




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:
<p>What is the overall <u>Deductible</u>?</p>	<p><u>Network</u>: \$1,000/Individual or \$2,000/Family per Calendar Year <u>Out-of-Network</u>: \$2,000/Individual or \$4,000/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 <u>plan</u>, they have to meet their own individual <u>Deductible</u> until the overall family <u>Deductible</u> amount has been satisfied. <u>Network/Out-of-Network Deductibles</u> cross-satisfy one another.</p>
<p>Are there services covered before you meet your <u>Deductible</u>?</p>	<p>Yes: <u>Network</u> preventive care (excluding routine colonoscopies & sigmoidoscopies), <u>Network</u> office visits (including chiropractic manipulations), <u>Network</u> urgent care, <u>Network</u> psychiatric outpatient visits; <u>Network</u> smoking cessation products, and <u>Network</u> organ transplant travel/lodging.</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 <u>preventive</u> services without cost-sharing and before you meet your <u>Deductible</u>. See a list of covered <u>preventive</u> services 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 don't have to meet <u>Deductibles</u> for specific services.</p>
<p>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</p>	<p><u>Network</u>: \$5,000/Individual or \$10,000/Family per Calendar Year <u>Out-of-Network</u>: \$6,000/Individual or \$12,000/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. The combined <u>out-of-pocket limit</u> shall not exceed the federal maximum. The <u>deductible</u> and <u>coinsurance</u> are included in the <u>out-of-pocket limit</u>. <u>Network/Out-of-Network out-of-pocket limits</u> cross-satisfy one another.</p>

Important Questions	Answers	Why This Matters:
<p>What is not included in the <u>out-of-pocket limit</u>?</p>	<p><u>Co-Payments</u>, cost containment penalties, 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.</p>	<p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.</p>
<p>Will you pay less if you use a <u>Network provider</u>?</p>	<p>Yes, see the back of your ID card for more information.</p>	<p>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 charge</u> and what your <u>plan</u> pays (a <u>balance bill</u>). 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.</p>
<p>Do you need a <u>referral</u> to see a <u>specialist</u>?</p>	<p>No.</p>	<p>You can see the <u>specialist</u> you choose without a referral.</p>

 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
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (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	\$25 <u>Co-Payment</u> /office visit and 0% <u>Coinsurance</u> ; <u>Deductible</u> does not apply.	50% <u>Coinsurance</u>	<u>Co-Payment</u> applies to the office visit fee (evaluation and management fee) only.
	<u>Specialist</u> visit	\$35 <u>Co-Payment</u> /office visit and 0% <u>Coinsurance</u> ; <u>Deductible</u> does not apply.	50% <u>Coinsurance</u>	<u>Co-Payment</u> applies to the office visit fee (evaluation and management fee) only. Includes chiropractic care, limited to 20 visits per Calendar Year.
	<u>Preventive care</u> /screening/ Immunization	\$25 <u>Co-Payment</u> /office visit and 0% <u>Coinsurance</u> ; <u>Deductible</u> does not apply.	50% <u>Coinsurance</u>	Mammograms limited to 1 per Calendar Year. There is no charge for smoking cessation products limited to a 90-day supply per smoking cessation attempt; limited to 2 attempts per Calendar Year. You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	There is no charge for diagnostic tests provided in a <u>Network</u> physician's office or by a <u>Network</u> Independent lab.
	Imaging (CT/PET scans, MRIs)	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	There is no charge for diagnostic tests provided in a <u>Network</u> physician's office.

* 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> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at: https://www.truescripts.com/members	Generic drugs	\$10 <u>Co-Payment</u> (30-day Retail) \$30 <u>Co-Payment</u> (90-day Retail) \$25 <u>Co-Payment</u> (Mail Order)	Not Covered	Covers up to a 30-day or 90-day supply (Retail).
	Preferred Brand name drugs	\$35 <u>Co-Payment</u> (30-day Retail) \$105 <u>Co-Payment</u> (90-day Retail) \$87.50 <u>Co-Payment</u> (Mail Order)	Not Covered	Covers up to a 90-day supply (Mail Order). There is no charge for smoking cessation products limited to a 90-day supply per smoking cessation attempt; limited to two attempts per Calendar Year.
	Non-Preferred Brand name drugs	\$45 <u>Co-Payment</u> (30-day Retail) \$135 <u>Co-Payment</u> (90-day Retail) \$112.50 <u>Co-Payment</u> (Mail Order)	Not Covered	
	<u>Specialty drugs</u>	\$100 <u>Co-Payment</u>	Not Covered	Covers up to a 30-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	—————none—————
	Physician/surgeon fees	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	There is no charge for surgery performed in a <u>Network</u> physician's office.
If you need immediate medical attention	<u>Emergency room care</u>	\$200 <u>Co-Payment</u> , then 20% <u>Coinsurance</u>	Paid at <u>Network</u> level	<u>Co-Payment</u> is waived if the patient is admitted to the hospital.
	<u>Emergency medical transportation</u>	20% <u>Coinsurance</u>	Paid at <u>Network</u> level	—————none—————
	<u>Urgent care</u>	\$35 <u>Co-Payment</u> /urgent care visit, <u>Deductible</u> does not apply; 20% <u>Coinsurance</u> for other services	50% <u>Coinsurance</u>	—————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> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	Pre-certification is required for non-emergency admissions.
	Physician/surgeon fees	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	—————none—————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	<u>Co-Payment</u> applies to office visit charges only. Emergency Room, Urgent Care, Office evaluation & management, Office counseling, and Lab/X-ray fees are paid same as any other illness.
	Inpatient services	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	Pre-certification is required for non-emergency admissions.
If you are pregnant	Office visits	Paid same as any other illness	Paid same as any other illness	<u>Co-Payment</u> applies to the initial office visit fee (evaluation and management fee) only. Cost sharing does not apply to certain preventive services. 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) Pre-certification is required for non-emergency admissions.
	Childbirth/delivery professional services	Paid same as any other illness	Paid same as any other illness	
	Childbirth/delivery facility services	Paid same as any other illness	Paid same as any other illness	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	Limited to 90 visits per Calendar Year.
	<u>Rehabilitation services</u>	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	Includes Speech Therapy, Physical Therapy, and Occupational Therapy.
	<u>Habilitation services</u>	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	
	<u>Skilled nursing care</u>	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	30 days per Calendar Year in a skilled nursing facility (60 days per Calendar Year for inpatient rehabilitation facility). Confinement must begin within seven days of hospital discharge. Pre-certification is required for non-emergency admissions.
	<u>Durable medical equipment</u>	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	—————none—————
	<u>Hospice services</u>	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	Limited to 90 days per Calendar Year.

* 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> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	See Vision Benefit Plan.
	Children's glasses	Not Covered	Not Covered	See Vision Benefit Plan.
	Children's dental check-up	Not Covered	Not Covered	See Vision Benefit Plan.

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

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> 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">• Acupuncture• Bariatric surgery• Cosmetic surgery	<ul style="list-style-type: none">• Dental care (adult)• Infertility treatment• Long-term care	<ul style="list-style-type: none">• Routine eye care (adult)• Routine foot care• Weight loss programs
Other Covered Services (This isn't a complete list. Check your plan document for other covered services and your costs for these services.)		
<ul style="list-style-type: none">• Chiropractic care	<ul style="list-style-type: none">• Hearing aids	<ul style="list-style-type: none">• 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, kwijjigo holne' 800-475-2232.

Pennsylvania Dutch (Deutsch): Fer Hilf griege in Deutsch, ruf 800-475-2232 uff.

————— *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>	\$1,000
■ <u>Specialist</u> [cost sharing]	\$35
■ <u>Hospital (facility)</u> [cost sharing]	20%
■ <u>Other</u> [cost sharing]	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
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In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,000
<u>Co-Payments</u>	\$10
<u>Coinsurance</u>	\$2,300
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$3,370

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>	\$1,000
■ <u>Specialist</u> [cost sharing]	\$35
■ <u>Hospital (facility)</u> [cost sharing]	20%
■ <u>Other</u> [cost sharing]	20%

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:

Cost Sharing	
<u>Deductibles</u>	\$900
<u>Co-Payments</u>	\$1,000
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,920

Mia's Simple Fracture

(Network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>Deductible</u>	\$1,000
■ <u>Specialist</u> [cost sharing]	\$35
■ <u>Hospital (facility)</u> [cost sharing]	20%
■ <u>Other</u> [cost sharing]	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
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In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,400
<u>Co-Payments</u>	\$100
<u>Coinsurance</u>	\$300
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,800