



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> : \$3,400/Individual or \$6,800/Family per Calendar Year <u>Out-of-Network</u> : \$3,400/Individual or \$6,800/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 <u>plan</u> , each family must meet their own individual <u>Deductible</u> until the total amount of <u>Deductible</u> expenses paid by all the family members meets the overall family <u>Deductible</u> amount has been met.
Are there services covered before you meet your <u>Deductible</u>?	Yes: <u>Network preventive care</u> .	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 cost-sharing 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/ .
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> : \$3,400/Individual or \$6,800/Family per Calendar Year <u>Out-of-Network</u> : \$6,800/Individual or \$13,600/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 <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u>?	Cost containment penalties, 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.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

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 referral 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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	No Charge	20% <u>Coinsurance</u>	—————none—————
	<u>Specialist</u> visit	No Charge	20% <u>Coinsurance</u>	—————none—————
	<u>Preventive care/screening/Immunization</u>	No Charge	20% <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	Diagnostic test (x-ray, blood work)	No Charge	20% <u>Coinsurance</u>	—————none—————
	Imaging (CT/PET scans, MRIs)	No Charge	20% <u>Coinsurance</u>	<u>Pre-certification</u> is required. Failure to obtain approval may result in the cost of the service being your responsibility.

* 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 you need drugs to treat your illness or condition See your ID card for more information about <u>prescription drug coverage.</u>	Generic drugs	No Charge	Not applicable	Covers up to a 34-day Retail supply. Covers up to a 102-day Mail order supply. <u>Deductible</u> applies before <u>Co-Payments</u> . 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.
	Preferred Brand name drugs	No Charge	Not applicable	
	Non-Preferred brand name drugs	No Charge	Not applicable	
	<u>Specialty drugs</u>	No Charge	Not applicable	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	20% <u>Coinsurance</u>	<u>Pre-certification</u> is required. Failure to obtain approval may result in the cost of the service being your responsibility.
	Physician/surgeon fees	No Charge	20% <u>Coinsurance</u>	—————none—————
If you need immediate medical attention	<u>Emergency room care</u>	No Charge	Paid at <u>Network</u> level	—————none—————
	<u>Emergency medical transportation</u>	No Charge	Paid at <u>Network</u> level	—————none—————
	<u>Urgent care</u>	No Charge	20% <u>Coinsurance</u>	—————none—————
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	20% <u>Coinsurance</u>	<u>Pre-certification</u> is required. Failure to obtain approval may result in the cost of the service being your responsibility.
	Physician/surgeon fees	No Charge	20% <u>Coinsurance</u>	—————none—————

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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 need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge	20% <u>Coinsurance</u>	_____none_____
	Inpatient services	No Charge	20% <u>Coinsurance</u>	<u>Pre-certification</u> is required. Failure to obtain approval may result in the cost of the service being your responsibility.
If you are pregnant	Office visits	No Charge	20% <u>Coinsurance</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). <u>Pre-certification</u> is required. Failure to obtain approval may result in the cost of the service being your responsibility.
	Childbirth/delivery professional services	No Charge	20% <u>Coinsurance</u>	
	Childbirth/delivery facility services	No Charge	20% <u>Coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	No Charge	20% <u>Coinsurance</u>	Limited to 60 visits per Calendar Year.
	<u>Rehabilitation services</u>	No Charge	20% <u>Coinsurance</u>	Physical therapy and Occupational therapy limited to 60 visits per Calendar Year combined. Speech therapy and Hearing therapy limited to 20 visits per Calendar Year combined. Additional visits may be covered with prior certification. <u>Pre-certification</u> is required. Failure to obtain approval may result in the cost of the service being your responsibility.
	<u>Habilitation services</u>			
	<u>Skilled nursing care</u>	No Charge	20% <u>Coinsurance</u>	Limited to 30 days per Calendar Year. <u>Pre-certification</u> is required. Failure to obtain approval may result in the cost of the service being your responsibility.

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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)	
	<u>Durable Medical Equipment</u>	No Charge	20% <u>Coinsurance</u>	<u>Pre-certification</u> is required. Failure to obtain approval may result in the cost of the service being your responsibility.
	<u>Hospice services</u>	No Charge	20% <u>Coinsurance</u>	Limited to 14 days per Lifetime at an inpatient facility. <u>Pre-certification</u> is required. Failure to obtain approval may result in the cost of the service being your responsibility.
If your child needs dental or eye care	Children's eye exam	\$20 <u>Co-Payment</u> then, 0% <u>Coinsurance</u> , <u>Deductible</u> does not apply	\$20 <u>Co-Payment</u> then, 0% <u>Coinsurance</u> , <u>Deductible</u> does not apply	Limited to one exam 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.

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">• Abortion (except when the life of the mother is endangered)• Acupuncture• Bariatric surgery• Cosmetic surgery	<ul style="list-style-type: none">• Dental care (adult)• Infertility treatment• Long-term care	<ul style="list-style-type: none">• Routine foot 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.)		
<ul style="list-style-type: none">• Chiropractic care	<ul style="list-style-type: none">• Hearing aids• Coverage provided outside the U.S.	<ul style="list-style-type: none">• Private-duty Nursing• Routine eye care (adult)

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 (Deitsch): Fer Hilf griegie 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.* —————

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>	\$3,400
■ <u>Specialist</u> [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
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In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$3,400
<u>Co-Payments</u>	\$0
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$3,460

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>	\$3,400
■ <u>Specialist</u> [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
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In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$3,400
<u>Co-Payments</u>	\$0
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$3,400

Mia's Simple Fracture

(Network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>Deductible</u>	\$3,400
■ <u>Specialist</u> [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
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In this example, Mia would pay:

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