Lac du Flambeau Tribe
LAC DU FLAMBEAU BAND OF LAKE SUPERIOR CHIPPEWA INDIANS

Medical Insurance

HSA Plan

Clinic Plan

Lac du Flambeau Tribe
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HSA Plan

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?	Peter Christensen Health Center: **$2,000**/Individual or **$4,000**/Family per Calendar Year Network: **$2,000**/Individual or **$4,000**/Family per Calendar Year Out-of-Network: **$4,000**/Individual or **$8,000**/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, the overall family Deductible must be met. The Peter Christensen Health Center and Network Deductibles and any other benefit maximums cross-satisfy each other. However, the Peter Christensen Health Center and Network/Out-of-Network Deductibles do not cross-satisfy one another.
Are there services covered before you meet your Deductible?	**Yes**: Peter Christensen Health Center and Network preventive care; and wellness program.	This plan covers some items and services even if you haven't yet met the annual Deductible amount. 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?	Peter Christensen Health Center: **$4,000**/Individual or **$6,000**/Family per Calendar Year Network: **$4,000**/Individual or **$6,000**/Family per Calendar Year Out-of-Network: **$6,350**/Individual or **$12,700**/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 maximums until the overall family out-of-pocket maximum has been met. The Peter Christensen Health Center and Network out-of-pocket maximum and any other benefit maximums cross-satisfy one another. However, the Peter Christensen Health Center and Network/Out-of-Network out-of-pocket 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, 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 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
		Peter Christensen Health Center (You will pay the least)	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	10% Coinsurance	10% Coinsurance	40% Coinsurance	——————none——————
	Specialist visit	10% Coinsurance	10% Coinsurance	40% Coinsurance	Chiropractor care is limited to 24 visits per Calendar Year.
	Preventive care/screening/ Immunization	No Charge	No Charge	Not Covered	The first colonoscopy each calendar year will be paid as preventive care regardless of diagnosis. Includes routine hearing exams, limited to 1 every 2 Calendar Years. 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)	10% Coinsurance	10% Coinsurance	40% Coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	N/A	10% Coinsurance	40% Coinsurance	Pre-authorization is required for MRI/MRA/PET/CT scans. Failure to obtain pre-authorization will result in a reduction in benefits by $250.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Peter Christensen Health Center (You will pay the least)	Network Provider	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	20% Coinsurance	N/A	Covers up to a 30-day supply (Retail); Covers up to a 90-day supply (Peter Christensen Health Center only); Covers up to a 90-day supply (Mail Order) Mail Order is not available through Peter Christensen Health Center. 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 limited to a 30-day supply.
	Preferred Brand name drugs	0% Coinsurance	20% Coinsurance	N/A	
	Non-Preferred brand name drugs	0% Coinsurance	20% Coinsurance	N/A	
	Specialty drugs	0% Coinsurance	20% Coinsurance	N/A	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	N/A	10% Coinsurance	40% Coinsurance	——————none——————
	Physician/surgeon fees	N/A	10% Coinsurance	40% Coinsurance	——————none——————
If you need immediate medical attention	Emergency room care	10% Coinsurance	10% Coinsurance	Paid at Network Level	——————none——————
	Emergency medical transportation	10% Coinsurance	10% Coinsurance	Paid at Network Level	——————none——————
	Urgent care	10% Coinsurance	10% Coinsurance	40% Coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	N/A	10% Coinsurance	40% 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	N/A	10% Coinsurance	40% Coinsurance	——————none——————

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Peter Christensen Health Center (You will pay the least)	Network Provider	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% Coinsurance	10% Coinsurance	40% Coinsurance	Emergency Room, Urgent Care, Office evaluation & management, Office counseling, and Lab/X-ray fees are paid same as any other Illness.
	Inpatient services	10% Coinsurance	10% Coinsurance	40% 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	Paid same as any other Illness	Paid same as any other Illness	Paid same as any other Illness	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	Paid same as any other Illness	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	Paid same as any other Illness	
If you need help recovering or have other special health needs	Home health care	10% Coinsurance	10% Coinsurance	40% Coinsurance	Pre-authorization is required for home health care. Failure to obtain pre-authorization will result in a reduction in benefits by $250. Limited to 40 visits per Calendar Year.
	Rehabilitation services	10% Coinsurance	10% Coinsurance	40% Coinsurance	Includes speech therapy, physical therapy, and occupational therapy. Occupational and physical therapy limited to a combined maximum (rehabilitation and habilitation) of 30 visits per Calendar Year. Pre-authorization required for any visits thereafter.
	Habilitation services	10% Coinsurance	10% Coinsurance	40% Coinsurance	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Peter Christensen Health Center (You will pay the least)	Network Provider	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Skilled nursing care	10% Coinsurance	10% Coinsurance	40% Coinsurance	Limited to 30 days per confinement. 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	10% Coinsurance	10% Coinsurance	40% Coinsurance	Pre-authorization is required for purchase of DME exceeding $500 and all rentals. Failure to obtain pre-authorization will result in a reduction in benefits by $250.
	Hospice services	10% Coinsurance	10% Coinsurance	40% Coinsurance	Includes respite care & bereavement counseling. Respite care limited to 10 visits per Lifetime. Bereavement counseling must be completed within 6 months of the person's death.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered	Refer to Vision Plan Document.
	Children's glasses	Not Covered	Not Covered	Not Covered	Refer to Vision Plan Document.
	Children's dental check-up	Not Covered	Not Covered	Not Covered	——————none——————

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

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.)		
• Cosmetic surgery • Dental care (adult)	• Infertility treatment • Long-term care	• Routine foot care
Other Covered Services (This isn't a complete list. Check your plan document for other covered services and your costs for these services.)		
• Acupuncture • Bariatric surgery • Chiropractic care	• Hearing aids • Non-emergency care when traveling outside the U.S.	• Private-duty nursing • Routine Eye Care (Adult) (separate vision plan) • Weight loss programs

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, Cedar Rapids, IA 52404 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** **$2,000**
- **Specialist *[cost sharing]*** **10%**
- **Hospital (facility) *[cost sharing]*** **10%**
- **Other *[cost sharing]*** **10%**

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	$2,000
Co-Payments	$0
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,160**

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

- **The plan's overall Deductible** **$2,000**
- **Specialist *[cost sharing]*** **10%**
- **Hospital (facility) *[cost sharing]*** **10%**
- **Other *[cost sharing]*** **10%**

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	$2,000
Co-Payments	$0
Coinsurance	$600
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,620**

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

- **The plan's overall Deductible** **$2,000**
- **Specialist *[cost sharing]*** **10%**
- **Hospital (facility) *[cost sharing]*** **10%**
- **Other *[cost sharing]*** **10%**

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	$2,000
Co-Payments	$0
Coinsurance	$80
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,080**

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

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Important Questions	Answers	Why This Matters:
What is the overall Deductible?	Peter Christensen Health Center: **$0**/Individual or **$0**/Family per Calendar Year Network: **$2,000**/Individual or **$4,000**/Family per Calendar Year Out-of-Network: **$4,000**/Individual or **$8,000**/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. The Peter Christensen Health Center and Network Deductibles and any other benefit maximums cross-satisfy one another. However, the Peter Christensen Health Center and Network/Out-of-Network Deductibles do not cross-satisfy one another.
Are there services covered before you meet your Deductible?	**Yes.** services provided by the Peter Christensen Health Center; surgical second opinions; inpatient rehabilitation facility services; Peter Christensen Health Center and Network preventive care; and wellness program.	This plan covers some items and services even if you haven't yet met the annual Deductible amount. A Co-Payment or Coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing 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?	Peter Christensen Health Center: **$4,000**/Individual or **$6,000**/Family per Calendar Year Network: **$4,000**/Individual or **$6,000**/Family per Calendar Year Out-of-Network: **$6,350**/Individual or **$12,700**/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 maximums until the overall family out-of-pocket maximum has been met. The Peter Christensen Health Center and Network out-of-pocket maximum and any other benefit maximums cross-satisfy one another. However, the Peter Christensen Health Center and Network/Out-of-Network out-of-pocket maximums do not 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.
Do you need a referral to see a specialist?	**No**.	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
		Peter Christensen Health Center (You will pay the least)	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	$10 Co-Payment, then 0% Coinsurance; Deductible does not apply	10% Coinsurance	40% Coinsurance	One Co-Payment per day, per service provider (will apply additional Co-Payments if more than one provider bills from same visit).
	Specialist visit	$10 Co-Payment, then 0% Coinsurance; Deductible does not apply	10% Coinsurance	40% Coinsurance	One Co-Payment per day, per service provider (will apply additional Co-Payments if more than one provider bills from same visit). Chiropractor care is limited to 24 visits per Calendar Year.
	Preventive care/screening/ Immunization	No Charge	No Charge	Not Covered	The first colonoscopy each Calendar Year will be paid as preventive care regardless of diagnosis. Includes routine hearing exams, limited to 1 every 2 Calendar Years. 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)	No Charge	10% Coinsurance	40% Coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	N/A	10% Coinsurance	40% Coinsurance	Pre-authorization is required for MRI/MRA/PET/CT scans. Failure to obtain pre-authorization will result in a reduction in benefits by $250.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Peter Christensen Health Center (You will pay the least)	Network Provider	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	$5 Co-Payment (Retail); $10 Co-Payment (Retail Peter Christensen Health Center)	20% Coinsurance	N/A	Covers up to a 30-day supply (Retail); Covers up to a 90-day supply (Peter Christensen Health Center only); Covers up to a 90-day supply (Mail Order) Mail Order is not available through Peter Christensen Health Center. Deductible does not apply to prescription drugs dispensed by Peter Christensen Health Center. 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 limited to a 30-day supply.
	Preferred Brand name drugs	$10 Co-Payment (Retail); $20 Co-Payment (Retail Christensen Health Center)	20% Coinsurance	N/A	
	Non-Preferred brand name drugs	$50 Co-Payment (Retail); $100 Co-Payment (Retail Christensen Health Center)	20% Coinsurance	N/A	
	Specialty drugs	Same as Retail Co-Payments	20% Coinsurance	N/A	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	N/A	10% Coinsurance	40% Coinsurance	——————none——————
	Physician/surgeon fees	N/A	10% Coinsurance	40% Coinsurance	——————none——————
If you need immediate medical attention	Emergency room care	No Charge	10% Coinsurance	Paid at Network Level	——————none——————
	Emergency medical transportation	No Charge	10% Coinsurance	Paid at Network Level	——————none——————
	Urgent care	$10 Co-Payment, then 0% Coinsurance; Deductible does not apply	10% Coinsurance	40% Coinsurance	Co-Payment applies to facility fee.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Peter Christensen Health Center (You will pay the least)	Network Provider	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	N/A	10% Coinsurance	40% 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	N/A	10% Coinsurance	40% Coinsurance	——————none——————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge	10% Coinsurance	40% Coinsurance	Emergency Room, Urgent Care, Office evaluation & management, Office counseling, and Lab/X-ray fees are paid same as any other Illness.
	Inpatient services	No Charge	10% Coinsurance	40% 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	First visit: $10 Co-Payment, then 0% Coinsurance; Deductible does not apply Subsequent visits: No Charge	Paid same as any other Illness	Paid same as any other Illness	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	N/A	Paid same as any other Illness	Paid same as any other Illness	
	Childbirth/delivery facility services	N/A	Paid same as any other Illness	Paid same as any other Illness	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Peter Christensen Health Center (You will pay the least)	Network Provider	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No Charge	10% Coinsurance	40% Coinsurance	Pre-authorization is required for home health care. Failure to obtain pre-authorization will result in a reduction in benefits by $250. Limited to 40 visits per Calendar Year.
	Rehabilitation services	No Charge	10% Coinsurance	40% Coinsurance	Includes speech therapy, physical therapy, and occupational therapy. Occupational and physical therapy limited to a combined maximum (rehabilitation and habilitation) of 30 visits per Calendar Year. Pre-authorization required for any visits thereafter.
	Habilitation services	No Charge	10% Coinsurance	40% Coinsurance	
	Skilled nursing care	No Charge	10% Coinsurance	40% Coinsurance	Limited to 30 days per Confinement. 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	No Charge	10% Coinsurance	40% Coinsurance	Pre-authorization is required for purchase of DME exceeding $500 and all rentals. Failure to obtain pre-authorization will result in a reduction in benefits by $250.
	Hospice services	No Charge	10% Coinsurance	40% Coinsurance	Includes respite care & bereavement counseling. Respite care limited to 10 visits per Lifetime. Bereavement counseling must be completed within 6 months of the person's death.
If your child needs dental or eye care	Children's eye exam	No Charge	No Charge	Not Covered	——————none——————
	Children's glasses	Not Covered	Not Covered	Not Covered	——————none——————
	Children's dental check-up	Not Covered	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.)		
• Cosmetic surgery • Dental care (adult)	• Infertility treatment • Long-term care	• Routine foot care
Other Covered Services (This isn't a complete list. Check your plan document for other covered services and your costs for these services.)		
• Acupuncture • Bariatric surgery • Chiropractic care	• Hearing aids • Non-emergency care when traveling outside the U.S.	• Private-duty nursing • Routine Eye Care (Adult) (separate vision plan) • Weight loss programs

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, Cedar Rapids, IA 52404 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** **$2,000**
- **Specialist *[cost sharing]*** **10%**
- **Hospital (facility) *[cost sharing]*** **10%**
- **Other *[cost sharing]*** **10%**

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	$2,000
Co-Payments	$0
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,160**

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

- **The plan's overall Deductible** **$2,000**
- **Specialist *[cost sharing]*** **10%**
- **Hospital (facility) *[cost sharing]*** **10%**
- **Other *[cost sharing]*** **10%**

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	$2,000
Co-Payments	$0
Coinsurance	$600
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,620**

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

- **The plan's overall Deductible** **$2,000**
- **Specialist *[cost sharing]*** **10%**
- **Hospital (facility) *[cost sharing]*** **10%**
- **Other *[cost sharing]*** **10%**

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	$2,000
Co-Payments	$0
Coinsurance	$80
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,080**

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