READ THIS FIRST, before you turn the page.

- **A Voluntary Employees Beneficiary Association Plan** is referred to herein as a VEBA.
- Because you are enrolled in a VEBA Health Reimbursement Arrangement (HRA), the enclosed Summary of Benefits and Coverage (SBC) is being provided as mandated by health care reform.
- SBCs are intended to provide information to easily compare coverage under different plans for which you are eligible.
- A VEBA is not a health insurance plan; you pay no premiums for it, and no copays or deductibles apply.
- A VEBA HRA is funded by your employer and used to reimburse your out-of-pocket eligible healthcare expenses. Participants request reimbursement for eligible expenses, thereby depleting the VEBA balance.
- Written to describe *insurance* plans, many of the terms used in SBCs pertain to health insurance and not to VEBAs. Despite this, we are required by law to provide the information in the format presented.

What is an SBC?
A Summary of Benefits and Coverage is a four page, two-sided document that describes certain "benefits and coverage under the applicable plan or coverage." It does not describe all aspects of the plan, and some terms used do not directly apply to VEBAs.

The SBC refers to a "Uniform Glossary of Terms" and how to obtain a copy. Common health plan terms are defined in the Glossary to aid your comparison of various coverages for which you are eligible.

What should I do with the SBC?
Use the SBC to review the coverage available under the plan. If you are eligible for coverage under other plans, compare the SBCs. Some plans are designed to work with another employer-sponsored plan. If so, consider the SBCs of both plans together. Retain all SBCs with other important plan materials.

What should I do if I have questions?
For answers to questions regarding the SBC, use the contact information provided in the SBC.

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, http://www.co.marshall.ia.us/ 1-641-844-2714. 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 https://www.healthcare.gov/sbc-glossary/ or call 1-641-844-2714 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes.	This plan has no deductible.
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?	Not Applicable.	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	Not Applicable.	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	Not Applicable.	This plan does not use a provider network. You can receive covered services from any provider.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No Charge	The plan provides benefits for unreimbursed medical expenses up to your account balance under the plan. Coverage is (a) limited to expenses incurred after termination of employment and (b) limited to individual's account balance.
	Specialist visit		
	Preventive care/screening/ immunization		
If you have a test	Diagnostic test (x-ray, blood work)		
	Imaging (CT/PET scans, MRIs)		
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.[insert].com	Generic drugs (Tier 1)		
	Preferred brand drugs (Tier 2)		
	Non-preferred brand drugs (Tier 3)		
	Specialty drugs (Tier 4)		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)		
	Physician/surgeon fees		
If you need immediate medical attention	Emergency room care		
	Emergency medical transportation		
	Urgent care		
If you have a hospital stay	Facility fee (e.g., hospital room)		
	Physician/surgeon fees		
If you need mental health, behavioral health, or substance abuse services	Outpatient services		
	Inpatient services		
If you are pregnant	Office visits		
	Childbirth/delivery professional services		
	Childbirth/delivery facility services		

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	Home health care	No Charge	The plan provides benefits for unreimbursed medical expenses up to your account balance under the plan. Coverage is (a) limited to expenses incurred after termination of employment and (b) limited to individual's account balance..
	Rehabilitation services		
	Habilitation services		
	Skilled nursing care		
	Durable medical equipment		
	Hospice services		
If your child needs dental or eye care	Children's eye exam		
	Children's glasses		
	Children's dental check-up		

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.)

- Cosmetic Surgery

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric Surgery
- Chiropractic care
- Dental care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight Loss Programs

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: 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, contact: 1-641-844-2714.

Does this plan provide Minimum Essential Coverage? Yes.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? No.
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 1-641-844-2714.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-641-844-2714.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-641-844-2714.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-641-844-2714.

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	$0
Specialist copayment	$0
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	*
The total Peg would pay is	**

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

The plan's overall deductible	$0
Specialist copayment	$0
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	**$7,400**

In this example, Joe would pay:

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

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

The plan's overall deductible	$0
Specialist copayment	$0
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	*
The total Mia would pay is	**

*Amount in excess of individual's account balance.
**Amount in excess of his/her account balance under this plan if expense is not covered by another plan (i.e. the group medical coverage).

The **plan** would be responsible for the other costs of these EXAMPLE covered services if not covered by another plan .