



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 <u>Deductible</u>?	<u>Network</u>: \$3,000/Individual or \$6,000/Family per Calendar Year <u>Out-of-Network</u>: \$4,000/Individual or \$8,000/Family per Calendar Year	Generally, you must pay all of the costs from <u>providers</u> up to the <u>Deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, they have to meet their own individual <u>Deductible</u> until the overall family <u>Deductible</u> has been met. <u>Network/Out-of-Network Deductibles</u> and any other benefit maximums do not cross-satisfy one another.
Are there services covered before you meet your <u>Deductible</u>?	Yes: <u>Network</u> Primary Physician and Specialist Office visits, <u>Network</u> Telemedicine services, <u>Network</u> Diagnostic test (x-ray, blood work) Office, <u>Network</u> Dialysis Treatment Office, and <u>Network</u> Urgent Care Clinic Lab/X-ray/ Supplies, and <u>Network</u> Preventive care.	This <u>plan</u> covers some items and services even if you haven't yet met the annual <u>Deductible</u> amount. But a <u>Co-Payment</u> or <u>Coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive</u> services without <u>cost-sharing</u> and before you meet your <u>Deductible</u> . See a list of covered <u>preventive</u> services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>Deductibles</u> for specific services?	No.	You don't have to meet <u>Deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	<u>Network</u>: \$4,500/Individual or \$9,000/Family per Calendar Year <u>Out-of-Network</u>: \$6,000/Individual or \$12,000/Family per Calendar Year	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own individual <u>out-of-pocket limit</u> until the overall family <u>out-of-pocket limit</u> has been met. <u>Network/Out-of-Network out-of-pocket limits</u> and any other benefit maximums do not cross-satisfy one another.

Important Questions	Answers	Why This Matters:
What is not included in the <u>out-of-pocket limit</u>?	Cost containment penalties, ineligible charges, amount over the <u>maximum allowable charge</u> , <u>premiums</u> , <u>out-of-network</u> organ transplants, balanced-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>Network provider</u>?	Yes , see the back of your ID card for more information.	This <u>plan</u> uses a <u>Provider Network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's Network</u> . You will pay the most if you use an <u>Out-of-Network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (a <u>balance bill</u>). Be aware, your <u>Network provider</u> might use an <u>Out-of-Network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No , you do not need a <u>referral</u> to see a <u>specialist</u> .	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$30 <u>Co-Payment</u> , then 0% <u>Coinsurance</u> , <u>Deductible</u> does not apply	40% <u>Coinsurance</u>	One <u>Co-Payment</u> per day, per service provider (will apply additional copays if more than one provider bills from same visit).
	<u>Specialist</u> visit	\$60 <u>Co-Payment</u> , then 0% <u>Coinsurance</u> , <u>Deductible</u> does not apply	40% <u>Coinsurance</u>	One <u>Co-Payment</u> per day, per service provider (will apply additional copays if more than one provider bills from same visit).
	<u>Preventive care/screening/Immunization</u>	No Charge	40% <u>Coinsurance</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	<u>Network</u> Office and Independent Lab - 100% covered, No Charge.
	Imaging (CT/PET scans, MRIs)	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	—————none—————
If you need drugs to treat your illness or condition See your ID card for more information about <u>prescription drug coverage</u> .	Generic Drugs	20% <u>Coinsurance</u>	Not applicable	Covers up to a 30-day supply Retail. Covers up to a 90-day supply Mail Order. <u>Deductible</u> applies; then <u>Coinsurance</u> .
	Preferred Brand Name Drugs	20% <u>Coinsurance</u>	Not applicable	No <u>Co-Payment</u> for generic prescriptions mandated by the Affordable Care Act (ACA), including but not limited to tobacco cessation medications and generic women's contraceptives.
	Non-Preferred Brand Name Drugs	20% <u>Coinsurance</u>	Not applicable	A description of these services can be found at: www.healthcare.gov/coverage/preventive-care-benefits/
	<u>Specialty Drugs</u>	20% <u>Coinsurance</u>	Not applicable	<u>Specialty Drugs</u> limited to 30-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	—————none—————
	Physician/surgeon fees	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	—————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	<u>Emergency room care</u>	20% <u>Coinsurance</u>	Paid at <u>Network</u> level	—————none—————
	<u>Emergency medical transportation</u>	20% <u>Coinsurance</u>	Paid at <u>Network</u> level	—————none—————
	<u>Urgent care</u>	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	<u>Network</u> Urgent Care Clinic Lab/X-Ray/Supplies - 100% Covered, No Charge.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	<u>Pre-certification</u> is required.
	Physician/surgeon fees	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	—————none—————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 <u>Co-Payment</u> , then 0% <u>Coinsurance</u> , <u>Deductible</u> does not apply	40% <u>Coinsurance</u>	Office includes Evaluation & Management Fee.
	Inpatient services	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	<u>Pre-certification</u> is required.
If you are pregnant	Office visits	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	<u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Depending on the type of services, a <u>Coinsurance</u> or <u>Deductible</u> may apply. Maternity care may include tests described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	
	Childbirth/delivery facility services	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	Limited to 100 visits per Calendar Year.
	<u>Rehabilitation services</u>	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	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. <u>Co-Payments</u> will apply to office visits.
	<u>Habilitation services</u>		40% <u>Coinsurance</u>	
	<u>Skilled nursing care</u>	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	Limited to 90 days per Calendar Year.
	<u>Durable Medical Equipment</u>	0% <u>Coinsurance</u>	40% <u>Coinsurance</u>	—————none—————
	<u>Hospice services</u>	20% <u>Coinsurance</u>	40% <u>Coinsurance</u>	Bereavement and Respite Included.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No Charge	40% <u>Coinsurance</u>	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_____

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
• 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 <u>plan</u> 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): Dinekehgo shika at'ohwol ninisingo, kwijigo holne' 800-245-0533.

Pennsylvania Dutch (Deutsch): Fer Hilf griege in Deutsch, ruf 800-245-0533 uff.

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

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 <u>plan's</u> overall <u>Deductible</u>	\$3,000
■ <u>Specialist</u> [<u>cost sharing</u>]	\$60
■ Hospital (facility) [<u>cost sharing</u>]	20%
■ Other [<u>cost sharing</u>]	20%

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
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In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$3,000
<u>Co-Payments</u>	\$0
<u>Coinsurance</u>	\$1,500
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$4,560

Managing Joe's type 2 Diabetes

(a year of routine Network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>Deductible</u>	\$3,000
■ <u>Specialist</u> [<u>cost sharing</u>]	\$60
■ Hospital (facility) [<u>cost sharing</u>]	20%
■ Other [<u>cost sharing</u>]	20%

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
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In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$3,000
<u>Co-Payments</u>	\$400
<u>Coinsurance</u>	\$300
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$3,720

Mia's Simple Fracture

(Network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>Deductible</u>	\$3,000
■ <u>Specialist</u> [<u>cost sharing</u>]	\$60
■ Hospital (facility) [<u>cost sharing</u>]	20%
■ Other [<u>cost sharing</u>]	20%

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
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In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,800
<u>Co-Payments</u>	\$300
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,100