum per person for exam and glasses combined; coverage can be declined; $1,000 expense maximum per person per calendar year payable from member's HRA)	• Routine foot care (only foot orthotics, coverage limited to $400 per calendar year per person) • Weight loss programs (only as required by health reform law)

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 Department of Labor's 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 on how 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 the Plan at 515-243-3246. You may also contact the Department of Labor's 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.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 515-243-3246.

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 network pre-natal care and a hospital delivery)

The Plan's overall deductible	$750
Specialist coinsurance	20%
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	$750
Copayments	$0
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,810**

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

The Plan's overall deductible	$750
Specialist coinsurance	20%
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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$750
Copayments	$0
Coinsurance	$780
What isn't covered	
Limits or exclusions	$750
The total Joe would pay is	**$2,280**

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

The Plan's overall deductible	$750
Specialist coinsurance	20%
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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$750
Copayments	$390
Coinsurance	$330
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,470**

***NOTE:** A Health Reimbursement Account (HRA) is available under this Plan. The HRA generally covers expenses that qualify as allowable "medical care" by the IRS and satisfy any requirements imposed by the Plan. Please refer to the SPD for details.

The **Plan** would be responsible for the other costs of these EXAMPLE covered services.