




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, go to [www.asrhealthbenefits.com](http://www.asrhealthbenefits.com). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or call 616-957-1751 or 1-800-968-2449 to request a copy.

Important Questions	Answers	Why this Matters:
<p>What is the overall <u>deductible</u>?</p>	<p>\$2,500/covered person or \$5,000/family for services rendered by <u>in-network providers</u>, and \$5,000/covered person or \$10,000/family for services rendered by <u>out-of-network providers</u>. Amounts applied toward the <u>deductible</u> for <u>in-network</u> services will also accrue toward the <u>deductible</u> for <u>out-of-network</u> services, and vice versa.</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>, each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u>.</p>
<p>Are there services covered before you meet your <u>deductible</u>?</p>	<p>Yes. <u>In-network preventive care</u>, most <u>in-network</u> physician exam charges (primary care, <u>urgent care</u>, <u>specialist</u> visits), routine immunizations administered in a pharmacy or at the Department of Community Health, physician fees for an exam in an emergency room, some chiropractic care, and <u>prescription drug coverage</u> are covered before you meet your <u>deductible</u>.</p>	<p>This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without cost-sharing 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>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>The <u>out-of-pocket limits</u> for <u>coinsurance</u> only are \$3,000/covered person and \$6,000/family for services rendered by <u>in-network providers</u>, and \$15,000/covered person and \$30,000/family for services rendered by <u>out-of-network providers</u>. These figures do not include the <u>deductible</u> or any <u>copayments</u>. Amounts applied toward this <u>out-of-pocket limit</u> for <u>in-network</u> services will also accrue toward this <u>out-of-pocket limit</u> for <u>out-of-network</u> services, and vice versa.</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 <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.</p>

Important Questions	Answers	Why this Matters:
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?, cont.	The total <u>out-of-pocket limits</u> are \$6,600/covered person and \$13,200/family, and they apply to services rendered by in- <u>network providers</u> only. These figures include the <u>deductibles</u> and the <u>coinsurance out-of-pocket limits</u> shown above as well as <u>prescription drug copayments</u> and in- <u>network</u> medical <u>copayments</u> .	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 limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Deductibles</u> and <u>copayments</u> on certain services are not included in the <u>out-of-pocket limits</u> applicable to only <u>coinsurance</u> (but would be included in the total <u>out-of-pocket limits</u> as specified above). Services rendered by out-of- <u>network providers</u> are not included in the above total <u>out-of-pocket limits</u> . In general, <u>out-of-pocket limits</u> do not include penalties; charges that exceed the <u>plan's usual, customary, and reasonable</u> fee allowance or are in excess of stated maximums; <u>premiums</u> ; <u>balance-billing</u> charges; 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 www.asrhealthbenefits.com or call 616-957-1751 or 1-800-968-2449 for a list of <u>network providers</u> .	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 provider's charge and what your <u>plan</u> pays ( <u>balance billing</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> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 All copayment 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
		In Network Provider (You will pay the least)	Out of Network Provider (You will pay the most)	
If you visit a <u>health care provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$30 <u>copay/visit</u> ; <u>deductible</u> does not apply	50% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In 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, cont.	<u>Specialist visit</u>	\$30 <u>copay/visit</u> ; <u>deductible</u> does not apply and 30% <u>coinsurance</u> for hearing care services	50% <u>coinsurance</u>	Covers up to \$300 for audiometric examinations, hearing aid evaluations, and conformity tests per person in any 36-consecutive-month period.
	<u>Preventive care/screening/immunization</u>	No charge	50% <u>coinsurance</u> . No charge for routine immunizations administered in a pharmacy or at the Department of Community Health	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test (X-ray, blood work)</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Imaging (CT/PET scans, MRIs)</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at <a href="http://www.navitus.com">www.navitus.com</a>	Generic drugs	\$20 <u>copay/prescription</u> (retail or mail order); <u>deductible</u> does not apply		Covers up to a 34-day supply (retail), up to a 90-day supply (mail order), or up to a 30-day supply for <u>specialty drugs</u> (specialty pharmacy).  Specialty drugs generally can be filled through the specialty pharmacy only.
	Formulary (preferred) brand drugs	\$50 <u>copay/prescription</u> (retail or mail order); <u>deductible</u> does not apply		
	Non-formulary (non-preferred) brand drugs	\$100 <u>copay/prescription</u> (retail or mail order); <u>deductible</u> does not apply		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Physician/surgeon fees	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need immediate medical attention	<u>Emergency room care</u>	\$150 <u>copay/visit</u> and 30% <u>coinsurance</u>	\$150 <u>copay/visit</u> and 30% <u>coinsurance</u>	<u>Copay</u> may be waived if admitted inpatient.
	<u>Emergency medical transportation</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<u>Urgent care</u>	\$30 <u>copay/visit</u> ; <u>deductible</u> does not apply	50% <u>coinsurance</u>	
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Certification (sometimes called <u>preauthorization</u> ) is suggested.
	Physician/surgeon fees	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In 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	\$30 <u>copay</u> /office visit ( <u>deductible</u> does not apply) and 30% <u>coinsurance</u> for other outpatient services	50% <u>coinsurance</u>	None
	Inpatient services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Certification (sometimes called <u>preauthorization</u> ) is suggested.
If you are pregnant	Office visits	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or a <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Dependent child maternity care is excluded, except as may be required by Health Care Reform.
	Childbirth/delivery professional services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Certification (sometimes called <u>preauthorization</u> ) is required. \$100 penalty applies if not certified. 40 visits/year
	<u>Rehabilitation services</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Certification (sometimes called <u>preauthorization</u> ) is required. \$100 penalty applies if not certified.
	<u>Habilitation services</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Certification (sometimes called <u>preauthorization</u> ) is required. \$100 penalty for outpatient services or \$250 for inpatient services applies if not certified.
	<u>Skilled nursing care</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Certification (sometimes called <u>preauthorization</u> ) is required. \$100 penalty applies if not certified.
	<u>Durable medical equipment</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Certification (sometimes called <u>preauthorization</u> ) is required. \$100 penalty applies if not certified. Vehicle and home modifications are excluded.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network Provider (You will pay the least)	Out of Network Provider (You will pay the most)	
If you need help recovering or have other special health needs, cont.	<u>Hospice services</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Certification (sometimes called <u>preauthorization</u> ) is required. \$100 penalty for outpatient services or \$250 for inpatient services applies if not certified.
If your child needs dental or eye care	Children's eye exam	Not covered (except to the extent required by law)	Not covered (except to the extent required by law)	No coverage for routine eye care under the medical <u>plan</u> , except as required by Health Care Reform.
	Children's glasses	Not covered	Not covered	No coverage for glasses under the medical <u>plan</u> .
	Children's dental check-up	Not covered (except to the extent required by law)	Not covered (except to the extent required by law)	No coverage for routine dental care under the medical <u>plan</u> , except as required by Health Care Reform.

#### 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.)

- Cosmetic surgery
- Dental care (except to the extent required to be covered by Health Care Reform)
- Glasses
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (except to the extent required to be covered by Health Care Reform)
- Routine foot care
- Weight loss programs

##### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric surgery
- Chiropractic care up to \$1,000 paid annually, including \$200 for X-rays
- Hearing aids up to \$500 paid in any 36-consecutive-month period
- Infertility treatment up to \$500 paid in a lifetime plus infertility medications
- Private-duty nursing

**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 Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). 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: ASR Health Benefits at 616-957-1751 or 1-800-968-2449 or at [www.asrhealthbenefits.com](http://www.asrhealthbenefits.com). Additionally, a Consumer Assistance Program may be able to help you file your appeal. Visit [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or <http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/> to see if your state has a Consumer Assistance Program that may be able to help you file your appeal.

**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 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:**

Para obtener asistencia en Español, llame al 616-957-1751 o 1-800-968-2449.

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

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## 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, copayments 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 in network pre natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$2,500
■ <u>Specialist coinsurance</u>	30%
■ Hospital (facility) <u>coinsurance</u>	30%
■ Other <u>coinsurance</u>	30%

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>\$12,800</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,500
Copayments	\$40
Coinsurance	\$3,000
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$5,600</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in network care of a well controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$2,500
■ <u>Specialist copayment</u>	\$30
■ Hospital (facility) <u>coinsurance</u>	30%
■ Other <u>coinsurance</u>	30%

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>\$7,400</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,700
Copayments	\$1,300
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$3,060</b>

### Mia's Simple Fracture

(in network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$2,500
■ <u>Specialist copayment</u>	\$150
■ Hospital (facility) <u>coinsurance</u>	30%
■ Other <u>coinsurance</u>	30%

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>\$1,900</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,400
Copayments	\$200
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,600</b>

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