This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at ***www.auxiant.com*** or by calling **1-800-279-6772**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For Network: **$1,250** person/**$2,500** family per Calendar Year For Non-Network: **$1,250** person/**$2,500** family per Calendar Year	You must pay all the costs up to the ***deductible*** amount before this plan begins to pay for covered services you use. The ***deductible*** for this plan is based on a calendar year (1/1 to 12/31). See the chart starting on page 3 for how much you pay for covered services after you meet the ***deductible***. Network/Non-Network ***deductibles*** do not cross-satisfy one another. ***Deductible*** does not apply to network office visits, diagnostic testing, emergency room visits, urgent care, network preventative care.
Are there other deductibles for specific services?	Yes, **$100** per person per Calendar Year for prescription drug costs.	You must pay all of the costs for these services up to the specific prescription ***deductible*** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	For Network: **$2,500** person/**$5,000** family per Calendar Year For Non-Network: **$5,000** person/**$10,000** family per Calendar Year	The ***out-of-pocket limit*** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. Network/Non-Network ***out-of-pocket limits*** and any other benefit maximums cross-satisfy one another. The deductible, prescription co-payments and medical network copayments are included in the ***out-of-pocket limit***. The ***out-of-pocket limit*** and Prescription costs combined shall not exceed the federal maximum.

Important Questions	Answers	Why this Matters:
What is not included in the out–of–pocket limit?	Cost containment penalties including ineligible charges, amounts over the usual & customary, Organ Transplants through the National Union Fire Transplant Program, 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***.
Is there an overall annual limit on what the plan pays?	No. This policy has no overall annual limit on the amount it will pay each year.	The chart starting on page 3 describes any limits on what the insurer will pay for specific covered services.
Does this plan use a network of providers?	Yes. Please contact your Employer for a list of these providers.	If you use an in-network doctor or other health care ***provider***, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network ***provider*** for some services. Plans use the term in-network, ***preferred***, or participating for ***providers*** in their ***network***. See the chart starting on page 3 for how this plan pays different kinds of ***providers***.
Do I 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 permission from this plan. If the specialist is not in your network, the coverage is at an out of network cost.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 9. See your plan document for additional information about excluded services under ***General Limitations***.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 co-pay, then 0% coinsurance and no Deductible	$35 co-pay, then 20% coinsurance after Deductible	none
	Specialist visit	$50 co-pay, then 20% coinsurance and no Deductible	$50 co-pay, then 40% coinsurance after Deductible	none
	Other practitioner office visit	Deductible then 20% coinsurance	Deductible then 40% coinsurance	Applies to Cardiac Rehabilitation, Chiropractic Services, Chemo/Radiation therapy, Hemodialysis, Home Infusion therapy, Occupational therapy, Physical therapy and Speech therapy. Chiropractic services are limited to 20 visits per Calendar Year, limited to $35 paid maximum per visit to $700 per Calendar Year maximum. Pre-authorization is required for Chemo/Radiation. Hemodialysis is limited to $10,000 maximum per month; begins the first month of treatment for Home treatment and begins the fourth month of treatment for Outpatient treatment.
	Preventive care/screening/ immunization	0% coinsurance and no Deductible	Deductible then 40% coinsurance	none

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
	Preventive routine surgeries	0% coinsurance and no Deductible	Deductible then 40% coinsurance	When services are performed at a Preferred Plus Provider, employee will be eligible for reimbursement. Preferred Plus Providers are those identified as providing the best overall hospital value – as measured by FocusHealth cost and quality.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance and no Deductible	Deductible then 20% coinsurance	When services are performed through a Primary Care Physician.
	Imaging (CT/PET scans, MRIs)	Deductible then 20% coinsurance	Deductible then 40% coinsurance	If services are performed through One Call, 100% deductible waived.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.true-rx.com	Generic drugs	$10 co-pay or 30% of cost, whichever is greater (retail) $20 co-pay or 25% of cost, whichever is greater (mail order)	N/A	Prescriptions subject to a $100 deductible per person per Calendar Year. Covers up to a 30-day supply (retail/specialty); 90-day supply (mail order prescription) No co-pay for tobacco cessation medications (includes both prescription and over the counter medications) up to 90-day treatment; two smoking cessation attempts are allowed per year. No co-pay for Women's Contraceptives.
	Preferred and Non-Preferred brand name drugs	$35 co-pay or 30% of cost, whichever is greater (retail) $70 co-pay or 25% of cost, whichever is greater (mail order)	N/A	
	Speciality drugs	Tier 1: 20% coinsurance Tier 2: 20% coinsurance to $550 maximum Tier 3: 20% coinsurance Tier 4: 50% coinsurance	N/A	

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center and outpatient surgeries)	Deductible then 20% coinsurance	Deductible then 40% coinsurance	When services are performed at a Preferred Plus Provider, employee will be eligible for reimbursement. Preferred Plus Providers are those identified as providing the best overall hospital value – as measured by FocusHealth cost and quality.
	Physician/surgeon fees	Deductible then 20% coinsurance	Deductible then 40% coinsurance	none
If you need immediate medical attention	Emergency room services	$100 co-pay, then 20% coinsurance and no Deductible	Paid at Network Level	Co-pay will be waived if admitted.
	Emergency medical transportation	Deductible then 20% coinsurance	Deductible then 40% coinsurance	none
	Urgent Care	$30 co-pay, then 20% coinsurance and no Deductible	$30 co-pay, then 40% coinsurance after Deductible	none
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible then 20% coinsurance	$100 co-pay, then 40% coinsurance after Deductible	When services are performed at a Preferred Plus Provider, employee will be eligible for reimbursement. Preferred Plus Providers are those identified as providing the best overall hospital value – as measured by FocusHealth cost and quality.
	Physician/surgeon fee	Deductible then 20% coinsurance	Deductible then 40% coinsurance	none

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Deductible then 20% coinsurance	Deductible then 40% coinsurance	Emergency Room, Urgent Care, Office evaluation & management, Office counseling, and Lab/X-ray fees are paid same as any other Illness.
	Mental/Behavioral health inpatient services	Deductible then 20% coinsurance	$100 co-pay, then 40% coinsurance after Deductible	When services are performed at a Preferred Plus Provider, employee will be eligible for reimbursement. Preferred Plus Providers are those identified as providing the best overall hospital value – as measured by FocusHealth cost and quality.
	Substance use disorder outpatient services	Deductible then 20% coinsurance	Deductible then 40% coinsurance	Emergency Room, Urgent Care, Office evaluation & management, Office counseling, and Lab/X-ray fees are paid same as any other Illness.
	Substance use disorder inpatient services	Deductible then 20% coinsurance	$100 co-pay, then 40% coinsurance after Deductible	When services are performed at a Preferred Plus Provider, employee will be eligible for reimbursement. Preferred Plus Providers are those identified as providing the best overall hospital value – as measured by FocusHealth cost and quality.
If you are pregnant	Prenatal and postnatal care	Paid as any other Illness	Paid as any other Illness	none
	Delivery and all inpatient services	Paid as any other Illness	Paid as any other Illness	none

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	Deductible then 20% coinsurance	Deductible then 40% coinsurance	Limited to 60 visits per Calendar Year. One visits equals four hours.
	Rehabilitation services	Deductible then 20% coinsurance	Deductible then 40% coinsurance	——————none——————
	Habilitation services	Not Covered	Not Covered	——————none——————
	Skilled nursing care	Deductible then 20% coinsurance	Deductible then 40% coinsurance	Limited to 60 visits per Calendar Year. Must be inpatient for at least three consecutive days.
	Durable medical equipment	Deductible then 20% coinsurance	Deductible then 40% coinsurance	——————none——————
	Hospice service	Deductible then 20% coinsurance	Deductible then 40% coinsurance	——————none——————
If your child needs dental or eye care	Eye exam	See Preventive Care Benefits	See Preventive Care Benefits	Routine vision exams are covered to age 5 under the preventative benenfit.
	Glasses	0% coinsurance and no Deductible	0% coinsurance and no deductible	Limited to a maximum of $250 per person per Calendar Year.
	Dental check-up	0% coinsurance and no Deductible	0% coinsurance and no deductible	Limited to a maximum of $250 per person per Calendar Year.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other *excluded services*.)

- Bariatric surgery
- Cosmetic surgery
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Dental care (Adult)
- Routine eye care (Adult)
- Private-duty nursing

Your Rights to Continue Coverage:

You can keep this coverage as long as you pay your premium, unless one of the following things happen:

- You commit fraud or misrepresentations of a material fact
- The plan sponsor terminates this plan
- Your employment terminates and you are not eligible to continue coverage under COBRA or state law.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. You can also contact Auxiant at 424 1st Avenue NE, Ste 200, Cedar Rapids, IA 52401.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,444
- **Plan pays** $3,394
- **Patient pays** $4,050

Sample care costs:

Hospital charges (mother)	$2,672
Routine obstetric care	$2,084
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$527
Prescriptions	$150
Radiology	$176
Vaccines, other preventive	$35
Total	**$7,444**

Patient pays:

Deductibles	$1,500
Co-pays	$50
Co-insurance	$2,500
Limits or exclusions	$0
Total	**$4,050**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,418
- **Plan pays** $2,410
- **Patient pays** $3,008

Sample care costs:

Prescriptions	$2,849
Medical Equipment and Supplies	$1,279
Office Visits and Procedures	$852
Education	$161
Laboratory tests	$137
Vaccines, other preventive	$140
Total	**$5,418**

Patient pays:

Deductibles	$1,500
Co-pays	$500
Co-insurance	$563
Limits or exclusions	$445
Total	**$3,008**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include ***premiums***.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network ***providers***. If the patient had received care from out-of-network ***providers***, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how ***deductibles***, ***co-payments***, and ***co-insurance*** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your ***providers*** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the ***premium*** you pay. Generally, the lower your ***premium***, the more you'll pay in out-of-pocket costs, such as ***co-payments***, ***deductibles***, and ***co-insurance***. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.