



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 1-800-245-0533. 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 1-800-245-0533 to request a copy.

Important Questions	Answers	Why This Matters:
<p>What is the overall <u>Deductible</u>?</p>	<p><u>Network</u>: \$5,000/Individual or \$10,000/Family per Calendar Year <u>Out-of-Network</u>: \$10,000/Individual or \$20,000/Family per Calendar Year</p>	<p>Generally, you must pay all of the costs from <u>providers</u> up to the <u>Deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, they have to meet their own individual <u>Deductible</u> until the overall family <u>Deductible</u> has been met. <u>Network/Out-of-Network Deductibles</u> do not cross-satisfy one another.</p>
<p>Are there services covered before you meet your <u>Deductible</u>?</p>	<p>Yes: <u>Network Preventive Care</u>.</p>	<p>This <u>plan</u> covers some items and services even if you haven't yet met the annual <u>Deductible</u> amount. But a <u>Co-Payment</u> or <u>Coinsurance</u> may apply. For example, this <u>plan</u> covers certain preventive services without cost-sharing 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/.</p>
<p>Are there other <u>Deductibles</u> for specific services?</p>	<p>No.</p>	<p>You must pay all of the costs for these services up to the specific <u>Deductible</u> amount before this <u>plan</u> begins to pay for these services.</p>
<p>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</p>	<p><u>Network</u>: \$6,900/Individual or \$13,800/Family per Calendar Year <u>Out-of-Network</u>: \$20,000/Individual or \$40,000/Family per Calendar Year</p>	<p>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 limits</u> until the overall family <u>out-of-pocket limit</u> has been met. <u>Network/Out-of-Network out-of-pocket limits</u> do not cross-satisfy one another.</p>

Important Questions	Answers	Why This Matters:
What is not included in the <u>out-of-pocket limit</u>?	Ineligible charges, amounts over the <u>maximum allowable charge</u> , <u>premiums</u> , <u>balanced-billed</u> charges, and health care this <u>plan</u> doesn't 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 the back of your ID card for more information.	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 an <u>Out-of-Network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (a balance bill). Be aware, your <u>Network provider</u> might use an <u>Out-of-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 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	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	<u>Deductible</u> , then \$25 <u>Co-Payment</u>	50% <u>Coinsurance</u>	Chiropractic Care limited to 20 visits per Calendar Year.
	<u>Specialist</u> visit	<u>Deductible</u> , then \$75 <u>Co-Payment</u>	50% <u>Coinsurance</u>	_____none_____
	<u>Preventive care/screening/Immunization</u>	No Charge	50% <u>Coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what the <u>plan</u> will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% <u>Coinsurance</u>	50% <u>Coinsurance</u>	_____none_____
	Imaging (CT/PET scans, MRIs)	0% <u>Coinsurance</u>	50% <u>Coinsurance</u>	_____none_____

* 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
		<u>Network Provider</u>	<u>Out-of-Network Provider</u> (You will pay the most)	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.medone-rx.com/	Generic Drugs	Preferred Generic \$10 <u>Co-Payment</u> (Retail) \$25 <u>Co-Payment</u> (Mail Order) / Non-Preferred Generic \$35 <u>Co-Payment</u> (Retail) \$87.50 <u>Co-Payment</u> (Mail Order)	Not Covered	<u>Deductible</u> must be met before <u>Co-Payment</u> will apply. Covers up to a 90-day Mail Order supply. No <u>Co-Payment</u> for generic prescriptions mandated by the Affordable Care Act (ACA), including, but not limited to, tobacco cessation medications and generic women's contraceptives.
	Preferred Brand Name Drugs	\$70 <u>Co-Payment</u> (Retail) \$175 <u>Co-Payment</u> (Mail Order)	Not Covered	
	Non-Preferred Brand Name Drugs	\$150 <u>Co-Payment</u> (Retail) \$175 <u>Co-Payment</u> Mail Order)	Not Covered	
	<u>Specialty Drugs</u>	Preferred Generic \$10/Non-Preferred Generic \$150/Preferred Brand \$350/Non-Preferred Brand \$500	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% <u>Coinsurance</u>	50% <u>Coinsurance</u>	_____none_____
	Physician/surgeon fees	0% <u>Coinsurance</u>	50% <u>Coinsurance</u>	_____none_____
If you need immediate medical attention	<u>Emergency room care</u>	<u>Deductible</u> , then \$300 <u>Co-Payment</u> ,	Paid at <u>Network</u> level	_____none_____

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u>	<u>Out-of-Network Provider</u> (You will pay the most)	
	<u>Emergency medical transportation</u>	0% <u>Coinsurance</u>	Paid at <u>Network</u> level	_____none_____
	<u>Urgent care</u>	<u>Deductible</u> , then \$50 <u>Co-Payment</u>	50% <u>Coinsurance</u>	_____none_____
If you have a hospital stay	Facility fee (e.g., hospital room)	0% <u>Coinsurance</u>	50% <u>Coinsurance</u>	_____none_____
	Physician/surgeon fees	0% <u>Coinsurance</u>	50% <u>Coinsurance</u>	_____none_____
If you need mental health, behavioral health, or substance abuse services	Outpatient services	<u>Deductible</u> , then \$25 <u>Co-Payment</u>	50% <u>Coinsurance</u>	_____none_____
	Inpatient services	0% <u>Coinsurance</u>	50% <u>Coinsurance</u>	_____none_____
If you are pregnant	Office visits	Primary Care: <u>Deductible</u> , then \$25 <u>Co-Payment</u> Specialist: <u>Deductible</u> , then \$75 <u>Co-Payment</u>	50% <u>Coinsurance</u>	Depending on the type of services, a <u>Coinsurance</u> or <u>Deductible</u> may apply. Maternity care may include tests described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	0% <u>Coinsurance</u>	50% <u>Coinsurance</u>	

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u>	<u>Out-of-Network Provider</u> (You will pay the most)	
	Childbirth/delivery facility services	0% <u>Coinsurance</u>	50% <u>Coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	0% <u>Coinsurance</u>	50% <u>Coinsurance</u>	Limited to 30 visits per Calendar Year.
	<u>Rehabilitation and Habilitation services</u>	0% <u>Coinsurance</u>	50% <u>Coinsurance</u>	Includes Speech Therapy, Physical Therapy and Occupational Therapy.
	<u>Skilled nursing care</u>	0% <u>Coinsurance</u>	50% <u>Coinsurance</u>	Limited to 60 days per Calendar Year combined with Inpatient Rehabilitation.
	<u>Durable medical equipment</u>	0% <u>Coinsurance</u>	50% <u>Coinsurance</u>	—————none—————
	<u>Hospice services</u>	0% <u>Coinsurance</u>	50% <u>Coinsurance</u>	—————none—————
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	Routine vision exams covered to age 19 under Preventive Care benefit.
	Children's glasses	Not Covered	Not Covered	—————none—————

* 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	Out-of-Network Provider (You will pay the most)	
	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.)		
<ul style="list-style-type: none"> • Bariatric surgery • Cosmetic surgery • Dental care 	<ul style="list-style-type: none"> • Infertility treatment • Long-term Care • Routine eye care (adult) 	<ul style="list-style-type: none"> • Routine foot care • TMJ (temporomandibular joint disorder) • Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none"> • Acupuncture • Chiropractic care 	<ul style="list-style-type: none"> • Hearing aids • Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> • 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: 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 at 424 1st Avenue NE, Ste 200, 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](#).

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

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 800-245-0533.

—————*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, 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 <u>plan's</u> overall <u>Deductible</u>	\$5,000
■ <u>Specialist [cost sharing]</u>	\$75
■ <u>Hospital (facility) [cost sharing]</u>	0%
■ <u>Other [cost sharing]</u>	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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$5,000
<u>Co-Payments</u>	\$10
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$5,070

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>	\$5,000
■ <u>Specialist [cost sharing]</u>	\$75
■ <u>Hospital (facility) [cost sharing]</u>	0%
■ <u>Other [cost sharing]</u>	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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$5,000
<u>Co-Payments</u>	\$200
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$5,220

Mia's Simple Fracture

(Network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>Deductible</u>	\$5,000
■ <u>Specialist [cost sharing]</u>	\$75
■ <u>Hospital (facility) [cost sharing]</u>	0%
■ <u>Other [cost sharing]</u>	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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$2,800
<u>Co-Payments</u>	\$0
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,800