

 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](http://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](http://www.Auxiant.com) or call 1-800-245-0533 to request a copy.

Important Questions	Answers	Why This Matters:
<p><b>What is the overall <u>Deductible</u>?</b></p>	<p><u>Network</u>: \$5,000/Individual or \$10,000/Family per Calendar Year  <u>Out-of-Network</u>: \$5,000/Individual or \$10,000/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, they have to meet their own individual <u>Deductible</u> until the overall family <u>Deductible</u> has been met.</p>
<p><b>Are there services covered before you meet your <u>Deductible</u>?</b></p>	<p>Yes: <u>Preventive Care</u> services.</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</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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</p>
<p><b>Are there other <u>Deductibles</u> for specific services?</b></p>	<p>No.</p>	<p>You don't have to meet <u>Deductibles</u> for specific services.</p>
<p><b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b></p>	<p><u>Network</u>: \$6,450/Individual or \$12,900/Family per Calendar Year  <u>Out-of-Network</u>: \$12,900/Individual or \$25,800/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>
<p><b>What is not included in the <u>out-of-pocket limit</u>?</b></p>	<p>Ineligible charges, amounts over the <u>maximum allowable charge</u>, <u>premiums</u>, <u>balanced-billed</u> charges, 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><b>Will you pay less if you use a <u>Network provider</u>?</b></p>	<p><b>Yes</b>, 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><b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b></p>	<p><b>No</b>, 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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	10% <u>Coinsurance</u>	30% <u>Coinsurance</u>	—————none—————
	<u>Specialist</u> visit	10% <u>Coinsurance</u>	30% <u>Coinsurance</u>	—————none—————
	<u>Preventive care/screening/Immunization</u>	No Charge	30% <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.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>Coinsurance</u>	30% <u>Coinsurance</u>	—————none—————
	Imaging (CT/PET scans, MRIs)	10% <u>Coinsurance</u>	30% <u>Coinsurance</u>	—————none—————
<b>If you need drugs to treat your illness or condition</b> More information about <b><u>prescription drug coverage</u></b> is available at: <a href="https://truerx.com">https://truerx.com</a>	Generic Drugs	10% <u>Coinsurance</u>	Not Covered	Covers up to a 34-day Retail supply. Covers up to a 102-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. Drugs costing above \$350 for a 30-day supply not covered unless SHARx program fails to provide a solution.
	Preferred Brand Name Drugs	10% <u>Coinsurance</u>	Not Covered	
	Non-Preferred Brand Name Drugs	10% <u>Coinsurance</u>	Not Covered	
	<u>Specialty Drugs</u>	Not covered unless SHARx program fails to provide a solution.	Not Covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	10% <u>Coinsurance</u>	30% <u>Coinsurance</u>	—————none—————
	Physician/surgeon fees	10% <u>Coinsurance</u>	30% <u>Coinsurance</u>	—————none—————

\* For more information about limitations and exceptions, see the plan or policy document at [www.auxiant.com](http://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 immediate medical attention	<u>Emergency room care</u>	10% <u>Coinsurance</u>	Paid at <u>Network</u> level	<u>Out-of-Network</u> benefits are subject to the plan's <u>maximum allowable charge</u> . <u>Out-of-Network providers</u> may bill the member for the remaining balance.
	<u>Emergency medical transportation</u>	10% <u>Coinsurance</u>	Paid at <u>Network</u> level	Ground Ambulance – <u>Out-of-Network</u> benefits are subject to the plan's <u>maximum allowable charge</u> . <u>Out-of-Network providers</u> may bill the member for the remaining balance.
	<u>Urgent care</u>	10% <u>Coinsurance</u>	30% <u>Coinsurance</u>	—————none—————
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>Coinsurance</u>	30% <u>Coinsurance</u>	Pre-certification is required.
	Physician/surgeon fees	10% <u>Coinsurance</u>	30% <u>Coinsurance</u>	—————none—————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% <u>Coinsurance</u>	30% <u>Coinsurance</u>	—————none—————
	Inpatient services	10% <u>Coinsurance</u>	30% <u>Coinsurance</u>	—————none—————
If you are pregnant	Office visits	10% <u>Coinsurance</u>	30% <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). Dependent daughters are not covered for maternity services.
	Childbirth/delivery professional services	10% <u>Coinsurance</u>	30% <u>Coinsurance</u>	
	Childbirth/delivery facility services	10% <u>Coinsurance</u>	30% <u>Coinsurance</u>	

\* For more information about limitations and exceptions, see the plan or policy document at [www.auxiant.com](http://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)	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	10% <u>Coinsurance</u>	30% <u>Coinsurance</u>	Limited to 60 visits per Calendar Year for <u>Network</u> and <u>Out-of-Network Providers</u> . Pre-certification is required.
	<u>Rehabilitation services</u>	10% <u>Coinsurance</u>	30% <u>Coinsurance</u>	Limited to 60 visits per Calendar Year combined with Occupational Therapy, Physical Therapy, and Chiropractic Care. Speech therapy limited to 20 visits per Calendar Year combined with Hearing therapy for <u>Network</u> and <u>Out-of-Network Providers</u> .
	<u>Habilitation services</u>			
	<u>Skilled nursing care</u>	10% <u>Coinsurance</u>	30% <u>Coinsurance</u>	Limited to 30 days per Calendar Year for <u>Network</u> and <u>Out-of-Network Providers</u> . Pre-certification is required.
	<u>Durable Medical Equipment</u>	10% <u>Coinsurance</u>	30% <u>Coinsurance</u>	Pre-certification is required.
	<u>Hospice services</u>	10% <u>Coinsurance</u>	30% <u>Coinsurance</u>	Limited to 14 days per Lifetime. Includes bereavement counseling and respite care.
<b>If your child needs dental or eye care</b>	Children's eye exam	10% <u>Coinsurance</u>	30% <u>Coinsurance</u>	Limited to 1 routine eye exam per Calendar Year. <u>Out-of-Network</u> benefits limited to \$45 per Calendar Year.
	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](http://www.auxiant.com).

## 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> .)		
<ul style="list-style-type: none"><li>• Acupuncture</li><li>• Bariatric surgery</li><li>• Cosmetic surgery</li><li>• Dental care (adult/child)</li></ul>	<ul style="list-style-type: none"><li>• Infertility treatment</li><li>• Long term care</li><li>• Routine eye care (adult/child)</li></ul>	<ul style="list-style-type: none"><li>• Routine foot care</li><li>• Weight loss programs</li></ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none"><li>• Chiropractic care</li></ul>	<ul style="list-style-type: none"><li>• Hearing aids</li></ul>	

**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](http://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](http://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](http://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>	\$5,000
■ <u>Specialist [cost sharing]</u>	10%
■ <u>Hospital (facility) [cost sharing]</u>	10%
■ <u>Other [cost sharing]</u>	10%

#### 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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#### In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$5,000
<u>Co-Payments</u>	\$0
<u>Coinsurance</u>	\$800
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$5,860</b>

### 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>	\$5,000
■ <u>Specialist [cost sharing]</u>	10%
■ <u>Hospital (facility) [cost sharing]</u>	10%
■ <u>Other [cost sharing]</u>	10%

#### 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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#### In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$5,000
<u>Co-Payments</u>	\$0
<u>Coinsurance</u>	\$40
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$5,060</b>

### Mia's Simple Fracture

(Network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>Deductible</u>	\$5,000
■ <u>Specialist [cost sharing]</u>	10%
■ <u>Hospital (facility) [cost sharing]</u>	10%
■ <u>Other [cost sharing]</u>	10%

#### This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
Diagnostic test (*x-ray*)  
Durable Medical Equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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#### In this example, Mia would pay:

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