



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>?	<p><u>Network</u>: \$700/Individual or \$1,400/Family per Calendar Year</p> <p><u>Out-of-Network</u>: \$700/Individual or \$1,400/Family per Calendar Year</p>	<p>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, each family member must meet their own individual <u>Deductible</u> until the overall family <u>Deductible</u> has been met.</p>
Are there services covered before you meet your <u>Deductible</u>?	<p>Yes. <u>Network Preventive care</u> services (first \$600) and Routine eye exams (all <u>providers</u>) are covered before you meet your <u>Deductible</u>.</p>	<p>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 services</u> without <u>cost-sharing</u> and before you meet your <u>Deductible</u>. See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/.</p>
Are there other <u>Deductibles</u> for specific services?	<p>No.</p>	<p>You don't have to meet <u>Deductibles</u> for specific services.</p>
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	<p><u>Network</u>: \$4,450/Individual or \$8,900/Family per Calendar Year</p> <p><u>Out-of-Network</u>: \$8,700/Individual or \$17,400/Family per Calendar Year</p>	<p>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.</p>
What is not included in the <u>out-of-pocket limit</u>?	<p>Premiums, <u>emergency room co-payments</u>, <u>pre-certification</u> penalties, amounts over the <u>maximum allowable charge</u>, <u>balanced-billed charges</u>, and health care this <u>plan</u> doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.</p>

Important Questions	Answers	Why This Matters:
<p>Will you pay less if you use a <u>Network provider</u>?</p>	<p>Yes, see the back of your ID card for more information.</p>	<p>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 charge</u> 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.</p>
<p>Do you need a <u>referral</u> to see a <u>specialist</u>?</p>	<p>No, you do not need a <u>referral</u> to see a <u>specialist</u>.</p>	<p>You can see the <u>specialist</u> you choose without a <u>referral</u>.</p>



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
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (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	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	—————none—————
	<u>Specialist</u> visit	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	—————none—————
	<u>Preventive care/screening/Immunization</u>	1 st \$600 per Calendar Year, <u>Deductible</u> does not apply, then 20% <u>Coinsurance</u>	50% <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>	50% <u>Coinsurance</u>	—————none—————
	Imaging (CT/PET scans, MRIs)	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	—————none—————

* 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 you need drugs to treat your illness or condition More information about prescription drug coverage is available at: www.serveyourx.com	Generic Drugs	Retail: 20% <u>Coinsurance</u> Mail Order: \$30 <u>Co-Payment</u> or 10% <u>Coinsurance</u> , whichever is greater	Not applicable	Covers up to a 34-day Retail supply. Covered up to a 90-day Mail Order supply. 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. Excludes emergency contraceptive pill or morning after pill.
	Formulary Brand Drugs	Retail: 20% <u>Coinsurance</u> Mail Order: \$90 <u>Co-Payment</u> or 10% <u>Coinsurance</u> , whichever is greater	Not applicable	
	Non-Formulary Brand Drugs	Retail: 20% <u>Coinsurance</u> Mail Order: \$90 <u>Co-Payment</u> or 10% <u>Coinsurance</u> , whichever is greater	Not applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	_____none_____
	Physician/surgeon fees	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	_____none_____
If you need immediate medical attention	<u>Emergency room care</u>	\$100 <u>Co-Payment</u> , then 20% <u>Coinsurance</u>	Paid at <u>Network</u> level	<u>Co-Payment</u> waived if admitted.
	<u>Emergency medical transportation</u>	20% <u>Coinsurance</u>	Paid at <u>Network</u> level	_____none_____
	<u>Urgent care</u>	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	_____none_____
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	<u>Pre-certification</u> is required. If you fail to obtain <u>pre-certification</u> benefits could be reduced by \$100 of the total cost of the service.
	Physician/surgeon fees	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	_____none_____

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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	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	—————none—————
	Inpatient services	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	<u>Pre-certification</u> is required. If you fail to obtain <u>pre-certification</u> benefits could be reduced by \$100 of the total cost of the service.
If you are pregnant	Office visits	20% <u>Coinsurance</u>	50% <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>	50% <u>Coinsurance</u>	
	Childbirth/delivery facility services	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	<u>Pre-certification</u> required. If you fail to obtain <u>pre-certification</u> benefits could be reduced by \$100 of the total cost of the service.
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	<u>Pre-certification</u> is required. If you fail to obtain <u>pre-certification</u> benefits could be reduced by \$100 of the total cost of the service.
	<u>Rehabilitation services</u>	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	Physical therapy limited to 30 visits per Calendar Year. Speech therapy limited to 90 visits per Calendar Year.
	<u>Habilitation services</u>			
	<u>Skilled nursing care</u>	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	Limited to 60 days per Calendar Year combined with Inpatient Rehabilitation Facility. <u>Pre-certification</u> is required. If you fail to obtain <u>pre-certification</u> benefits could be reduced by \$100 of the total cost of the service.
	<u>Durable Medical Equipment (DME)</u>	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	<u>Pre-certification</u> required for electric/ motorized scooters or wheelchairs and pneumatic compression devices. If you fail to obtain <u>pre-certification</u> benefits could be reduced by \$100 of the total cost of the service.
	<u>Hospice services</u>	20% <u>Coinsurance</u>	50% <u>Coinsurance</u>	Includes bereavement counseling and respite care.

* 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
		<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	Not Covered	Not Covered	_____none_____
	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.)		
<ul style="list-style-type: none">• Acupuncture (except in lieu of anesthesia)• Cosmetic surgery• Dental care (adult & child)	<ul style="list-style-type: none">• Hearing aids (except initial aid when hearing loss results from surgery)• Infertility treatment (except diagnosis)	<ul style="list-style-type: none">• Long-term care• Routine foot care (except for metabolic or peripheral vascular disease)
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none">• Bariatric surgery (for treatment of morbid obesity only; limited to \$25,000 per Lifetime)• Chiropractic care (Limited to 15 visits or \$500 whichever is met first)	<ul style="list-style-type: none">• Private duty nursing (Limited to 30 days per Calendar Year)• Routine eye care (adult - \$75 per Calendar Year)	<ul style="list-style-type: none">• Non-emergency care when traveling outside the U.S.• Weight loss programs (for the treatment of morbid obesity only; limited to \$25,000 per Lifetime.)

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 St, 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, kwijigo holne' 800-245-0533.

Pennsylvania Dutch (Deutsch): Fer Hilf griegie 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>	\$700
■ <u>Specialist [cost sharing]</u>	20%
■ <u>Hospital (facility) [cost sharing]</u>	20%
■ <u>Other [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:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$700
<u>Co-Payments</u>	\$0
<u>Coinsurance</u>	\$2,400
<i>What isn't covered</i>	
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 <u>plan's</u> overall <u>Deductible</u>	\$700
■ <u>Specialist [cost sharing]</u>	20%
■ <u>Hospital (facility) [cost sharing]</u>	20%
■ <u>Other [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:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$700
<u>Co-Payments</u>	\$0
<u>Coinsurance</u>	\$1,000
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,720

Mia's Simple Fracture

(Network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>Deductible</u>	\$700
■ <u>Specialist [cost sharing]</u>	20%
■ <u>Hospital (facility) [cost sharing]</u>	20%
■ <u>Other [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:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$700
<u>Co-Payments</u>	\$100
<u>Coinsurance</u>	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,100