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?	Network: **$6,000**/Individual or **$12,000**/Family per Plan Year Out-of-Network: **$7,500**/Individual or **$22,500**/Family per Plan 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 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 Primary Physician and Specialist Office visits, Network Telemedicine services, Network Diagnostic test (x-ray, blood work) Office, Network Dialysis Treatment Office, and Network Urgent Care Clinic Lab/X-ray/ Supplies, and Network Preventive care.	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 Plan Year Out-of-Network: **$20,000**/Individual or **$60,000**/Family per Plan 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 individual out-of-pocket limit 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?	Ineligible charges, amounts over the maximum allowable charge, balanced-billed charges, premiums, out-of-network organ transplants, 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 (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	$30 Co-Payment, then 0% Coinsurance, Deductible does not apply	50% Coinsurance	One Co-Payment per day, per service provider (will apply additional copays if more than one provider bills from same visit).
	Specialist visit	$60 Co-Payment, then 0% Coinsurance, Deductible does not apply	50% Coinsurance	One Co-Payment per day, per service provider (will apply additional copays 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 your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% Coinsurance	50% Coinsurance	Network Office and Independent Lab - 100% covered, No Charge.
	Imaging (CT/PET scans, MRIs)	0% Coinsurance	50% Coinsurance	——————none——————
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at: www.southernscripts.net	Generic Drugs	$10 Co-Payment	Not applicable	Covers up to a 30-day supply Retail. Covers up to a 90-day supply Mail Order. Deductible applies; then Coinsurance. 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. A description of these services can be found at: www.healthcare.gov/coverage/preventive-care-benefits/ Specialty Drugs limited to 30-day supply.
	Preferred Brand Name Drugs	0% Coinsurance	Not applicable	
	Non-Preferred Brand Name Drugs	0% Coinsurance	Not applicable	
	Specialty Drugs	0% Coinsurance	Not applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% Coinsurance	50% Coinsurance	——————none——————
	Physician/surgeon fees	0% Coinsurance	50% 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 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	50% Coinsurance	Network Urgent Care Clinic Lab/X-Ray/Supplies - 100% Covered, No Charge.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% Coinsurance	50% Coinsurance	Pre-certification is required.
	Physician/surgeon fees	0% Coinsurance	50% Coinsurance	——————none——————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 Co-Payment, then 0% Coinsurance, Deductible does not apply	50% Coinsurance	Office includes Evaluation & Management Fee.
	Inpatient services	0% Coinsurance	50% Coinsurance	Pre-certification is required.
If you are pregnant	Office visits	0% 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).
	Childbirth/delivery professional services	0% Coinsurance	50% Coinsurance	
	Childbirth/delivery facility services	0% Coinsurance	50% Coinsurance	
If you need help recovering or have other special health needs	Home health care	0% Coinsurance	50% Coinsurance	Limited to 100 visits per Calendar Year.
	Rehabilitation services	Office: $30 Co-Payment, then 0% Coinsurance, Deductible does not apply Outpatient: 0% Coinsurance	50% Coinsurance	Includes Speech therapy, Physical therapy, and Occupational therapy. Physical and Occupational therapy limited to 20 visits per Calendar Year. Inpatient Rehabilitation Facility limited to 60 Days per Calendar Year.
	Habilitation services		50% Coinsurance	
	Skilled nursing care	0% Coinsurance	50% Coinsurance	Limited to 90 days per Calendar Year.
	Durable Medical Equipment	0% Coinsurance	50% Coinsurance	——————none——————
	Hospice services	0% Coinsurance	50% Coinsurance	Bereavement and Respite Included.

* 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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No Charge	50% Coinsurance	Routine vision exam Covered to age 19.
	Children's glasses	Not Covered	Not Covered	——————none——————
	Children's dental check-up	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.)		
• Acupuncture • Bariatric Surgery • Cosmetic Surgery	• Dental Care • Non-emergency care when traveling outside the U.S.	• Routine Foot Care
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic care - Limited to 26 visits per Calendar Year; Maintained Not Covered. • Contact Lenses/Eyeglasses – 1 pair per Calendar year for treatment of Keratoconus.	• Hearing aids – Cochlear implants • Private Duty Nursing – Limited to 82 visit per Calendar Year; 164 visits per Lifetime.	• Routine Eye Care • Wigs (after cancer treatment/alopecia)

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, 3002 Perry Street, Madison, WI 53713 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.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 800-245-0533.
Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 800-245-0533 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	**$6,000**
Specialist *[cost sharing]*	**$60**
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	$6,000
Co-Payments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,060**

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

The plan's overall Deductible	**$6,000**
Specialist *[cost sharing]*	**$60**
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	$900
Co-Payments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$4,280**

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

The plan's overall Deductible	**$6,000**
Specialist *[cost sharing]*	**$60**
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	$1,700
Co-Payments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,800**

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