



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>: <b>\$2,000</b>/Individual or <b>\$4,000</b>/Family per Calendar Year</p> <p><u>Out-of-Network</u>: <b>\$6,000</b>/Individual or <b>\$12,000</b>/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. <u>Network/Out-of-Network Deductibles</u> and any other benefit maximums do not cross-satisfy one another.</p>
<p><b>Are there services covered before you meet your <u>Deductible</u>?</b></p>	<p><b>Yes:</b> <u>Network</u> preventive care, <u>Network</u> office visits, <u>Network</u> outpatient and Independent Lab diagnostic lab/x-rays, <u>Network</u> outpatient and office Imaging (MRIs/CT/PET scans), <u>Network</u> (prescription drugs, <u>emergency room</u> visits and <u>Network</u> <u>urgent care</u> facility.</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 <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><b>No.</b></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>: <b>\$4,000</b>/Individual or <b>\$8,000</b>/Family per Calendar Year</p> <p><u>Out-of-Network</u>: <b>\$8,000</b>/Individual or <b>\$16,000</b>/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. <u>Network/Out-of-Network out-of-pocket limits</u> and any other benefit maximums do not cross-satisfy one another.</p>

Important Questions	Answers	Why This Matters:
<p><b>What is not included in the <u>out-of-pocket limit</u>?</b></p>	<p>Penalties for failure to obtain <u>pre-authorization</u>, amounts over the <u>maximum allowable charge</u>, <u>balanced-billed</u> charges, <u>premiums</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>
<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</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.</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 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
		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	\$25 <u>Co-Payment</u> then, 0% <u>Coinsurance</u> ; <u>Deductible</u> does not apply	30% <u>Coinsurance</u>	One <u>Co-Payment</u> per day, per service provider (will apply additional <u>Co-Payments</u> if more than one provider bills from same visit).
	<u>Specialist</u> visit	\$30 <u>Co-Payment</u> then, 0% <u>Coinsurance</u> ; <u>Deductible</u> does not apply	30% <u>Coinsurance</u>	One <u>Co-Payment</u> per day, per service provider (will apply additional <u>Co-Payments</u> if more than one provider bills from same visit). Includes Chiropractic Manipulations, Evaluation & Management fee, and X-ray/lab/supplies; limited to 20 visits per Calendar Year. Maintenance not covered.
	<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)	0% <u>Coinsurance</u>	30% <u>Coinsurance</u>	Network Office services are subject to the PCP and/or SPC <u>Co-Payment</u> , then 0% <u>Coinsurance</u> and <u>Deductible</u> does not apply.
	Imaging (CT/PET scans, MRIs)	0% <u>Coinsurance</u>	30% <u>Coinsurance</u>	<u>Pre-certification</u> is required for certain services failure to obtain <u>pre-certification</u> will result in a \$750 penalty fee.

\* 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
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
<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="http://www.medone-rx.com">www.medone-rx.com</a>	Generic Drugs	30-day: \$15 <u>Co-Payment</u> 90-day: \$38 <u>Co-Payment</u>	N/A	Covers up to a 31-day supply Retail; Covers up to a 90-day supply Mail Order or Retail; 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	30-day: \$40 <u>Co-Payment</u> 90-day: \$100 <u>Co-Payment</u>	N/A	
	Non-Preferred Brand Name Drugs	30-day: \$75 <u>Co-Payment</u> 90-day: \$188 <u>Co-Payment</u>	N/A	
	<u>Specialty Drugs</u>	30-day: \$15 <u>Co-Payment</u> 90-day: \$38 <u>Co-Payment</u>	Not Covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	0% <u>Coinsurance</u>	30% <u>Coinsurance</u>	<u>Pre-certification</u> is required for certain services failure to obtain <u>pre-certification</u> will result in a \$750 penalty fee.
	Physician/surgeon fees	0% <u>Coinsurance</u>	30% <u>Coinsurance</u>	<u>Pre-certification</u> is required for certain services failure to obtain <u>pre-certification</u> will result in a \$750 penalty fee.
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	\$300 <u>Co-Payment</u> then, 0% <u>Coinsurance</u> ; <u>Deductible</u> does not apply	Paid at <u>Network</u> level	<u>Co-Payment</u> waived if admitted.
	<u>Physician services ER</u>			
	<u>Emergency medical transportation</u>	0% <u>Coinsurance</u>	Paid at <u>Network</u> level	_____none_____
	<u>Urgent care</u>	\$100 <u>Co-Payment</u> then, 0% <u>Coinsurance</u> ; <u>Deductible</u> does not apply	30% <u>Coinsurance</u>	Network Urgent Care Clinic Lab/X-Ray/Supplies and/or Network Urgent Care Clinic Evaluation & Management Fees subject to \$50 <u>Co-Payment</u> , 0% <u>Coinsurance</u> , <u>Deductible</u> does not apply.

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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)	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	0% <u>Coinsurance</u>	30% <u>Coinsurance</u>	<u>Pre-certification</u> is required. Failure to obtain <u>pre-certification</u> will result in a \$750 penalty fee.
	Physician/surgeon fees	0% <u>Coinsurance</u>	30% <u>Coinsurance</u>	<u>Pre-certification</u> is required. Failure to obtain <u>pre-certification</u> will result in a \$750 penalty fee.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	0% <u>Coinsurance</u> , Deductible does not apply	30% <u>Coinsurance</u>	Includes Evaluation & Management and Counseling services; 0% <u>Coinsurance</u> , <u>Deductible</u> does not apply.
	Inpatient services	0% <u>Coinsurance</u>	30% <u>Coinsurance</u>	<u>Pre-certification</u> is required. Failure to obtain <u>pre-certification</u> will result in a \$750 penalty fee.
<b>If you are pregnant</b>	Office visits	Paid same as any other illness	Paid same as any other illness	<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). <u>Pre-certification</u> is required for non-emergency admissions. Failure to obtain <u>pre-certification</u> will result in a \$750 penalty fee.
	Childbirth/delivery professional services	Paid same as any other illness	Paid same as any other illness	
	Childbirth/delivery facility services	Paid same as any other illness	Paid same as any other illness	

\* 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>	0% <u>Coinsurance</u>	30% <u>Coinsurance</u>	<u>Pre-certification</u> is required. Failure to obtain <u>pre-certification</u> will result in a \$750 penalty fee. Limited to 60 visits per Calendar Year.
	<u>Rehabilitation services</u>	(Office/Outpatient) \$30 <u>Co-Payment</u> ; then 0% <u>Coinsurance</u> ;	30% <u>Coinsurance</u>	Includes Hearing therapy, Physical therapy, Occupational therapy and Speech therapy; limited to 20 visits per Calendar year per type of therapy service. Cognitive therapy and Cardiac and Pulmonary Rehabilitation are subject to <u>Deductible</u> and 0% <u>Coinsurance</u> .
	<u>Habilitation services</u>	<u>Deductible</u> does not apply	30% <u>Coinsurance</u>	
	<u>Skilled nursing care</u>	0% <u>Coinsurance</u>	30% <u>Coinsurance</u>	<u>Pre-certification</u> is required. Failure to obtain <u>pre-certification</u> will result in a \$750 penalty fee. Limited to 60 days per Calendar Year combined with Inpatient Rehabilitation Facility.
	<u>Durable medical equipment (DME)</u>	0% <u>Coinsurance</u>	30% <u>Coinsurance</u>	—————none—————
	<u>Hospice services</u>	0% <u>Coinsurance</u>	30% <u>Coinsurance</u>	Bereavement and Respite care included.
<b>If your child needs dental or eye care</b>	Children's eye exam	No Charge	Not Covered	Routine vision exams covered to age 19,
	Children's glasses	Not Covered	N/A	—————none—————
	Children's dental check-up	Not Covered	N/A	—————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:

<b>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</b>		
<ul style="list-style-type: none"><li>• Acupuncture</li><li>• Bariatric Surgery</li><li>• Cosmetic Surgery</li><li>• Dental Care (adult/children)</li><li>• Hearing aids</li></ul>	<ul style="list-style-type: none"><li>• Infertility treatment</li><li>• Long term care</li><li>• Non-emergency care when traveling outside the U.S.</li></ul>	<ul style="list-style-type: none"><li>• Routine eye care (adult/children)</li><li>• Routine foot care</li><li>• Weight loss programs</li></ul>
<b>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)</b>		
<ul style="list-style-type: none"><li>• Chiropractic care (20 visits per Calendar Year)</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, 2450 Rimrock Road, Ste 301, 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.

————— *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>	\$2,000
■ <u>Specialist [cost sharing]</u>	\$30
■ <u>Hospital (facility) [cost sharing]</u>	0%
■ <u>Other [cost sharing]</u>	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*)

<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>	\$2,000
<u>Co-Payments</u>	\$40
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Peg would pay is</b>	<b>\$2,060</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>	\$2,000
■ <u>Specialist [cost sharing]</u>	\$30
■ <u>Hospital (facility) [cost sharing]</u>	0%
■ <u>Other [cost sharing]</u>	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*)

<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>	\$200
<u>Co-Payments</u>	\$900
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,120</b>

### Mia's Simple Fracture

(Network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>Deductible</u>	\$2,000
■ <u>Specialist [cost sharing]</u>	\$30
■ <u>Hospital (facility) [cost sharing]</u>	0%
■ <u>Other [cost sharing]</u>	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*)

<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>	\$1,000
<u>Co-Payments</u>	\$500
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,500</b>