

 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, 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:
<p>What is the overall <u>Deductible</u>?</p>	<p><u>Tier 1</u>: \$750/individual or \$1,500/family per Calendar Year <u>Tier 2</u>: \$3,000/individual or \$6,000/family per Calendar Year <u>Tier 3</u>: \$5,000/individual or \$10,000/family per Calendar Year <u>Tier 4</u>: \$6,000/individual or \$12,000/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 <u>plan</u>, they have to meet their own individual <u>Deductible</u> until the overall family <u>Deductible</u> amount has been met. <u>Network/Out-of-Network Deductibles</u> and any other benefit maximums cross-satisfy one another.</p>
<p>Are there services covered before you meet your <u>Deductible</u>?</p>	<p>Yes: Emergency room services; Tier 1 and Tier 2 urgent care room and urgent care free-standing facility room; Tier 1 and Tier 2 office services with <u>Co-Payments</u>; Tier 1 and Tier 2 preventive care; and prescription drugs dispensed by a <u>Network</u> provider.</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 preventive services without cost-sharing and before you meet your <u>Deductible</u>.</p>
<p>Are there other <u>Deductibles</u> for specific services?</p>	<p>No.</p>	<p>You don't have to meet <u>Deductibles</u> for specific services.</p>
<p>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</p>	<p><u>For Deductible & Coinsurance:</u> <u>Tier 1</u>: \$750/individual or \$1,500/family per Calendar Year <u>Tier 2</u>: \$3,000/individual or \$6,000/family per Calendar Year <u>Tier 3</u>: \$5,000/individual or \$10,000/family per Calendar Year <u>Tier 4</u>: \$7,000/individual or \$14,000/family per Calendar Year</p>	

Important Questions	Answers	Why This Matters:
<p>What is the <u>out-of-pocket limit</u> for this plan?</p>	<p><u>For Medical Co-Payments:</u> <u>Tier 1:</u> \$1,000/individual or \$2,000/family per Calendar Year <u>Tier 2:</u> \$1,000/individual or \$2,000/family per Calendar Year <u>Tier 3:</u> \$1,000/individual or \$2,000/family per Calendar Year <u>Tier 4:</u> N/A <u>For Prescription Drug Co-Payments:</u> <u>Tier 1:</u> \$1,900/individual or \$3,800/family per Calendar Year <u>Tier 2:</u> \$1,900/individual or \$3,800/family per Calendar Year <u>Tier 3:</u> \$1,900/individual or \$3,800/family per Calendar Year <u>Tier 4:</u> N/A</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 out-of-pocket limits until the overall family <u>out-of-pocket</u> has been met. <u>Network/out-of-network out-of-pocket limits</u> cross satisfy one another.</p>
<p>What is not included in the <u>out-of-pocket limit</u>?</p>	<p>Cost containment penalties, ineligible charges, amounts over the <u>usual, reasonable & customary</u>, <u>premiums</u>, balanced-billed 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>
<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 balance bill). 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.</p>	<p>You can see the <u>specialist</u> you choose without a referral.</p>

* For more information about limitations and exceptions, see the plan or policy document at www.auxiant.com.

 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			Tier 4 Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
		Tier 1 Provider (You will pay the least)	Tier 2 Provider	Tier 3 Provider		
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$15 <u>Co-Payment</u> , then 0% <u>Coinsurance</u> ; <u>Deductible</u> does not apply	\$50 <u>Co-Payment</u> , then 0% <u>Coinsurance</u> ; <u>Deductible</u> does not apply	\$50 <u>Co-Payment</u> , then 0% <u>Coinsurance</u> ; <u>Deductible</u> does not apply	30% <u>Coinsurance</u>	<u>Co-Payment</u> is applied to the office visit fee (evaluation & management fee). One <u>Co-Payment</u> per day, per service provider (will apply additional <u>Co-Payments</u> if more than one provider bills from the same visit.) Related labs/x-rays are paid at 0% <u>Coinsurance</u> after <u>Deductible</u> for Tier 1 and Tier 2 providers.
	<u>Specialist</u> visit	\$15 <u>Co-Payment</u> , then 0% <u>Coinsurance</u> ; <u>Deductible</u> does not apply	\$50 <u>Co-Payment</u> , then 0% <u>Coinsurance</u> ; <u>Deductible</u> does not apply	\$50 <u>Co-Payment</u> , then 0% <u>Coinsurance</u> ; <u>Deductible</u> does not apply	30% <u>Coinsurance</u>	Same requirements as a primary care visit. Chiropractic care by a provider, including a chiropractor, is limited to 25 visits per Calendar Year.
	<u>Preventive care</u> /screening /Immunization	No Charge	No Charge	No Charge	30% <u>Coinsurance</u>	Includes routine vision exams for age 5 and over. You pay a \$15 <u>Co-Payment</u> for Tier 1 providers and a \$50 <u>Co-Payment</u> for Tier 2 providers. Mammograms limited to one per Calendar Year. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% <u>Coinsurance</u>	0% <u>Coinsurance</u>	0% <u>Coinsurance</u>	30% <u>Coinsurance</u>	—————none—————
	Imaging (CT/PET scans, MRIs)	0% <u>Coinsurance</u>	0% <u>Coinsurance</u>	0% <u>Coinsurance</u>	30% <u>Coinsurance</u>	—————none—————

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Common Medical Event	Services You May Need	What You Will Pay			Tier 4 Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
		Tier 1 Provider (You will pay the least)	Tier 2 Provider	Tier 3 Provider		
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.clearscript.org	Generic drugs	\$5 <u>Co-Payment</u> /30-day Retail; \$12.50 <u>Co-Payment</u> /90-day Retail	\$20 <u>Co-Payment</u> /30-day Retail; \$60 <u>Co-Payment</u> /90-day Retail; \$60 <u>Co-Payment</u> /90-day Mail Order	\$20 <u>Co-Payment</u> /30-day Retail; \$60 <u>Co-Payment</u> /90-day Retail; \$60 <u>Co-Payment</u> /90-day Mail Order	Not Covered	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. Specialty drugs limited to Tier 1 providers unless the prescription is not available; then, it may be filled at a Tier 2 provider.
	Brand name drugs	\$20 <u>Co-Payment</u> /30-day Retail; \$50 <u>Co-Payment</u> /90-day Retail	\$40 <u>Co-Payment</u> /30-day Retail; \$120 <u>Co-Payment</u> /90-day Retail; \$120 <u>Co-Payment</u> /90-day Mail Order	\$40 <u>Co-Payment</u> /30-day Retail; \$120 <u>Co-Payment</u> /90-day Retail; \$120 <u>Co-Payment</u> /90-day Mail Order	Not Covered	
	Non-Preferred brand name drugs	\$50 <u>Co-Payment</u> /30-day Retail; \$125 <u>Co-Payment</u> /90-day Retail	\$80 <u>Co-Payment</u> /30-day Retail; \$240 <u>Co-Payment</u> /90-day Retail; \$240 <u>Co-Payment</u> /90-day Mail Order	\$80 <u>Co-Payment</u> /30-day Retail; \$240 <u>Co-Payment</u> /90-day Retail; \$240 <u>Co-Payment</u> /90-day Mail Order	Not Covered	
	Specialty drugs	20% with a \$250 <u>Co-Payment</u> maximum/30-day Retail	20% with a \$250 <u>Co-Payment</u> maximum/30-day Retail	20% with a \$250 <u>Co-Payment</u> maximum/30-day Retail	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% <u>Coinsurance</u>	0% <u>Coinsurance</u>	0% <u>Coinsurance</u>	30% <u>Coinsurance</u>	When services are performed at a Preferred Plus <u>Provider</u> , employee will be eligible for reimbursement to a level determined by the Plan Sponsor. Preferred Plus <u>Providers</u> are those identified as providing the best overall hospital value – as measured by FocusHealth cost and quality.

* 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
		Tier 1 Provider (You will pay the least)	Tier 2 Provider	Tier 3 Provider	Tier 4 Provider (You will pay the most)	
	Physician/surgeon fees	0% <u>Coinsurance</u>	0% <u>Coinsurance</u>	0% <u>Coinsurance</u>	30% <u>Coinsurance</u>	—————none—————
If you need immediate medical attention	<u>Emergency room care</u>	\$100 <u>Co-Payment</u> , then 0% <u>Coinsurance</u> ; <u>Deductible</u> does not apply	\$150 <u>Co-Payment</u> , then 0% <u>Coinsurance</u> ; <u>Deductible</u> does not apply	\$150 <u>Co-Payment</u> , then 0% <u>Coinsurance</u> ; <u>Deductible</u> does not apply	Paid at Tier 2 Level	Applies to the facility fee. <u>Co-Payment</u> is waived if admitted. All other services are payable subject to 0% <u>Coinsurance</u> after <u>Deductible</u> for Tier 1 and Tier 2 providers.
	<u>Emergency medical transportation</u>	Not Applicable	0% <u>Coinsurance</u>	0% <u>Coinsurance</u> after Tier 2 <u>Deductible</u>	0% <u>Coinsurance</u> after Tier 2 <u>Deductible</u>	—————none—————
	<u>Urgent care</u>	No Charge	\$50 <u>Co-Payment</u> , then 0% <u>Coinsurance</u> ; <u>Deductible</u> does not apply	\$50 <u>Co-Payment</u> , then 0% <u>Coinsurance</u> ; <u>Deductible</u> does not apply	30% <u>Coinsurance</u>	Applies to the facility fee. Labs, x-rays, surgery & supplies are subject to 0% <u>Coinsurance</u> after <u>Deductible</u> for Tier 1 and Tier 2 providers. For hospital billed urgent care, there is no charge for Tier 1 physicians and 0% after <u>Deductible</u> for Tier 2. Also, you pay a \$15 <u>Co-Payment</u> for hospital billed urgent care provided by a Tier 1 provider.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% <u>Coinsurance</u>	0% <u>Coinsurance</u>	0% <u>Coinsurance</u>	30% <u>Coinsurance</u>	Pre-certification is required for non-emergency admissions or benefits will be reduced by 50% up to \$500. When services are performed at a Preferred Plus <u>Provider</u> , employee will be eligible for reimbursement to a level determined by the Plan Sponsor. Preferred Plus <u>Providers</u> are those identified as providing the best overall hospital value – as measured by FocusHealth cost and quality.
	Physician/surgeon fees	0% <u>Coinsurance</u>	0% <u>Coinsurance</u>	0% <u>Coinsurance</u>	30% <u>Coinsurance</u>	—————none—————

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Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Tier 1 Provider (You will pay the least)	Tier 2 Provider	Tier 3 Provider	Tier 4 Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% <u>Coinsurance</u>	0% <u>Coinsurance</u>	0% <u>Coinsurance</u>	30% <u>Coinsurance</u>	Emergency Room, Urgent Care, Office evaluation & management, Office counseling, and Lab/X-ray fees are paid same as any other illness.
	Inpatient services	0% <u>Coinsurance</u>	0% <u>Coinsurance</u>	0% <u>Coinsurance</u>	30% <u>Coinsurance</u>	Pre-certification is required for non-emergency admissions or benefits will be reduced by 50% up to \$500. When services are performed at a Preferred Plus <u>Provider</u> , employee will be eligible for reimbursement to a level determined by the Plan Sponsor. Preferred Plus <u>Providers</u> are those identified as providing the best overall hospital value – as measured by FocusHealth cost and quality.
If you are pregnant	Office visits	Paid same as any other illness	Paid same as any other illness	Paid same as any other illness	Paid same as any other illness	Home births are not covered. Cost sharing does not apply to certain preventive services. 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). Pre-certification is required for non-emergency admissions or benefits will be reduced by 50% up to \$500. When services are performed at a Preferred Plus <u>Provider</u> , employee will be eligible for reimbursement to a level determined by the Plan Sponsor. Preferred Plus <u>Providers</u> are those identified as providing the best overall hospital value – as measured by FocusHealth cost and quality.
	Childbirth/delivery professional services	Paid same as any other illness	Paid same as any other illness	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	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.

Common Medical Event	Services You May Need	What You Will Pay			Tier 4 Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
		Tier 1 Provider (You will pay the least)	Tier 2 Provider	Tier 3 Provider		
If you need help recovering or have other special health needs	<u>Home health care</u>	0% <u>Coinsurance</u>	0% <u>Coinsurance</u>	0% <u>Coinsurance</u>	30% <u>Coinsurance</u>	Limited to 40 visits per Calendar Year. Home care through Home Health United in Reedsburg covered as Tier 1.
	<u>Rehabilitation and Habilitation services</u>	\$15 <u>Co-Payment</u> , then 0% <u>Coinsurance</u> ; <u>Deductible</u> does not apply	\$50 <u>Co-Payment</u> , then 0% <u>Coinsurance</u> ; <u>Deductible</u> does not apply	\$50 <u>Co-Payment</u> , then 0% <u>Coinsurance</u> ; <u>Deductible</u> does not apply	30% <u>Coinsurance</u>	Includes athletic training, speech therapy, physical therapy & occupational therapy, limited to a combined maximum of 50 visits for the four therapy types per Calendar Year (rehabilitation and habilitation services).
	<u>Skilled nursing care</u>	0% <u>Coinsurance</u>	0% <u>Coinsurance</u>	0% <u>Coinsurance</u>	30% <u>Coinsurance</u>	Limited to 120 days per Calendar Year. Pre-certification is required for non-emergency admissions or benefits will be reduced by 50% up to \$500.
	<u>Durable medical equipment</u>	0% <u>Coinsurance</u>	0% <u>Coinsurance</u>	0% <u>Coinsurance</u>	30% <u>Coinsurance</u>	—————none—————
	<u>Hospice services</u>	0% <u>Coinsurance</u>	0% <u>Coinsurance</u>	0% <u>Coinsurance</u>	30% <u>Coinsurance</u>	—————none—————
If your child needs dental or eye care	Children's eye exam	No Charge	No Charge	No Charge	30% <u>Coinsurance</u>	Covers routine vision exams to age 5. For ages 5 and over, see preventive care.
	Children's glasses	Not Covered	Not Covered	Not Covered	Not Covered	—————none—————
	Children's dental check-up	Not Covered	Not Covered	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.)

- | | | |
|---------------------|-----------------------|------------------------|
| • Acupuncture | • Dental care (Adult) | • Routine foot care |
| • Bariatric surgery | • Long-term care | • Weight loss programs |
| • Cosmetic surgery | | |

Other Covered Services (This isn't a complete list. Check your plan document for other covered services and your costs for these services.)

- | | | |
|---------------------|--|----------------------------|
| • Chiropractic care | • Infertility treatment | • Private-duty nursing |
| • Hearing aids | • Non-emergency care when traveling outside the U.S. | • 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, 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.

Does this plan provide Minimum Essential Coverage? **Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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>	\$750
■ <u>Specialist</u> [<i>cost sharing</i>]	\$15
■ Hospital (facility) [<i>cost sharing</i>]	0%
■ Other [<i>cost sharing</i>]	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	\$12,731
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$750
<u>Co-Payments</u>	\$50
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$860

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>	\$750
■ <u>Specialist</u> [<i>cost sharing</i>]	\$15
■ Hospital (facility) [<i>cost sharing</i>]	0%
■ Other [<i>cost sharing</i>]	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	\$7,389
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$750
<u>Co-Payments</u>	\$565
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$55
The total Joe would pay is	\$1,370

Mia's Simple Fracture

(network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>Deductible</u>	\$750
■ <u>Specialist</u> [<i>cost sharing</i>]	\$15
■ Hospital (facility) [<i>cost sharing</i>]	0%
■ Other [<i>cost sharing</i>]	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	\$1,925
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$750
<u>Co-Payments</u>	\$105
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,070