



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>?	Tier 1/Network: \$750 /Individual or \$1,500 /Family per Calendar Year Out-of-Network: \$2,000 /Individual or \$4,000 /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 member must meet their own Individual <u>Deductible</u> until the overall amount of Family <u>Deductible</u> has been satisfied. <u>Network/Out-of-Network Deductibles</u> and any other benefit maximums do cross-satisfy one another.
Are there services covered before you meet your <u>Deductible</u>?	Yes: <u>Network Preventive care</u> , Chiropractic Spinal Manipulations, Ambulance service, and Outpatient <u>Emergency Room</u> visits. For a full list of services see the Schedule of Medical Benefits.	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> . See a list of covered preventive services 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>?	Network: \$2,000 /Individual or \$4,000 /Family per Calendar Year Out-of-Network: \$5,000 /Individual or \$10,000 /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 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 cross-satisfy one another.

Important Questions	Answers	Why This Matters:
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 charges</u> , <u>Out-of-Network</u> transplant services, 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> .
Will you pay less if you use a <u>Network provider</u>?	Yes , see the back of your ID card for more information.	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.
Do you need a <u>referral</u> to see a <u>specialist</u>? (Out-of-Area Retirees)	No .	You can see the <u>specialist</u> you choose without a <u>referral</u> .
Do you need a <u>referral</u> to see a <u>specialist</u>? (No <u>Referral</u> Required)	No . You do not need a referral from a Select Health <u>Network provider</u> in order to see a Select Health <u>Network provider</u> .	You can see the <u>specialist</u> you choose without a <u>referral</u> .
Do you need a <u>referral</u> to see a <u>specialist</u>? (<u>Referral</u> Required)	No . To prevent a 30% reduction in benefits a Select <u>Primary Care Provider</u> can submit a referral request to Select Health prior using an Encore <u>provider</u> if services are not available in the Select Health <u>Network</u>	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .



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>	<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	\$20 <u>Co-Payment</u> , then 0% <u>Coinsurance</u> ; <u>Deductible</u> does not apply	50% <u>Coinsurance</u>	Network: Office <u>Co-Payment</u> includes: x-rays, labs, allergy injections and allergy testing performed in the office. All other services subject to <u>Coinsurance</u> after <u>Deductible</u> .
	<u>Specialist</u> visit	\$40 <u>Co-Payment</u> , then 0% <u>Coinsurance</u> ; <u>Deductible</u> does not apply	50% <u>Coinsurance</u>	Network: Office <u>Co-payment</u> includes x-rays, labs, allergy injections and allergy testing performed in the office. All other services subject to <u>Coinsurance</u> after <u>Deductible</u> . Chiropractic services – \$30 <u>Co-Payment</u> , then 0% <u>Coinsurance</u> ; <u>Deductible</u> does not apply. Chiropractic services provided by an <u>Out-of-Network provider</u> and/or <u>Encore provider</u> will be paid at <u>Network</u> level. Limited to 12 visits per Calendar Year.
	<u>Preventive care</u> /screening/Immunization	No Charge	Not Covered	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 the <u>plan</u> will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% <u>Coinsurance</u>	50% <u>Coinsurance</u>	Diagnostic Labs – 100% covered; <u>Deductible</u> waived.
	Imaging (CT/PET scans, MRIs)	10% <u>Coinsurance</u>	50% <u>Coinsurance</u>	Pre-certification is required for PET, MRA and MRI scans. Failure to obtain pre-certification may result in a reduction in benefits by 30%.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u>	<u>Out-of-Network Provider</u> (You will pay the most)	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.rxbenefits.com	Generic Drugs	\$10 <u>Co-Payment</u> (Retail); \$15 <u>Co-Payment</u> (Mail order)	N/A	31-day supply (Retail); 90-day supply (Mail order). 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. Pre-certification is required for Specialty drugs.
	Preferred Brand Drugs	\$30 <u>Co-Payment</u> (Retail); \$45 <u>Co-Payment</u> (Mail order)	N/A	
	Non-Preferred Brand Drugs	\$50 <u>Co-Payment</u> (Retail); \$60 <u>Co-Payment</u> (Mail order)	N/A	
	Specialty Drugs	Generic: \$10 <u>Co-Payment</u> (30-day) \$15 <u>Co-Payment</u> (90-day) Preferred Brand: \$30 <u>Co-Payment</u> (30-day) \$45 <u>Co-Payment</u> (90-day) Non-Preferred Brand: \$50 <u>Co-Payment</u> (30-day) \$60 <u>Co-Payment</u> (90-day)	N/A	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>Coinsurance</u>	50% <u>Coinsurance</u>	_____none_____
	Physician/surgeon fees	10% <u>Coinsurance</u>	50% <u>Coinsurance</u>	Pre-certification is required for select Outpatient procedures. Failure to obtain pre-certification may result in a reduction in benefits by 30%.
If you need immediate medical attention	<u>Emergency room care</u>	\$250 <u>Co-Payment</u> , then 0% <u>Coinsurance</u> ; <u>Deductible</u> does not apply	Paid at <u>Network</u> level	Physician services ER – 100% covered, <u>Deductible</u> waived.
	<u>Emergency medical transportation</u>	0% <u>Coinsurance</u> ; <u>Deductible</u> does not apply	Paid at <u>Network</u> level	_____none_____
	<u>Urgent care</u>	\$40 <u>Co-Payment</u> , then 0% <u>Coinsurance</u> ; <u>Deductible</u> does not apply	Paid at <u>Network</u> level	_____none_____

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u>	<u>Out-of-Network Provider</u> (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>Coinsurance</u>	50% <u>Coinsurance</u>	Pre-certification is required. Failure to obtain pre-certification may result in a reduction in benefits by 30%.
	Physician/surgeon fees	10% <u>Coinsurance</u>	50% <u>Coinsurance</u>	Pre-certification is required. Failure to obtain pre-certification may result in a reduction in benefits by 30%.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	(New Avenues Midwest Behavioral Health Network -Office): \$20 <u>Co-Payment</u> , then 0% <u>Coinsurance</u> ; <u>Deductible</u> does not apply (All Other Services): 10% <u>Coinsurance</u>	50% <u>Coinsurance</u>	Office visit <u>Co-Payments</u> includes counseling/therapy, evaluation/interview, testing and medication management. Emergency Room, Urgent Care, Office Evaluation & management, Office counseling, and Lab/X-ray fees are paid same as any other illness. Pre-certification is required for Intensive Outpatient and ABA Therapy. Failure to obtain pre-certification may result in a reduction in benefits by 30%.
	Inpatient services	10% <u>Coinsurance</u>	50% <u>Coinsurance</u>	Pre-certification is required for Inpatient, Residential Treatment (RES), and Partial Hospitalization (PHP). Failure to obtain pre-certification may result in a reduction in benefits by 30%.
If you are pregnant	Office visits	Paid same as any other illness	Paid same as any other illness	Network: Office <u>Co-Payment</u> includes x-rays and labs performed and billed in the office. All other services subject to <u>Coinsurance</u> after <u>Deductible</u> . Labs sent to an outside laboratory are subject to 10% <u>Coinsurance</u> after <u>Deductible</u> . Dependent daughter maternity is covered. 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	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	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u>	<u>Out-of-Network Provider</u> (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>Coinsurance</u>	50% <u>Coinsurance</u>	Pre-certification is required. Failure to obtain pre-certification may result in a reduction in benefits by 30%. Limited to 100 days per Calendar Year. Limit does not include Home Infusion therapy or Private-duty nursing rendered in the home.
	<u>Rehabilitation services</u>	\$30 <u>Co-Payment</u> , then 0% <u>Coinsurance</u> ; <u>Deductible</u> does not apply	50% <u>Coinsurance</u>	Includes occupational therapy, physical, and speech therapy. Physical and occupational therapy limited to 60 visits per Calendar Year. Speech therapy is limited to 20 visits per Calendar Year. When services are rendered in the home, Home Health Care service limits apply. Pre-certification is required for occupational, physical and speech therapy after the first (12) twelve treatments Failure to obtain pre-certification may result in a reduction in benefits by 30%.
	<u>Habilitation services</u>	\$30 <u>Co-Payment</u> , then 0% <u>Coinsurance</u> ; <u>Deductible</u> does not apply	50% <u>Coinsurance</u>	
	<u>Skilled nursing care</u>	10% <u>Coinsurance</u>	50% <u>Coinsurance</u>	Pre-certification is required. Failure to obtain pre-certification may result in a reduction in benefits by 30%.
	<u>Durable medical equipment</u>	10% <u>Coinsurance</u>	50% <u>Coinsurance</u>	Pre-certification required for equipment over \$750 and all rentals. Failure to obtain pre-certification may result in a reduction in benefits by 30%.
	<u>Hospice services</u>	10% <u>Coinsurance</u>	50% <u>Coinsurance</u>	Includes bereavement counseling. Pre-certification is required. Failure to obtain pre-certification may result in a reduction in benefits by 30%.
If your child needs dental or eye care	Children's eye exam	See Preventive Care Section	50% <u>Coinsurance</u>	Routine vision exams covered to age 19.
	Children's glasses	Not Covered	Not Covered	_____none_____
	Children's dental check-up	Not Covered	Not Covered	_____none_____

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 excluded services.)		
• Acupuncture • Cosmetic surgery • Dental care (adult)	• Hearing aids • Infertility treatment • Long-term care	• Routine eye care (adult) • Routine foot care • Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
• Bariatric surgery (Limit of one surgery per Lifetime and a \$125,000 Lifetime maximum)	• Chiropractic care (Limited to 12 visits per Calendar Year)	• Non-emergency care when traveling outside the U.S. • Private-duty nursing (Inpatient only)

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**

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>	\$750
■ <u>Specialist</u> [cost sharing]	\$40
■ Hospital (facility) [cost sharing]	10%
■ Other [cost sharing]	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*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$750
<u>Co-Payments</u>	\$10
<u>Coinsurance</u>	\$1,200
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$2,020

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> [cost sharing]	\$40
■ Hospital (facility) [cost sharing]	10%
■ Other [cost sharing]	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*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$750
<u>Co-Payments</u>	\$1,200
<u>Coinsurance</u>	\$20
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,990

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> [cost sharing]	\$40
■ Hospital (facility) [cost sharing]	10%
■ Other [cost sharing]	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*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$750
<u>Co-Payments</u>	\$500
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,250