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?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your Deductible?	**No.**	See the Common Medical Events chart below for your costs for services this plan covers.
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?	Not Applicable	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 cross-satisfy one another.
What is not included in the out-of-pocket limit?	Not Applicable	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
		Network Provider (You will pay the least)	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	0% Coinsurance	0% Coinsurance	——————none——————
	Specialist visit	0% Coinsurance	0% Coinsurance	Includes chiropractic care, limited to 20 visits per Calendar Year.
	Preventive care/screening/ Immunization	0% Coinsurance	0% Coinsurance	Mammograms limited to 1 per Calendar Year. 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 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)	0% Coinsurance	0% Coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	0% Coinsurance	0% Coinsurance	——————none——————

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	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: https://www.truescripts.com/members	Generic drugs	$10 Co-Payment (30-day Retail) $30 Co-Payment (90-day Retail) $25 Co-Payment (Mail Order)	Not Covered	Covers up to a 30-day or 90-day supply (Retail). 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.
	Preferred Brand name drugs	$35 Co-Payment (30-day Retail) $105 Co-Payment (90-day Retail) $87.50 Co-Payment (Mail Order)	Not Covered	
	Non-Preferred Brand name drugs	$45 Co-Payment (30-day Retail) $135 Co-Payment (90-day Retail) $112.50 Co-Payment (Mail Order)	Not Covered	
	Specialty drugs	$100 Co-Payment	Not Covered	Covers up to a 30-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% Coinsurance	0% Coinsurance	——————none——————
	Physician/surgeon fees	0% Coinsurance	0% Coinsurance	——————none——————
If you need immediate medical attention	Emergency room care	0% Coinsurance	Paid at Network level	——————none——————
	Emergency medical transportation	0% Coinsurance	Paid at Network level	——————none——————
	Urgent care	0% Coinsurance	0% Coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	0% Coinsurance	0% Coinsurance	Pre-certification is required for non-emergency admissions.
	Physician/surgeon fees	0% Coinsurance	0% Coinsurance	——————none——————

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% Coinsurance	0% Coinsurance	——————none——————
	Inpatient services	0% Coinsurance	0% Coinsurance	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	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.
	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	Home health care	0% Coinsurance	0% Coinsurance	Limited to 90 visits per Calendar Year.
	Rehabilitation services	0% Coinsurance	0% Coinsurance	Includes Speech Therapy, Physical Therapy, and Occupational Therapy.
	Habilitation services	0% Coinsurance	0% Coinsurance	
	Skilled nursing care	0% Coinsurance	0% Coinsurance	Limited to 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.
	Durable medical equipment	0% Coinsurance	0% Coinsurance	——————none——————
	Hospice services	0% Coinsurance	0% Coinsurance	Limited to 90 days per Calendar Year.
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.

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	• Dental care (adult)	• Routine eye care (adult)
• Bariatric surgery	• Infertility treatment	• Routine foot care
• Cosmetic surgery	• Long-term 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.)		
• Chiropractic care	• Hearing aids	• 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, 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** **$0**
- **Specialist *[cost sharing]*** **$0**
- **Hospital (facility) *[cost sharing]*** **0%**
- **Other *[cost sharing]*** **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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Co-Payments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$60**

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

- **The plan's overall Deductible** **$0**
- **Specialist *[cost sharing]*** **$0**
- **Hospital (facility) *[cost sharing]*** **0%**
- **Other *[cost sharing]*** **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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Co-Payments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$20**

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

- **The plan's overall Deductible** **$0**
- **Specialist *[cost sharing]*** **$0**
- **Hospital (facility) *[cost sharing]*** **0%**
- **Other *[cost sharing]*** **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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Co-Payments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$0**

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