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, **www.iaatpa.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.iaatpa.com** or call **1-856-470-1200** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0** Basic Benefits and **$100** person / **$200** family for Major Medical Benefits.	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	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?	**$0** Basic Benefits and **$500** person for Major Medical Benefits.	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.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, cost containment penalties 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	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 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
		Basic Benefits	Major Medical Benefits	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Not available	20% co-insurance after the deductible	——————None——————
	Specialist visit	Not available	20% co-insurance after the deductible	——————None——————
	Preventive care/screening/ immunization	Covered 100%	Not available	Contact IAA for specific limitations.
If you have a test	Diagnostic test (blood work)	100% $50 Per Plan Yr.	20% co-insurance	The first $50 covered at no charge.
	Imaging (X-ray, CT/PET scans, MRIs)	$125/test	20% co-insurance	The first $125 covered at no charge.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.iaatpa.com**.	Generic drugs	Not available	20% co-insurance for active employees and 20% co-insurance of the amount paid after the deductible for retirees	——————None——————
	Preferred brand drugs			
	Non-preferred brand drugs			
	Specialty drugs	Contact IAA for applicable cost		Please see your Prescription Drug Benefit section within your Plan Document for details.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Covered 100%	Not available	——————None——————
	Physician/surgeon fees	Covered 100%	20% co-insurance after the deductible	——————None——————
If you need immediate medical attention	Emergency room care	Covered 100%	Not available	100% of the usual and reasonable charge.
	~~Emergency medical transportation~~	Not available	20% co-insurance after the deductible	——————None——————
	Urgent care	Not available	20% co-insurance after the deductible	——————None——————
If you have a hospital stay	Facility fee (e.g., hospital room)	Covered 100% for 120 days, then $5/day	20% co-insurance after the deductible	Services must be pre-certified or allowable charges will be reduced by $200.
	Physician/surgeon fees	Covered 100%	20% co-insurance after the deductible	——————None——————

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Basic Benefits	Major Medical Benefits	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not available	20% co-insurance after the deductible	——————None——————
	Inpatient services	Covered 100% for 120 days, then $5/day	20% co-insurance after the deductible	Services must be pre-certified or allowable charges will be reduced by $200.
If you are pregnant	Office visits	Covered 100%	20% co-insurance after the deductible	——————None——————
	Childbirth/delivery professional services	Covered 100%	Not available	——————None——————
	Childbirth/delivery facility services	Covered 100% for 120 days, then $5/day	20% co-insurance after the deductible	Services must be pre-certified for vaginal deliveries requiring more than a 48 hour stay and for cesarean section deliveries requiring more than a 96 hour stay or allowable charges will be reduced by $200.
If you need help recovering or have other special health needs	Home health care	Covered 100%	Not available	Services must be pre-certified or allowable charges will be reduced by $200. Limited to 60 visits in the 120 days following hospital discharge. 3 visits will reduce the number of benefit days of hospital care by 1 day.
	~~Rehabilitation services~~	$50 per plan year for physical therapy	20% co-insurance after the deductible	Services must be pre-certified or allowable charges will be reduced by $200. Speech and occupational therapy are not available for Basic Benefit participants.
	~~Habilitation services~~	Not Available		
	~~Skilled nursing care~~	Covered 100%	Not available	Services must be pre-certified or allowable charges will be reduced by $200. Limited to 30 days plan year maximum. Must begin immediately after three (3) day inpatient hospitalization stay. This will reduce the 120 hospital benefit day maximum.
	Durable medical equipment	Not available	20% co-insurance after the deductible	——————None——————
	Hospice services	Not available	20% co-insurance after the deductible	Services must be pre-certified or allowable charges will be reduced by $200. Limited to a maximum of 6 months life expectancy.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Basic Benefits	Major Medical Benefits	
If your child needs dental or eye care	Children's eye exam	Not Covered		
	Children's glasses	Not Covered		
	Children's dental check-up	Not Covered		

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.)

- Bariatric surgery (Unless Medically Necessary)
- Cosmetic surgery
- Dental care (Adult)
- Dental check-up (Child)
- Eye exam (Child)
- Glasses (Child)
- Habilitation services
- Hearing aids
- Long-term care
- Non-emergency care when 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.)

- Acupuncture (Not available for Basic Benefit limited to 20 visits/treatment per plan year)
- Chiropractic care (20 visits)
- Private-duty nursing (outpatient only)

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: 1-856-470-1200. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or **www.dol.gov/ebsa**, or the U.S. Department of Health and Human Services 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: at 1-866-444-3272 or **www.dol.gov/ebsa**, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or **www.cciio.cms.gov**.

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 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 1-888-808-9008.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-808-9008.

* For more information about limitations and exceptions, see the plan or policy document at www.iaatpa.com.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-888-808-9008.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-808-9008.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see the plan or policy document at www.iaatpa.com.

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	$100
Specialist 20% coinsurance after deductible	
Hospital (facility)	100%
Other	100%

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	**$13,255**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$100
Copayments	$975
Coinsurance	$47
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,182**

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

The plan's overall deductible	$100
Specialist 20% coinsurance after deductible	
Hospital (facility)	100%
Other	100%

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	**$8,056**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$100
Copayments	$800
Coinsurance	$1,064
What isn't covered	
Limits or exclusions	$1,783
The total Joe would pay is	**$3,748**

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

The plan's overall deductible	$100
Specialist 20% coinsurance after deductible	
Hospital (facility)	100%
Other	100%

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	**$2,029**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$100
Copayments	$325
Coinsurance	$217
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$642**

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