



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?	<u>Network</u> : \$750 per person/ \$1,500 per family; <u>Non-Network</u> : \$1,500 per person/ \$3,000 per family	Generally, you must pay all of the costs from providers 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 deductible?	Yes. <u>Network preventive care</u> , dental and vision services, hearing aid benefits and LiveHealth Online services 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 https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	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>?	<u>Network</u> : \$2,750 per person/ \$5,500 per family; <u>Non-Network</u> : \$5,500 per person/ \$11,000 per family <u>Prescription Drugs</u> : \$3,850 per person/\$7,700 per family	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 limit</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-billing</u> charges, dental and vision services, hearing aids, and health care this <u>Plan</u> does not cover	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. See www.ulocal33.org or call 515-243-3246 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 a <u>non-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>Plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use a <u>non-network 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		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% <u>coinsurance</u>	30% <u>coinsurance</u>	You may also use LiveHealth Online for minor illnesses free of charge. If you use any other telehealth provider service, the <u>non-network provider deductible</u> and <u>coinsurance</u> applies.
	<u>Specialist</u> visit	20% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No charge. <u>Deductible</u> does not apply.	30% <u>coinsurance</u>	Office visits are not covered from a <u>non-network provider</u> . You may have to pay for services that are not 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 test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.savrx.com .	Generic drugs	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Prescription drugs</u> are not covered if <u>prescription drug</u> 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% <u>coinsurance</u> ; if a brand drug is purchased when a generic is available; you pay 20% <u>coinsurance</u> and the difference in cost between the brand and the generic.	20% <u>coinsurance</u> ; if a brand drug is purchased when a generic is available; you pay 20% <u>coinsurance</u> and the difference in cost between the brand and the generic.	
	<u>Specialty drugs</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	30% <u>coinsurance</u>	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	<u>Emergency room care</u>	\$100 <u>copayment</u> , and 20% <u>coinsurance</u>	\$100 <u>copayment</u> , and 20% <u>coinsurance</u>	\$100 <u>copayment</u> waived if you are admitted to the hospital within 24 hours.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Transportation to nearest appropriate facility for care of an <u>emergency medical condition</u> .
	<u>Urgent care</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	Not covered unless due to emergency; \$100 <u>copayment</u> and 20% <u>coinsurance</u> in case of emergency.	<u>Non-network</u> inpatient hospital stays are not covered unless due to emergency. You must pay 100% of charges for these stays.
	Physician/surgeon fees	20% <u>coinsurance</u>		
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Therapists and psychologists obtained from LiveHealth Online services are provided free of charge. If any other telehealth <u>provider</u> service is used, the <u>non-network provider deductible</u> and <u>coinsurance</u> applies.
	Inpatient services	20% <u>coinsurance</u>	Not covered unless due to emergency; \$100 <u>copayment</u> and 20% <u>coinsurance</u> in case of emergency.	<u>Non-network</u> 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% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Prenatal care (other than ACA-required preventive <u>screenings</u>) is not covered for dependent children. Delivery and other related inpatient charges are not covered for dependent children.
	Childbirth/delivery facility services	20% <u>coinsurance</u>	30% <u>coinsurance</u>	

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	<u>Home health care</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	Outpatient: 30% <u>coinsurance</u> . Inpatient not covered unless due to emergency; \$100 <u>copayment</u> and 20% <u>coinsurance</u> 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 <u>non-network</u> inpatient stays if not due to emergency.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	Outpatient: 30% <u>coinsurance</u> . Inpatient not covered unless due to emergency; \$100 <u>copayment</u> and 20% <u>coinsurance</u> in case of emergency.	You must pay 100% of charges for <u>non-network</u> inpatient stays if not due to emergency.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	Outpatient: 30% <u>coinsurance</u> . Inpatient not covered unless due to emergency; \$100 <u>copayment</u> and 20% <u>coinsurance</u> in case of emergency.	You must pay 100% of charges for <u>non-network</u> inpatient stays if not due to emergency.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Purchase price or maintenance expenses paid only once per item.
	<u>Hospice services</u>	20% <u>coinsurance</u>	Outpatient: 30% <u>coinsurance</u> . Inpatient not covered unless due to emergency; \$100 <u>copayment</u> and 20% <u>coinsurance</u> 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 <u>non-network</u> inpatient stays if not due to emergency.
If your child needs dental or eye care	Children's eye exam	No charge up to \$1,000 limit. <u>Deductible</u> does not apply.	No charge up to \$1,000 limit. <u>Deductible</u> does not apply.	\$1,000 maximum per person every two calendar years 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	No charge <u>Deductible</u> does not apply.	No charge. <u>Deductible</u> does not apply.	Limited to one check-up every 6 months. \$1,500 maximum per person per calendar year does not apply to individuals under age 19. Coverage can be declined.
	Children's dental check-up	No charge <u>Deductible</u> does not apply.	No charge. <u>Deductible</u> does not apply.	

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	• Non-emergency care when traveling outside the United States
• Bariatric surgery	• 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)	• Hearing aids (\$350 maximum per ear per person per four-year period)	• Routine foot care (only foot orthotics, coverage limited to \$400 per calendar year per person)
• Cosmetic surgery (only for reconstruction after a mastectomy)	• Routine eye care (Adult) (\$1,000 maximum per person every two calendar years for exam and glasses combined; coverage can be declined; \$1,000 expense maximum per person per calendar year payable from member's HRA)	• Weight loss programs (only as required by health reform law)
• Dental care (Adult) (One exam every 6 months; \$1,500 per person calendar year maximum; coverage can be declined)		

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](http://www.healthcare.gov). For more information about the Marketplace, visit [www.HealthCare.gov](http://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 <u>Plan's</u> overall <u>deductible</u>	\$750
■ <u>Specialist coinsurance</u>	20%
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	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	
<u>Deductibles</u>	\$750
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$2,000
<i>What isn't covered</i>	
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 <u>Plan's</u> overall <u>deductible</u>	\$750
■ <u>Specialist coinsurance</u>	20%
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other 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**

In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$750
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$780
<i>What isn't covered</i>	
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 <u>Plan's</u> overall <u>deductible</u>	\$750
■ <u>Specialist coinsurance</u>	20%
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other 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**

In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$750
<u>Copayments</u>	\$390
<u>Coinsurance</u>	\$330
<i>What isn't covered</i>	
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.