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 visit, www.Auxiant.com or call 1-800-475-2232. For general definitions of common terms, such as allowed amount, balance billing, Coinsurance, Co-Payment, Deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.Auxiant.com or call 1-800-475-2232 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall Deductible?	Network: **$3,500**/Individual or **$6,850**/Family per Calendar Year Out-of-Network: **$4,500**/Individual or **$9,000**/Family per Calendar Year	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 policy, each family member must meet their own individual Deductible until the overall family Deductible has been met. Network/Out-of-Network Deductibles and any other benefit maximums do cross-satisfy one another.
Are there services covered before you meet your Deductible?	**Yes.** Preventive services.	This plan covers some items and services even if you haven't yet met the annual Deductible amount. But a Co-Payment 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: **$3,500**/Individual or **$6,850**/Family per Calendar Year Out-of-Network: **$6,000**/Individual or **$12,000**/Family per Calendar Year	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, the overall family out-of-pocket limit must be met. The combined out-of-pocket limit shall not exceed the federal maximum. Network/Out-of-Network out-of-pocket maximums and any other benefit maximums do cross-satisfy one another.
What is not included in the out-of-pocket limit?	Cost containment penalties, ineligible charges, amounts over the maximum allowable charge, premiums, balanced-billed charges, 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**, see the back of your ID card for more information.	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 (a balance bill). 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.

Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist?	**No**, you do not need a referral to see a specialist.	You can see the specialist you choose without a referral.



All **Co-Payment** 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)	Out-of-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	0% Coinsurance	20% Coinsurance	——————none——————
	Specialist visit	0% Coinsurance	20% Coinsurance	——————none——————
	Teladoc Services	General: $49 Consult fee Psychiatrist: $190 fee for first visit then $95 fee for subsequent visits Psychologist: $85 Consult fee		——————none——————
	Preventive care/screening/ Immunization	No Charge	20% Coinsurance	You may have to pay for services that aren't 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)	0% Coinsurance	20% Coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	0% Coinsurance	20% 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)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition See your ID card for more information about **prescription drug coverage.**	Generic Drugs	0% Coinsurance	Not applicable	Covers up to a 31-day Retail supply. Covers up to a 93-day Mail Order supply. Deductible must be met before Coinsurance applies. No Co-Payment for generic prescriptions mandated by the Affordable Care Act (ACA), including, but not limited to, tobacco cessation medications and generic women's contraceptives. Specialty Drugs are limited to a 31-day supply.
	Formulary Brand Drugs	0% Coinsurance	Not applicable	
	Non-Formulary Brand Drugs	0% Coinsurance	Not applicable	
	Specialty Drugs	0% Coinsurance	Not applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% Coinsurance	20% Coinsurance	——————none——————
	Physician/surgeon fees	0% Coinsurance	20% Coinsurance	——————none——————
If you need immediate medical attention	Emergency room care	0% Coinsurance	Paid at Network level	——————none——————
	Emergency medical transportation	0% Coinsurance	Paid at Network level	——————none——————
	Urgent care	0% Coinsurance	20% Coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	0% Coinsurance	20% Coinsurance	Pre-Certification is required.
	Physician/surgeon fees	0% Coinsurance	20% Coinsurance	——————none——————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% Coinsurance	20% Coinsurance	——————none——————
	Inpatient services	0% Coinsurance	20% Coinsurance	Pre-Certification is required.
If you are pregnant	Office visits	No Charge	20% Coinsurance	

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery professional services	0% Coinsurance	20% Coinsurance	Cost sharing does not apply to certain preventive services and may vary based on location. Depending on the type of services, a Coinsurance or Deductible may apply. Maternity care may include tests described elsewhere in the SBC (i.e. ultrasound). Pre-Certification may be required.
	Childbirth/delivery facility services	0% Coinsurance	20% Coinsurance	
If you need help recovering or have other special health needs	Home health care	0% Coinsurance	20% Coinsurance	In-Network: Limited to 120 visits per Calendar Year. Out-of-Network: Limited to 60 visits per Calendar Year.
	Rehabilitation services	0% Coinsurance	20% Coinsurance	Out-of-Network: Limited to 20 visits per Calendar Year. Physical Therapy combined with Occupational Therapy. Speech Therapy limited to 20 visits per Calendar Year.
	Habilitation services			
	Skilled nursing care	0% Coinsurance	20% Coinsurance	Limited to 120 days per Calendar Year. Pre-Certification is required.
	Durable Medical equipment (DME)	0% Coinsurance	20% Coinsurance	——————none——————
	Hospice services	0% Coinsurance	20% Coinsurance	Respite care is limited to 5 episodes, up to 5 days per episode; Inpatient hospice services are limited to 15 days per lifetime. Includes bereavement counseling.
If your child needs dental or eye care	Children's eye exam	No Charge	20% Coinsurance	——————none——————
	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 • Cosmetic surgery • Dental care (Adult) • Hearing aids	• Infertility treatment • Long-term care • Private-duty nursing	• 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.)		
• Bariatric surgery	• Chiropractic care	• Non-emergency care when traveling outside the U.S.

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: 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 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: Auxiant, 424 1st Ave NE, Cedar Rapids, IA , 52401 or 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 800-475-2232.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 800-475-2232.
Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 800-475-2232 uff.

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.auxiant.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, Co-Payments 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** **$3,500**
- **Specialist *[cost sharing]*** **0%**
- **Hospital (facility) *[cost sharing]*** **0%**
- **Other *[cost sharing]*** **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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,500
Co-Payments	0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,560**

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

- **The plan's overall Deductible** **$3,500**
- **Specialist *[cost sharing]*** **0%**
- **Hospital (facility) *[cost sharing]*** **0%**
- **Other *[cost sharing]*** **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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3,500
Co-Payments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,520**

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

- **The plan's overall Deductible** **$3,500**
- **Specialist *[cost sharing]*** **0%**
- **Hospital (facility) *[cost sharing]*** **0%**
- **Other *[cost sharing]*** **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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,800
Co-Payments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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