**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 Deductible?** | Network: **$2,500**/Individual or **$5,000**/Family per Calendar Year<br><br>Out-of-Network: **N/A** | Generally, you must pay all of the costs from providers up to the Deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual Deductible until the overall amount of Deductible expenses paid by all family members meets the overall family Deductible. |
| **Are there services covered before you meet your Deductible?** | **Yes:** Network preventive care services, DPC Wellness center services, DPC telemedicine services, DPC urgent care services are all covered before you met your Deductible. | This plan covers some items and services even if you haven't yet met the annual Deductible amount. But a Co-Payment or Coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your Deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other Deductibles for specific services?** | **No.** | You don't have to meet Deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | Network: **$5,000**/Individual or **$10,000**/Family per Calendar Year<br><br>Out-of-Network: **N/A** | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limit until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | Premiums, ineligible charges, amounts over the maximum allowable charge, balanced-billed charges, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out–of–pocket limit. |

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **Will you pay less if you use a Network provider?** | **Yes**, see the back of your ID card for more information. | This plan uses a Provider Network. You will pay less if you use a provider in the plan's Network. You will pay the most if you use an Out-of-Network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (a balance bill). Be aware, your Network provider might use an Out-of-Network provider for some services (such as lab work). Check with your provider before you get services. |
| **Do you need a referral to see a specialist?** | **No**, you do not need a referral to see a specialist. | You can see the specialist you choose without a referral. |

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) | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $25 Co-Payment, then 0% Coinsurance; Deductible does not apply | Not Covered | Certain services/procedures that are performed in a physician's office are subject to the Network Deductible and Coinsurance.<br>$0 zero Co-Payment for services through OneMedical Clinic. |
| | DPC – Wellness Center | 0% Coinsurance; Deductible does not apply | Not Covered | ————————none———————— |
| | Telemedicine (virtual visits) through DPC | 0% Coinsurance; Deductible does not apply | Not Covered | ————————none———————— |
| | Specialist visit | $50 Co-Payment, then 0% Coinsurance; Deductible does not apply | Not Covered | ————————none———————— |
| | Preventive care/screening/ Immunization | No Charge | Not Covered | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% Coinsurance | Not Covered | Lab work performed in a Network Office or Independent Lab is 100% covered, No Charge. |
| | Imaging (CT/PET scans, MRIs) | 20% Coinsurance | Not Covered | ————————none———————— |

| 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 drugs to treat your illness or condition** More information about **prescription drug coverage** is available at: https://southernscripts.net | Generic Drugs | 30-day: $10 Co-Payment<br>90-day: $20 Co-Payment | N/A | Covers up to a 30-day or 90-day supply retail.<br>Covers up to a 90-day supply, Mail order.<br>Deductible does not apply.<br>No Co-Payment 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: $35 Co-Payment<br>90-day: $70 Co-Payment | N/A | |
| | Non-Preferred Brand Name Drugs | 30-day: $60 Co-Payment<br>90-day: $120 Co-Payment | N/A | |
| | Specialty Drugs | 25% Coinsurance with a maximum of $250 | N/A | Specialty Drugs limited to 30-day supply. Must be purchased through Southern Scripts. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% Coinsurance | Not Covered | Certain outpatient surgeries and services require Precertification. Failure to obtain precertification, will result in reduction of benefits. |
| | Physician/surgeon fees | 20% Coinsurance | Not Covered | ——————none—————— |
| **If you need immediate medical attention** | Emergency room care | 20% Coinsurance | Paid at Network level | ——————none—————— |
| | Emergency medical transportation | 20% Coinsurance | Paid at Network level | ——————none—————— |
| | Urgent Care (Non-DPC) | $75 Co-Payment, then 0% Coinsurance; Deductible does not apply. | Not Covered | ——————none—————— |
| | Urgent Care at DPC | 0% Coinsurance; Deductible does not apply. | Not Covered | ——————none—————— |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% Coinsurance | Not Covered | Precertification is required. Failure to obtain precertification will result in a reduction of benefits. |
| | Physician/surgeon fees | 20% Coinsurance | Not Covered | ——————none—————— |

| 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 mental health, behavioral health, or substance abuse services** | Outpatient services | 20% Coinsurance | Not Covered | Office visits are subject to Co-Payments. |
| | Inpatient services | 20% Coinsurance | Not Covered | Precertification is required. Failure to obtain precertification will result in a reduction of benefits. |
| **If you are pregnant** | Office visits | 20% Coinsurance | Not Covered | Cost sharing does not apply to certain preventive services. Depending on the type of services, a Coinsurance or Deductible may apply. Maternity care may include tests described elsewhere in the SBC (i.e., ultrasound). |
| | Childbirth/delivery professional services | 20% Coinsurance | Not Covered | |
| | Childbirth/delivery facility services | 20% Coinsurance | Not Covered | |
| **If you need help recovering or have other special health needs** | Home health care | 20% Coinsurance | Not Covered | Limited to 60 visits per Calendar Year combined with Private-duty Nursing. |
| | Rehabilitation services | 20% Coinsurance | Not Covered | Includes physical therapy, occupational therapy, and chiropractic manipulation limited to 60 visits combined per Calendar Year.<br>Speech and hearing therapy limited to 20 visits combined per Calendar Year, |
| | Habilitation services | | | |
| | Skilled nursing care | 20% Coinsurance | Not Covered | Limited to 30 days per Calendar Year. Precertification is required. Failure to obtain precertification will result in a reduction of benefits. |
| | Durable medical equipment | 20% Coinsurance | Not Covered | Precertification is required. Failure to obtain precertification will result in a reduction of benefits. |
| | Hospice services | 20% Coinsurance | Not Covered | 14-day Lifetime maximum at an inpatient hospice facility. Bereavement and respite care included. |

* 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 |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If your child needs dental or eye care** | Children's eye exam | No Charge | Not Covered | ——————none—————— |
| | 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.

## 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.) | | |
|---|---|---|
| • Abortion (except when the life of the mother is endangered)<br>• Acupuncture<br>• Bariatric surgery | • Cosmetic surgery<br>• Dental care<br>• Hearing aids<br>• Infertility treatment | • Long-term care<br>• Routine foot care |
| **Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)** | | |
| • Chiropractic care | • Routine eye care<br>• Private-duty nursing | • Non-emergency care when traveling outside the U.S. |

**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, kwiijigo holne' 800-245-0533.
Pennsylvania Dutch (Deitsch): Fer Hilf griege 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.*

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

## 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 plan's overall Deductible | $2,500 |
| Specialist *[cost sharing]* | $60 |
| Hospital (facility) *[cost sharing]* | 20% |
| Other *[cost sharing]* | 20% |

**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** |

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $2,500 |
| Co-Payments | $10 |
| Coinsurance | $2,000 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$4,570** |

### Managing Joe's type 2 Diabetes
(a year of routine Network care of a well-controlled condition)

| | |
|---|---|
| The plan's overall Deductible | $2,500 |
| Specialist *[cost sharing]* | $60 |
| Hospital (facility) *[cost sharing]* | 20% |
| Other *[cost sharing]* | 20% |

**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** |

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $900 |
| Co-Payments | $1,300 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$2,220** |

### Mia's Simple Fracture
(Network emergency room visit and follow up care)

| | |
|---|---|
| The plan's overall Deductible | $2,500 |
| Specialist *[cost sharing]* | $60 |
| Hospital (facility) *[cost sharing]* | 20% |
| Other *[cost sharing]* | 20% |

**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** |

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $2,500 |
| Co-Payments | $200 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2,700** |

The **plan** would be responsible for the other costs of these EXAMPLE covered services.