




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:
<b>What is the overall <u>deductible</u>?</b>	\$0/individual or \$0/family for most covered services. \$200/individual and \$400/family for the limited number of covered services identified throughout this summary as Master Medical Coverage.	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> .
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Yes. Those covered services not categorized as Master Medical Coverage, including, but not limited to, <u>preventive care</u> , outpatient physician services (primary care, <u>urgent care</u> , <u>specialist</u> visits, and telemedicine e-visits), <u>emergency room care</u> , and <u>hospitalization</u> , are covered before you meet your <u>deductible</u> .	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 <u>cost sharing</u> 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> .
<b>Are there other <u>deductibles</u> for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	The <u>out-of-pocket limit</u> for medical <u>coinsurance</u> is \$1,000/individual or family. The total <u>out-of-pocket limits</u> for medical services are \$4,125/individual and \$10,250/family. These figures include the <u>deductibles</u> (if applicable) and the <u>coinsurance out-of-pocket limits</u> shown above as well as <u>in-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. For the <u>coinsurance out-of-pocket limit</u> : if you have other family members in this <u>plan</u> , the overall family <u>out-of-pocket limit</u> must be met. For the total <u>out-of-pocket limits</u> : 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.

Important Questions	Answers	Why this Matters:
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<u>Deductibles</u> (if applicable) and <u>copayments</u> are not included in the above <u>out-of-pocket limits</u> applicable to medical <u>coinsurance</u> . In general, <u>out-of-pocket limits</u> do not include <u>out-of-network</u> medical <u>copayments</u> ; <u>prescription drug coverage copayments</u> (however these expenses will count towards a separate <u>out-of-pocket limit</u> that is not specified in this summary); 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> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. See <a href="http://www.asrhealthbenefits.com">www.asrhealthbenefits.com</a> 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 <u>provider's</u> 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.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	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)	
<b>If you visit a health care <u>provider's</u> office or clinic</b>	Primary care visit to treat an injury or illness	No charge for telemedicine e-visit, otherwise \$20 <u>copay/visit</u> ( <u>deductible</u> does not apply)	\$20 <u>copay/visit</u> and 15% <u>coinsurance</u> ; <u>deductible</u> does not apply	<u>Out-of-network copayment</u> costs do not track towards the <u>plan's out-of-pocket limit</u> .
	<u>Specialist</u> visit	\$20 <u>copay/visit</u> (or <u>copay/day</u> for most chiropractic care); <u>deductible</u> does not apply	\$20 <u>copay/visit</u> (or <u>copay/day</u> for most chiropractic care) and 15% <u>coinsurance</u> ; <u>deductible</u> does not apply	<u>Out-of-network copayment</u> costs do not track towards the <u>plan's out-of-pocket limit</u> . Certification (sometimes called <u>preauthorization</u> ) is required for infusion or injection of select products.

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.	Preventive care/screening/immunization	No charge	Not covered for most preventive care services; otherwise, depending on service type, either no charge or 15% coinsurance applies (deductible does not apply)	<p>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.</p> <p>Coverage for a breast pump purchased from an <u>out-of-network provider</u> is limited to \$250/birth. Certification (sometimes called <u>preauthorization</u>) is recommended for the rental and purchase of breast pumps.</p> <p><u>Preventive care</u>, including in-<u>network</u> well-baby and routine child care visits, are subject to various frequency limitations.</p> <p>This benefit includes one routine mammogram and one routine/diagnostic colonoscopy (and any mammogram- and colonoscopy-related services) per year. All diagnostic mammograms or any subsequent routine mammograms and routine/diagnostic colonoscopies performed in that year will be subject to <u>coinsurance</u> and <u>deductible</u>.</p>
	<u>Diagnostic test</u> (X-ray, blood work) Imaging (CT/PET scans, MRIs)	No charge No charge	15% <u>coinsurance</u> ; <u>deductible</u> does not apply 15% <u>coinsurance</u> ; <u>deductible</u> does not apply	None 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)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.navitus.com">www.navitus.com</a> or the Medical Option Comparison chart in your Natural Select workbook.	Generic drugs	Not covered when purchased through a pharmacy or mail order program		No coverage for <a href="#">prescription drugs</a> purchased through a pharmacy or mail order program under the <a href="#">plan's</a> medical coverage.
	Preferred brand drugs	Not covered when purchased through a pharmacy or mail order program		
	Non-preferred brand drugs	Not covered when purchased through a pharmacy or mail order program		
	<a href="#">Specialty drugs</a>	Not covered when purchased through a pharmacy or mail order program		
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	No charge	15% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply	None
	Physician/surgeon fees	No charge	15% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply	None
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$100 <a href="#">copay/visit</a> ; <a href="#">deductible</a> does not apply	\$100 <a href="#">copay/visit</a> ; <a href="#">deductible</a> does not apply	<a href="#">Copayment</a> may be waived if admitted inpatient or for an accidental injury.
	<a href="#">Emergency medical transportation</a>	10% <a href="#">coinsurance</a> ; Master Medical Coverage <a href="#">deductible</a> applies	10% <a href="#">coinsurance</a> ; Master Medical Coverage <a href="#">deductible</a> applies	Air ambulance transport is covered only when the patient is taken to the nearest facility that can treat him or her and no other method of <a href="#">emergency medical transportation</a> is appropriate.
	<a href="#">Urgent care</a>	\$20 <a href="#">copay/visit</a> ; <a href="#">deductible</a> does not apply	\$20 <a href="#">copay/visit</a> and 15% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply	<a href="#">Out-of-network copayment</a> costs do not track towards the <a href="#">plan's out-of-pocket limit</a> .
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	No charge	15% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply	Certification (sometimes called <a href="#">preauthorization</a> ) is recommended.
	Physician/surgeon fees	No charge	15% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply	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)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	No charge for telemedicine e-visit or for autism services (including ABA therapy); otherwise \$20 <u>copay</u> /office visit and no charge for other outpatient services; <u>deductible</u> does not apply	No charge for ABA therapy; otherwise 15% <u>coinsurance</u> (\$20 <u>copay</u> /office visit may also apply); <u>deductible</u> does not apply	<u>Out-of-network copayment</u> costs do not track towards the <u>plan's out-of-pocket limit</u> . Coverage for Applied Behavior Analysis (ABA) therapy is limited to \$50,000 annually (outpatient and inpatient services combined). For inpatient services only, certification (sometimes called <u>preauthorization</u> ) is recommended.
	Inpatient services	No charge	No charge for ABA therapy; otherwise 15% <u>coinsurance</u> ; <u>deductible</u> does not apply	
<b>If you are pregnant</b>	Office visits	No charge	15% <u>coinsurance</u> ; <u>deductible</u> does not apply	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> or <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	15% <u>coinsurance</u> ; <u>deductible</u> does not apply	
	Childbirth/delivery facility services	No charge	15% <u>coinsurance</u> ; <u>deductible</u> does not apply	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	No charge	15% <u>coinsurance</u> ; <u>deductible</u> does not apply	Certification (sometimes called <u>preauthorization</u> ) is recommended. Certification (sometimes called <u>preauthorization</u> ) is recommended.
	<u>Rehabilitation services</u>	No charge	15% <u>coinsurance</u> ; <u>deductible</u> does not apply	
	<u>Habilitation services</u>	No charge with an eligible diagnosis (e.g., autism spectrum disorder); otherwise not covered	No charge for ABA therapy or 15% <u>coinsurance</u> with an eligible diagnosis (e.g., autism spectrum disorder); otherwise not covered	For inpatient services only, certification (sometimes called <u>preauthorization</u> ) is recommended. Coverage for Applied Behavior Analysis (ABA) therapy is limited to \$50,000 annually (outpatient and inpatient services combined).
	<u>Skilled nursing care</u>	<i>Private-Duty Nursing</i> : 10% <u>coinsurance</u> (Master Medical Coverage <u>deductible</u> applies); <i>Other</i> : No charge	<i>Private-Duty Nursing</i> : 25% <u>coinsurance</u> (Master Medical Coverage <u>deductible</u> applies); <i>Other</i> : 15% <u>coinsurance</u> ( <u>deductible</u> does not apply)	Certification (sometimes called <u>preauthorization</u> ) is required for infusion or injection of select products.

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)	
<b>If you need help recovering or have other special health needs, cont.</b>	<u>Durable medical equipment</u>	<i>Diabetic Supplies: 10% coinsurance (deductible does not apply);</i> <i>Other: 10% coinsurance (Master Medical Coverage deductible applies)</i>	<i>Diabetic Supplies: 25% coinsurance (deductible does not apply);</i> <i>Other: 25% coinsurance (Master Medical Coverage deductible applies)</i>	Certification (sometimes called <u>preauthorization</u> ) is recommended for the rental and purchased of certain <u>durable medical equipment</u> . Vehicle and home modifications are excluded. Breastfeeding equipment is covered under the <u>plan</u> as <u>preventive care</u> .
	<u>Hospice services</u>	No charge	15% <u>coinsurance</u> ; <u>deductible</u> does not apply	None
<b>If your child needs dental or eye care</b> More information about eye care coverage is available at <a href="http://www.bcbsm.com">www.bcbsm.com</a> . More information about dental care coverage is available at <a href="http://www.deltadentalmi.com">www.deltadentalmi.com</a> . Also refer to the Medical Option Comparison chart in your <i>Natural Select</i> workbook.	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 <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Cosmetic surgery</li> <li>Dental care (except to the extent required to be covered by Health Care Reform)</li> <li>Glasses</li> <li>Hearing aids</li> </ul>	<ul style="list-style-type: none"> <li>Infertility treatment (except the treatment of the underlying cause of infertility may be covered)</li> <li>Long-term care</li> <li>Non-emergency care when traveling outside the U.S. (except certain care may be covered in specific situations as detailed in the <u>plan</u> document)</li> </ul>	<ul style="list-style-type: none"> <li><u>Prescription drugs</u> purchased through a pharmacy or mail order program</li> <li>Routine eye care (except to the extent required to be covered by Health Care Reform)</li> <li>Routine foot care</li> <li>Weight loss programs</li> </ul>

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

- Bariatric surgery
- Chiropractic care up to 38 visits allowed annually
- 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 on how 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**

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:**

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

*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>	\$0
■ <u>Specialist</u> coinsurance	0%
■ Hospital (facility) <u>coinsurance</u>	0%
■ Other <u>coinsurance</u>	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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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#### In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$ 70</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>	\$0
■ <u>Specialist</u> copayment	\$20
■ Hospital (facility) <u>coinsurance</u>	0%
■ Other <u>coinsurance</u>	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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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#### In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$400
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$ 620</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$200
■ <u>Specialist</u> copayment	\$100
■ Hospital (facility) <u>coinsurance</u>	0%
■ Other <u>coinsurance</u>	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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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#### In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$200
<u>Copayments</u>	\$100
<u>Coinsurance</u>	\$60
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$ 360</b>