This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the plan document at ***www.auxiant.com*** or by calling **1-800-279-6772**

Important Questions	Answers	Why this Matters:
What is the overall *deductible*?	Tier 1: **$1,000** person/**$2,000** family per Calendar Year Tier 2: **$2,000** person/**$4,000** family per Calendar Year Tier 3: **$3,000** person/**$6,000** family per Calendar Year ***Deductible*** does not apply to Tier 1 urgent care room, Network services with co-pays, Network routine services, emergency room services, and organ transplants through the National Union Fire Transplant (NUF) Program.	You must pay all the costs up to the ***deductible*** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the ***deductible*** starts over (on January 1st). See the chart starting on page 3 for how much you pay for covered services after you meet the ***deductible***. Network/Non Network ***deductible*** amounts cross-satisfy one another.
Are there other *deductibles* for specific services?	There are no other specific ***deductibles***.	Because you don't have to meet ***deductibles*** for specific services, this plan starts to cover costs sooner.
Is there an *out–of–pocket limit* on my expenses?	Tier 1: **$1,000** person/**$2,000** family per Calendar Year Tier 2: **$3,000** person/**$6,000** family per Calendar Year Tier 3: **$6,000** person/**$12,000** family per Calendar Year	The ***out-of-pocket limit*** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. Deductible is included in the ***out-of-pocket limit***. Network/Non Network ***out-of-pocket limits*** and any other benefit maximums cross-satisfy one another.

What is not included in the *out–of–pocket limit*?	Infertility testing, organ transplants through the National Union Fire (NUF) Transplant Program, ineligible charges, amounts over the usual & customary, premiums, 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***.
Is there a *co-pay out–of–pocket plan year limit* on my expenses?	Tier 1: **$5,350** person/**$10,700** family per Calendar Year Tier 2: **$3,350** person/**$6,700** family per Calendar Year Tier 3: **N/A** person/**N/A** family per Calendar Year	
Is there an overall annual limit on what the plan pays?	No. This policy has no overall annual limit on the amount it will pay each year.	The chart starting on page 3 describes any limits on what the insurer will pay for specific covered services, such as office visits.
Does this plan use a *network* of *providers*?	Yes. Please contact your Employer for a list of these providers.	If you use an in-network doctor or other health care ***provider***, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network ***provider*** for some services. Plans use the term in-network, ***preferred***, or participating for ***providers*** in their ***network***. See the chart starting on page 3 for how this plan pays different kinds of ***providers***.
Do I 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 permission from this plan. If the specialist is not in your network, the coverage is at an out of network cost.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 9. See your plan document for additional information about excluded services under ***General Limitations***.

- ***Co-payments*** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- ***Co-insurance*** is your share of the costs of a covered service, calculated as a percent of the ***allowed amount*** for the service. For example, if the plan's ***allowed amount*** for an overnight hospital stay is $1,000, your ***co-insurance*** payment of 20% would be $200. This may change if you haven't met your ***deductible***.
- The amount the plan pays for covered services is based on the ***allowed amount***. If an out-of-network ***provider*** charges more than the ***allowed amount***, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the ***allowed amount*** is $1,000, you may have to pay the $500 difference. (This is called ***balance billing***.)
- This plan may encourage you to use network ***providers*** by charging you lower ***deductibles***, ***co-payments*** and ***co-insurance*** amounts.

Common Medical Event	Services You May Need	Your cost if you use			Limitations & Exceptions
		Tier 1 Option	Tier 2 Option	Tier 3 Option	
If you have a test	Diagnostic test (x-ray, blood work)	Deductible then 0% coinsurance	Deductible then 20% coinsurance	Deductible then 30% coinsurance	none
	Imaging (CT/PET scans, MRIs)	Deductible then 0% coinsurance	Deductible then 20% coinsurance	Deductible then 30% coinsurance	none
If you visit a health care *provider's* office or clinic	Primary care visit to treat an injury or illness Includes: Chiropractic care, Occupational therapy, Physical therapy, and Speech therapy	$20 co-pay then 0% coinsurance and no deductible	$50 co-pay then 0% coinsurance and no deductible	Deductible then 30% coinsurance	Co-pay is on evaluation & management fee, occupational therapy, physical therapy and speech therapy only. Primary benefits apply to other services performed same day. One co-pay per day, per visit. Occupational therapy, physical therapy, and speech therapy are limited to a combined 50 visits maximum per calendar year. Chiropractic care is limited to 25 visits per calendar year.

Common Medical Event	Services You May Need	Your cost if you use			Limitations & Exceptions
		Tier 1 Option	Tier 2 Option	Tier 3 Option	
	Other practitioner office visit Includes: Chemo/Radiation therapy, Cardiac Rehab therapy, and Hemodialysis.	Deductible then 0% coinsurance	Deductible then 20% coinsurance	Deductble then 30% coinsurance	Pre-authorization is required for Chemo/Radiation. Dialysis is limited to $10,000 maximum per month; begins the first month of treatment for Home treatment and begins the fourth month of treatment for Outpatient treatment. Cardiac Rehab is limited to 18 visits per calendar year.
	Preventive care Includes: Mammograms, Pap smear, Prostrate Screening, Routine Surgeries (Colonoscopy) Immunizations, Well Child Care, Routine exams, Routine Hearing exams, X-rays, all other lab tests, Smoking Cessation office visit/counseling, and Routine Vision exams (to age 5).	0% coinsurance and no deductible	0% coinsurance and no deductible	Deductible then 30% coinsurance	Limited to one mammogram per calendar year with no age limits. Immunizations covered as recommended by the CDC.
	Preventive care – Routine Vision exams (age 5 and older)	$20 co-pay then 0% coinsurance and no deductible	$50 co-pay then 0% coinsurance and no deductible	Deductible then 30% coinsurance	——————none——————
If your child needs dental or eye care	Eye Exam	Same as Preventive Care Benefits	Same as Preventive Care Benefits	Same as Preventive Care Benefits	——————none——————
	Glasses	Not Covered	Not Covered	Not Covered	Only charges for initial contact lenses or eyeglasses following cataract surgery are covered.
	Dental check-up	Not Covered	Not Covered	Not Covered	——————none——————

Common Medical Event	Prescription Option	Generic Drugs	Brand Name Drugs	Non-Preferred Brand Name Drugs	4th Tier Specialty Drugs	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about ***prescription drug coverage*** is available at www.www.caremark.com	RAMC Option	$3 co-pay/ Prescription (30-day supply) $9 co-pay/ Prescription (90-day supply)	$12 co-pay/ Prescription (30-day supply) $36 co-pay/ Prescription (90-day supply)	$40 co-pay/ Prescription (30-day supply) $120 co-pay/ Prescription (90-day supply)	$100 co-pay	No Co-pay for Aspirin to prevent cardiovascular disease (Men age 45 to 79 & Women age 55 to 79), Folic acid (all Women planning or capable of pregnancy), Iron supplements (Children ages 6 to 12 months who are at increased risk for iron deficiency anemia), and Oral fluoride pills (Preschool Children older than 6 months whose primary water source is deficient in fluoride). Smoking Cessation drugs are paid same as generic drugs.
	Walgreen's Option	$15 co-pay/ Prescription (30-day supply) $45 co-pay/ Prescription (90-day supply)	$40 co-pay/ Prescription (30-day supply) $120 co-pay/ Prescription (90-day supply)	$80 co-pay/ Prescription (30-day supply) $240 co-pay/ Prescription (90-day supply)	$100 co-pay	Smoking Cessation drugs are paid same as generic drugs.
	Mail Order Option	$30 co-pay/ Prescription (90-day supply)	$75 co-pay/ Prescription (90-day supply)	$150 co-pay/ Prescription (90-day supply)	$100 co-pay	Smoking Cessation drugs are paid same as generic drugs.
	Other Pharmacy Option	$10 co-pay/ Prescription (30-day supply) $30 co-pay/ Prescription (90-day supply)	$25 co-pay/ Prescription (30-day supply) $75 co-pay/ Prescription (90-day supply)	$50 co-pay/ Prescription (30-day supply) $150 co-pay/ Prescription (90-day supply)	$100 co-pay	Includes Medical Arts Pharmacy, Walgreen's Specialty Drug Program, and Other Retail Pharmacies (excluding Walgreens). Smoking Cessation drugs are paid same as generic drugs.

Common Medical Event	Services You May Need	Your cost if you use			Limitations & Exceptions
		Tier 1 Option	Tier 2 Option	Tier 3 Option	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible then 0% coinsurance	Deductible then 20% coinsurance	Deductible then 30% coinsurance	none
	Physician/surgeon fee	Deductible then 0% coinsurance	Deductible then 20% coinsurance	Deductible then 30% coinsurance	none
If you need immediate medical attention	Emergency room services	$100 co-pay then 0% coinsurance and no deductible	$150 co-pay then 0% coinsurance and no deductible	Paid at Tier 2 level	Co-pay is waived if admitted. Physician charges are 0% after deductible for Tier 1, and 20% after deductible for Tier 2. Tier 3 is paid at Tier 2 level.
	Emergency medical transportation	N/A	Deductible then 20% coinsurance	Paid at Tier 2 level	none
	Urgent Care (facility billed)	0% coinsurance and no deductible	Deductible then 20% coinsurance	Deductible then 30% coinsurance	none
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible then 0% coinsurance	Deductible then 20% coinsurance	Deductible then 30% coinsurance	none
	Physician/surgeon fee	Deductible then 0% coinsurance	Deductible then 20% coinsurance	Deductible then 30% coinsurance	none
If you are pregnant	Prenatal and postnatal care	Paid as any other Illness	Paid as any other Illness	Paid as any other Illness	Home births are not covered.
	Delivery and all inpatient services	Paid as any other Illness	Paid as any other Illness	Paid as any other Illness	Home births are not covered.

Common Medical Event	Services You May Need	Your cost if you use			Limitations & Exceptions
		Tier 1 Option	Tier 2 Option	Tier 3 Option	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services (Office and Outpatient evaluation & management and counseling fees)	$20 co-pay then 0% coinsurance and no deductible	$50 co-pay then 0% coinsurance and no deductible	Deductible then 30% coinsurance	Emergency room, urgent care, and lab/x-ray charges are paid same as any other illness.
	Mental/Behavioral health inpatient services	Deductible then 0% coinsurance	Deductible then 20% coinsurance	Deductible then 30% coinsurance	——————none——————
	Substance Abuse disorder outpatient services (Office and Outpatient evaluation & management and counseling fees)	$20 co-pay then 0% coinsurance and no deductible	$50 co-pay then 0% coinsurance and no deductible	Deductible then 30% coinsurance	Emergency room, urgent care, and lab/x-ray charges are paid same as any other illness.
	Substance Abuse disorder inpatient services	Deductible then 0% coinsurance	Deductible then 20% coinsurance	Deductible then 30% coinsurance	——————none——————
If you need help recovering or have other special health needs	Home health care	Deductible then 0% coinsurance	Deductible then 20% coinsurance	Deductible then 30% coinsurance	Limited to 40 visits per calendar year.
	Rehabilitation services	Deductible then 0% coinsurance	Deductible then 20% coinsurance	Deductible then 30% coinsurance	Limited to 90 days per calendar year.
	Habilitation services	Not Covered	Not Covered	Not Covered	——————none——————
	Skilled nursing care	Deductible then 0% coinsurance	Deductible then 20% coinsurance	Deductible then 30% coinsurance	Limited to 120 days per calendar year. Must be admitted within 7 days of confinement after acute care confinement of 3 days or more.
	Durable medical equipment	Deductible then 0% coinsurance	Deductible then 20% coinsurance	Deductible then 30% coinsurance	——————none——————
	Hospice service	Deductible then 0% coinsurance	Deductible then 20% coinsurance	Deductible then 30% coinsurance	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your plan document for other *excluded services* in the General Limitations section)		
• Acupuncture • Bariatric surgery • Cosmetic surgery • Dental care (Adult) • Dental check-up	• Glasses • Habilitation services • Non-emergency care when traveling outside the U.S.	• Private-duty nursing unless individual meets the requirements stated in the plan • 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.)		
• Chiropractic care • Hearing aids	• Infertility treatment • Long-term care	• Routine eye care (Adult)

Your Rights to Continue Coverage:

You can keep this coverage as long as you pay your premium, unless one of the following things happen:

- You commit fraud or misrepresentations of a material fact
- The plan sponsor terminates this plan
- Your employment terminates and you are not eligible to continue coverage under COBRA or state law.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. You can also contact Auxiant at 2450 Rimrock Road, Ste 301, Madison, WI 53713.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,444
- **Plan pays** $4,377
- **Patient pays** $3,067

Sample care costs:

Hospital charges (mother)	$2,672
Routine obstetric care	$2,084
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$527
Prescriptions	$150
Radiology	$176
Vaccines, other preventive	$35
Total	**$7,444**

Patient pays:

Deductibles	$1,500
Co-pays	$15
Co-insurance	$1,052
Limits or exclusions	$0
Total	**$3,067**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,418
- **Plan pays** $4,437
- **Patient pays** $981

Sample care costs:

Prescriptions	$2,849
Medical Equipment and Supplies	$1,279
Office Visits and Procedures	$852
Education	$161
Laboratory tests	$137
Vaccines, other preventive	$140
Total	**$5,418**

Patient pays:

Deductibles	$298
Co-pays	$446
Co-insurance	$0
Limits or exclusions	$237
Total	**$981**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include ***premiums***.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network ***providers***. If the patient had received care from out-of-network ***providers***, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how ***deductibles***, ***co-payments***, and ***co-insurance*** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your ***providers*** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the ***premium*** you pay. Generally, the lower your ***premium***, the more you'll pay in out-of-pocket costs, such as ***co-payments***, ***deductibles***, and ***co-insurance***. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.