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:
What is the overall Deductible?	Network: $1,500/Individual or $3,000/Family per Calendar Year Out-of-Network: $3,000/Individual or $6,000/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, they have to meet their own individual Deductible until the overall family Deductible amount has been met. Network/Out-of-Network Deductibles and any other benefit maximums do not cross-satisfy one another.
Are there services covered before you meet your Deductible?	Yes: Network preventive care, Network office visits, emergency room visits, Network chiropractic care, Network office mental health and substance use visits, Network speech therapy, physical therapy, occupational therapy, and Network urgent care. To view the full list of services, visit the Schedule of Medical Benefits section.	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: $6,000/Individual or $12,000/Family per Calendar Year Out-of-Network:$18,000/Individual or $36,000/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, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. Network/Out-of-Network out-of-pocket limits and any other benefit maximums do not cross-satisfy one another.

Important Questions	Answers	Why This Matters:
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, Organ Transplants through the Specialty Organ Transplant program, 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.
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	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	$40 Co-Payment, then 0% Coinsurance; Deductible does not apply	50% Coinsurance	One Co-Payment per day, per service provider (will apply additional Co-Payments if more than one provider bills from same visit. Includes Chiropractic spinal manipulation, lab, x-rays, supplies and evaluation and management fees. Limited to 20 visits per Calendar Year.
	Specialist visit	$40 Co-Payment, then 0% Coinsurance; Deductible does not apply	50% Coinsurance	One Co-Payment per day, per service provider (will apply additional Co-Payments if more than one provider bills from same visit.
	Preventive care/screening/ Immunization	No Charge	50% Coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what the plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	30% Coinsurance	50% Coinsurance	Blood work and Diagnostics services by an Independent Lab – 30% Coinsurance; Deductible waived.
	Imaging (CT/PET scans, MRIs)	30% Coinsurance	50% Coinsurance	Pre-certification is required. Failure to obtain pre-certification will result in a reduction in benefits by $250.

* 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)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at: www.truerx.com	Generic	(Retail 30-day) $10 Co-Payment (Retail 90-day) $30 Co-Payment (Mail order) $25 Co-Payment	N/A	Covers up to a 30-day supply Retail; Covers up to a 90-day supply Retail and Mail order. 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. SHARx: Coverage for medications above $350 for a thirty (30) day supply, as listed in the summary of benefits, is only applicable if the SHARx program fails to provide a solution. The SHARx Program solutions come from a variety of sources, including manufacturer assistance programs, Co-Payment cards, grants, and mail order pharmacies. The Plan may cover the cost of these options so that the Covered Person's Out-of-Pocket cost will not exceed the cost under the pharmacy benefit. The Plan may also allow for a sixty (60) day grace period for urgent medications to allow time to complete the advocacy process. Prior Authorization is required on all specialty medications
	Preferred Brand Drugs	(Retail 30-day) $35 Co-Payment (Retail 90-day) $105 Co-Payment (Mail order) $88 Co-Payment	N/A	
	Non-Preferred Brand Drugs	(Retail 30-day) $60 Co-Payment (Retail 90-day) $180 Co-Payment (Mail order) $150 Co-Payment	N/A	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% Coinsurance	50% Coinsurance	——————none——————
	Physician/surgeon fees	30% Coinsurance	50% Coinsurance	——————none——————
If you need immediate medical attention	Emergency room care	$75 Co-Payment, then 30% Coinsurance; Deductible does not apply	Paid at Network level	Co-Payment waived if admitted.
	Emergency medical transportation	30% Coinsurance	Paid at Network level	——————none——————

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)	
	Urgent care	$50 Co-Payment, then 0% Coinsurance; Deductible does not apply	$100 Co-Payment, then 0% Coinsurance; Deductible does not apply	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	30% Coinsurance	50% Coinsurance	Pre-certification is required for non-emergency admissions. Failure to obtain pre-certification will result in a reduction in benefits by $250.
	Physician/surgeon fees	30% Coinsurance	50% Coinsurance	——————none——————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office - $40 Co-Payment, then 0% Coinsurance; Deductible does not apply All Other Services - 30% Coinsurance	50% Coinsurance	Emergency Room, Urgent Care, Office evaluation & management, Office counseling, and Lab/X-ray fees are paid same as any other illness.
	Inpatient services	30% Coinsurance	50% Coinsurance	Pre-certification is required for non-emergency admissions. Failure to obtain pre-certification will result in a reduction in benefits by $250.
If you are pregnant	Office visits	30% Coinsurance	50% Coinsurance	Cost sharing does not apply to certain preventive services. 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 is required for non-emergency admissions. Failure to obtain pre-certification will result in a reduction in benefits by $250.
	Childbirth/delivery professional services	30% Coinsurance	50% 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	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery facility services	30% Coinsurance	50% Coinsurance	
If you need help recovering or have other special health needs	Home health care	30% Coinsurance	50% Coinsurance	Limited to 60 visits per Calendar Year.
	Rehabilitation services	$40 Co-Payment, then 0% Coinsurance; Deductible does not apply	50% Coinsurance	Includes, Speech therapy, Physical therapy, and Occupational therapy. Physical therapy is limited to 30 visits per Calendar Year. Speech therapy and Occupational therapy limited to 60 visits each per Calendar Year per type of therapy service.
	Habilitation services	$40 Co-Payment, then 0% Coinsurance; Deductible does not apply	50% Coinsurance	
	Skilled nursing care	30% Coinsurance	50% Coinsurance	Limited to 60 days per Calendar Year. Pre-certification is required for non-emergency admissions. Failure to obtain pre-certification will result in a reduction in benefits by $250.
	Durable medical equipment	30% Coinsurance	50% Coinsurance	——————none——————
	Hospice services	30% Coinsurance	50% Coinsurance	——————none——————
If your child needs dental or eye care	Children's eye exam	See Preventive Care Benefit	See Preventive Care Benefit	Includes routine vision exams to age 19.
	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 • Bariatric surgery • Cosmetic surgery • Dental care (adult)	• Hearing aids • Infertility treatment • Long-term care • 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.)		
• Chiropractic care	• Non-emergency care when traveling outside of 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 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.

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.

* 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	$1,500
Specialist *[cost sharing]*	$40
Hospital (facility) *[cost sharing]*	30%
Other *[cost sharing]*	30%

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	$1,500
Co-Payments	$100
Coinsurance	$3,700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$5,360

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

The plan's overall Deductible	$1,500
Specialist *[cost sharing]*	$40
Hospital (facility) *[cost sharing]*	30%
Other *[cost sharing]*	30%

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	$1,300
Co-Payments	$1,200
Coinsurance	$600
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$3,120

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

The plan's overall Deductible	$1,500
Specialist *[cost sharing]*	$40
Hospital (facility) *[cost sharing]*	30%
Other *[cost sharing]*	30%

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	$1,000
Co-Payments	$300
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,700

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