**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 1-800-373-1327. 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 1-800-373-1327 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | **Preferred (Affiliated Providers)**<br>Single $1,000<br>Family $2,000<br><br>**In-Network (HealthSmart Providers)**<br>Single $1,500<br>Family $3,000<br><br>**Out-of-Network**<br>Single $2,000<br>Family $4,000<br><br>Deductible is per calendar year and does not apply to amounts in excess of UCR, services not covered, and preventive care. | 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. **Preferred (Affiliated Providers)** and **In-Network (HealthSmart Providers)** deductibles accumulate together. **Out-of-Network** is a separate and additional deductible. |
| **Are there services covered before you meet your deductible?** | Yes. | This plan covers some items and services even if you haven't yet met the deductible amount. 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?** | Yes. | All services that are available through an **Affiliated Provider** but performed at a **Non-Affiliated Provider**, are subject to an **"Added Deductible"** of **$500** per plan of care, unless a **"Waiver of the Added Deductible"** has been approved in writing by the Claims Administrator. |
| **What is the out-of-pocket limit for this plan?** | **Preferred (Affiliated Providers)**<br>Single $3,500<br>Family $7,000<br><br>**In-Network (HealthSmart Providers)**<br>Single $4,650<br>Family $9,300<br><br>**Out-of-Network**<br>Single $8,150<br>Family $16,300 | 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. **Preferred (Affiliated Providers)** and **In-Network (HealthSmart Providers)** out-of-pocket limits accumulate together. **Out-of-Network** is a separate and additional out-of-pocket limit. |

| | | |
|---|---|---|
| **What is not included in the out-of-pocket limit?** | Penalties for failing to follow pre-certification, amounts in excess of UCR, added deductible, 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 Preferred Provider?** | Yes. A current list of Preferred and In-Network Providers is available at **ebs.vbagateway.com**. | This plan uses provider networks. You will pay the least deductible and out-of-pocket if you use a **Preferred (Affiliated Provider)** You will pay a higher deductible and out-of-pocket if you use an **In-Network (HealthSmart Provider)**. You will pay the highest deductible and out-of-pocket 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 permission from this plan. |

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 |
|---|---|---|---|---|
| | | Preferred Providers & In-Network Providers (You will pay the least) | Out-of-Network Providers (You will pay the most) | |
| **If you visit a health care provider's office or clinic** | Primary care visit / Telehealth visit to treat an injury or illness | **Preferred (Affiliated Providers):** 20% (deductible waived)<br>**In-Network (HealthSmart Providers):** 30% after deductible | 40% after deductible | None |
| | Specialist visit / Telehealth visit | **Preferred (Affiliated Providers):** 20% (deductible waived)<br>**In-Network (HealthSmart Providers):** 30% after deductible | 40% after deductible | |
| | Chiropractor visit | **Preferred (Affiliated Providers):** 20% after deductible<br>**In-Network (HealthSmart Providers):** 30% after deductible | 40% after deductible | Limited to 12 visits per year |
| | Preventive care/screening/ Immunization | No charge for federally mandated services and annual audiogram | Not covered | You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive and check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | **Preferred (Affiliated Providers):** 20% (deductible waived)<br>**In-Network (HealthSmart Providers):** 30% after deductible | 40% after deductible is met | Covered services do not include dental examination or treatments. |
| | Imaging (CT/PET scans, MRIs) | **Preferred (Affiliated Providers):** 20% (deductible waived)<br>**In-Network (HealthSmart Providers):** Not covered | Not covered | In the event of an emergency away from a **Preferred (Affiliated Provider)**, benefits will be paid according to the emergency guidelines. |
| **If you need drugs to treat your illness or condition**<br><br>More information about | Generic | **Preferred (Affiliated Providers):** $6 copay<br>**In-Network (HealthSmart Providers):** $10 copay | Not covered | **Separate** $1,500 (single) / $3,000 (family) drug copay out-of-pocket maximum<br><br>**Specialty drug** out-of-pocket maximum combined with medical |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Preferred Providers & In-Network Providers (You will pay the least) | Out-of-Network Providers (You will pay the most) | |
| **prescription drug coverage** is available at the Human Resource's intranet. | Brand Name (Formulary) | **Preferred (Affiliated Providers):** $28 copay **In-Network (HealthSmart Providers):** $50 copay | Not covered | Covers up to a 30-day supply (initial prescriptions). Refills for prescriptions not to exceed a 90-day supply. Generic contraceptives are covered at 100%.<br><br>**Specialty drugs require pre-certification and must be filled at Heritage Park Pharmacy.** |
| | Brand Name (Non Formulary) | **Preferred (Affiliated Providers):** $55 copay **In-Network (HealthSmart Providers):** $80 copay | Not covered | |
| | Specialty drugs (Requires pre-certification and must be filled at Heritage Park Pharmacy | **Preferred (Affiliated Providers):** 20% after deductible **In-Network (HealthSmart Providers):** 30% after deductible | Not covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | **Preferred (Affiliated Providers):** 20% (deductible waived) **In-Network (HealthSmart Providers):** 30% after deductible | 40% after deductible | **Added Deductible** may apply if Waiver is not approved for **In-Network (HealthSmart Providers)** and **Out-of-Network**. |
| | Physician/surgeon fees | **Preferred (Affiliated Providers):** 20% (deductible waived) **In-Network (HealthSmart Providers):** 30% after deductible | 40% after deductible | None |
| **If you need immediate medical attention** | Emergency room care | **Emergency:** 20% after ded. Deductible waived if admitted. **Non-emergency: Preferred (Affiliated Providers):** 20% after deductible **In-Network (HealthSmart Providers):** 30% after deductible | **Emergency:** 20% after deductible. Deductible waived if admitted. **Non-emergency:** 40% after deductible | None |
| | Emergency medical transportation | **Emergency:** 20% after ded. Deductible waived if admitted. **Non-emergency: Preferred (Affiliated Providers):** 20% after deductible **In-Network (HealthSmart Providers):** 30% after deductible | **Emergency:** 20% after deductible. Deductible waived if admitted. **Non-emergency:** 40% after deductible | None |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Preferred Providers & In-Network Providers (You will pay the least) | Out-of-Network Providers (You will pay the most) | |
| | Urgent care | **Preferred (Affiliated Providers):** 20% (deductible waived)<br>**In-Network (HealthSmart Providers):** 30% after deductible | 40% after deductible | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | **Preferred (Affiliated Providers):** 20% (deductible waived)<br>**In-Network (HealthSmart Providers):** 30% after deductible | 40% after deductible | **Pre-certification** required. Payment may be reduced if pre-certification is not obtained, and an added deductible may apply if services are not at a **Preferred (Affiliated Provider)**. |
| | Physician/surgeon fees | **Preferred (Affiliated Providers):** 20% (deductible waived)<br>**In-Network (HealthSmart Providers):** 30% after deductible | 40% after deductible | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | **Preferred (Affiliated Providers):** 20% (deductible waived)<br>**In-Network (HealthSmart Providers):** 30% after deductible | 40% after deductible is met | **Pre-certification** required for Inpatient services. |
| | Inpatient services | **Preferred (Affiliated Providers):** 20% (deductible waived)<br>**In-Network (HealthSmart Providers):** 30% after deductible | 40% after deductible is met | |
| **If you are pregnant** | Office visits | **Preferred (Affiliated Providers):** 20% (deductible waived)<br>**In-Network (HealthSmart Providers):** 30% after deductible | 40% after deductible is met | None |
| | Childbirth/delivery professional services | **Preferred (Affiliated Providers):** 20% (deductible waived)<br>**In-Network (HealthSmart Providers):** 30% after deductible | 40% after deductible is met | **Pre-certification** required for extended stay. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Preferred Providers & In-Network Providers (You will pay the least) | Out-of-Network Providers (You will pay the most) | |
| | Childbirth/delivery facility services | **Preferred (Affiliated Providers):** 20% (deductible waived)<br>**In-Network (HealthSmart Providers):** 30% after deductible | 40% after deductible is met | |
| **If you need help recovering or have other special health needs** | Home health care | **Preferred (Affiliated Providers):** 20% (deductible waived)<br>**In-Network (HealthSmart Providers):** Not covered | Not covered | Services must be received from **Preferred (Affiliated Providers)** if available |
| | Physical Therapy | **Preferred (Affiliated Providers):** 20% (deductible waived)<br>**In-Network (HealthSmart Providers):** Not covered | Not covered | Limited to 30 visits per year |
| | Rehabilitation services | **Preferred (Affiliated Providers):** 20% (deductible waived)<br>**In-Network (HealthSmart Providers):** Not covered | Not covered | Limited to 30 visits per year<br><br>Autism Spectrum Treatment **In-Network (HealthSmart Providers):** 30%<br>**Out-of-Network:** 40% |
| | Habilitation services | **Preferred (Affiliated Providers):** 20% (deductible waived)<br>**In-Network (HealthSmart Providers):** Not covered | Not covered | Limited to 30 visits per year<br><br>Applied Behavior Analysis (ABA) **In-Network (HealthSmart Providers):** 30%<br>**Out-of-Network:** 40% |
| | Skilled nursing care | **Preferred (Affiliated Providers):** 20% (deductible waived)<br>**In-Network (HealthSmart Providers):** 30% after deductible | 40% after deductible | None |
| | Durable medical equipment | **Preferred (Affiliated Providers):** 20% (deductible waived)<br>**In-Network (HealthSmart Providers):** 30% after deductible | 40% after deductible | DME must be purchased or rented from a **Preferred (Affiliated Provider)** if available |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Preferred Providers & In-Network Providers (You will pay the least) | Out-of-Network Providers (You will pay the most) | |
| | Hospice services | **Preferred (Affiliated Providers):** 20% (deductible waived) **In-Network (HealthSmart Providers):** 30% after deductible | 40% after deductible | **Pre-certification** required. Limit of 15 days inpatient and 15 days outpatient. |
| **If your child needs dental or eye care** | Children's eye exam | No charge | Not covered | Visual acuity tests are covered under the preventive services benefit. Tests are limited to 1 visit per calendar year. Under age 5 as billed with your routine physical. |
| | Children's glasses | Not covered | Not covered | None |
| | Children's dental check-up | Not covered | Not covered | 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
- Bariatric Surgery
- Cosmetic Surgery
- Dental care (Adult)
- Hearing Aids
- Long-term care
- Non-Emergency care while traveling outside the U.S.
- 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.)**

- Chiropractic Care (12 visits maximum)
- Electric breast pumps
- Infertility treatment. Lifetime limit on treatment services of $15,000, no limit on diagnostic services
- Most coverage provided outside the U.S.
- Private-Duty 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: 1-866-444-3272 or www.dol.gov/ebsa/healthreform for the U.S. Department of Labor, Employee Benefits Security Administration, or 1-877-267-2323 or www.cciio.gms.gov for the U.S. Department of Health and Human Services. 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 EBS at 1-800-373-1327; or the 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 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 [319-752-3200].]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [319-752-3200].]
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 [319-752-3200].]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [319-752-3200].]

*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 | $1,000 |
| 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 | $0 |
| Copayments | $72 |
| Coinsurance | $2,540 |
| *What isn't covered* | |
| Limits or exclusions | $30 |
| **The total Peg would pay is** | **$2,642** |

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

| | |
|---|---|
| The plan's overall deductible | $1,000 |
| Specialist coinsurance | 20% |
| Hospital (facility) coinsurance | 20% |
| Other coinsurance | 20% |

**This EXAMPLE event includes services like:**
Primary care physician office visits
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 | $0 |
| Copayments | $408 |
| Coinsurance | $1,050 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Joe would pay is** | **$1,518** |

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

| | |
|---|---|
| The plan's overall deductible | $1,000 |
| 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 | $1,000 |
| Copayments | $0 |
| Coinsurance | $360 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,360** |

*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.