




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. 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 or call 616-957-1751 or 1-800-968-2449 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u>?	\$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> .
Are there services covered before you meet your <u>deductible</u>?	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> , <u>hospitalization</u> , and <u>prescription drug coverage</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 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>?	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 \$1,425/individual and \$10,250/family. These figures include the medical <u>deductible</u> (if applicable), the <u>coinsurance out-of-pocket limits</u> shown above, as well as in- <u>network</u> medical <u>copayments</u> . The <u>out-of-pocket limits</u> for prescription costs are \$3,775/individual and \$5,550/family.	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.

Important Questions	Answers	Why this Matters:
What is not included in the <u>out-of-pocket limit</u>?	<u>Deductible</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> . Amounts attributed to the above total <u>out-of-pocket limits</u> for medical services are not included in the <u>out-of-pocket limits</u> for prescription costs. In general, <u>out-of-pocket limits</u> do not include <u>out-of-network</u> medical <u>copayments</u> ; 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; amounts paid by manufacturers on your behalf (along with other payments from manufacturers), 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 <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.
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 health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	No charge for telemedicine e-visit, otherwise \$20 <u>copay</u> / visit (<u>deductible</u> does not apply)	\$20 <u>copay</u> /visit 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</u> /visit (or <u>copay</u> /day for most chiropractic care); <u>deductible</u> does not apply	\$20 <u>copay</u> /visit (or <u>copay</u> /day 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. No coverage for the infusion or injection of select products if <u>provider/site</u> of service is not approved.

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 <u>provider's</u> office or clinic, cont.	<u>Preventive care/screening/immunization</u>	No charge	Not covered for most <u>preventive care</u> services; otherwise, depending on service type, either no charge or 15% <u>coinsurance</u> applies (<u>deductible</u> 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)	No charge	15% <u>coinsurance</u> ; <u>deductible</u> does not apply	None
If you have a test	Imaging (CT/PET scans, MRIs)	No charge	15% <u>coinsurance</u> ; <u>deductible</u> 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)	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.navitus.com . Also refer to www.oakgov.com/benefits .	Rx <u>formulary</u> tier 1 (generally most generic drugs and may include some low-cost brand drugs)	\$5 <u>copay</u> /prescription (retail or mail order)		Covers up to a 90-day supply (retail) or up to a 90-day supply (mail order). Specific criteria may have to be met in order for some high-cost medications to be covered. When you need to fill certain <u>specialty drugs</u> that are dispensed through the specialty pharmacy, Lumicera will contact you to enroll in the Copay Max Program. Under this program, your <u>specialty drugs</u> are subject to a coinsurance of 40% (retail or mail order). Your total payment for a <u>specialty drugs</u> will be capped at \$0. You will be required to remain enrolled in Navitus' program for obtaining manufacturer assistance, including <u>copay</u> assistance. Amounts paid by manufacturers on your behalf (along with other payments from manufacturers, such as manufacturer coupons) will not count toward your annual <u>out-of-pocket limits</u> or <u>deductible</u> . Instead, only those payments made directly by you will count toward your <u>out-of-pocket limits</u> or <u>deductible</u> . Your <u>copay</u> will default to the formulary's current tiered <u>coinsurance/copay</u> if a <u>specialty drug</u> does not qualify or is removed from the program.
	Rx <u>formulary</u> tier 2 (preferred brand drugs and may include some high-cost generic drugs)	\$20 <u>copay</u> /prescription (retail or mail order)		
	Rx <u>formulary</u> tier 3 (generally all non-preferred drugs [brand and generic])	\$40 <u>copay</u> /prescription (retail or mail order)		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	15% <u>coinsurance</u> ; <u>deductible</u> does not apply	Certification (sometimes called <u>preauthorization</u>) is recommended for select procedures.
	Physician/surgeon fees	No charge	15% <u>coinsurance</u> ; <u>deductible</u> does not apply	

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 immediate medical attention	<u>Emergency room care</u>	\$100 <u>copay</u> /visit; <u>deductible</u> does not apply	\$100 <u>copay</u> /visit; <u>deductible</u> does not apply	<u>Copayment</u> may be waived if admitted inpatient or for an accidental injury.
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u> ; Master Medical Coverage <u>deductible</u> applies	10% <u>coinsurance</u> ; Master Medical Coverage <u>deductible</u> applies	<u>Emergency medical transportation</u> is limited to the rate for ground transport (or air transport if determined to be appropriate) to the nearest facility that can provide sufficient treatment.
	<u>Urgent care</u>	\$20 <u>copay</u> /visit; <u>deductible</u> does not apply	\$20 <u>copay</u> /visit 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> .
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	15% <u>coinsurance</u> ; <u>deductible</u> does not apply	Certification (sometimes called <u>preauthorization</u>) is recommended.
	Physician/surgeon fees	No charge	15% <u>coinsurance</u> ; <u>deductible</u> does not apply	
If you need mental health, behavioral health, or substance abuse services	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> . 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	
If you are pregnant	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	
If you need help recovering or have other special health needs	<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.

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>Rehabilitation services</u>	No charge	15% <u>coinsurance</u> ; <u>deductible</u> does not apply	None
	<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.
	<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. No coverage for the infusion or injection of select products if <u>provider</u> /site of service is not approved.
	<u>Durable medical equipment</u>	<i>Diabetic Supplies</i> : 10% <u>coinsurance</u> (<u>deductible</u> does not apply); <i>Other</i> : 10% <u>coinsurance</u> (Master Medical Coverage <u>deductible</u> applies)	<i>Diabetic Supplies</i> : 25% <u>coinsurance</u> (<u>deductible</u> does not apply); <i>Other</i> : 25% <u>coinsurance</u> (Master Medical Coverage <u>deductible</u> applies)	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
If your child needs dental or eye care More information about eye care coverage is available at www.e-nva.com . More information about dental care coverage is available at www.deltadentalmi.com . Also refer to www.oakgov.com/benefits .	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.)

- Acupuncture
- Cosmetic surgery
- Dental care (except to the extent required to be covered by Health Care Reform)
- Glasses
- Hearing aids
- Infertility treatment (except the treatment of the underlying cause of infertility may be covered)
- Long-term care
- Non-emergency care when traveling outside the U.S. (except certain care may be covered in specific situations as detailed in the plan document)
- Routine eye care (except to the extent required to be covered by Health Care Reform)
- Routine foot care
- Weight loss programs (except to the extent required to be covered by Health Care Reform)

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. 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 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. Additionally, a Consumer Assistance Program may be able to help you file your appeal. Visit 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> <u>coinsurance</u>	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*)

Total Example Cost	\$12,700
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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
The total Peg would pay is	\$ 70

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> <u>copayment</u>	\$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*)

Total Example Cost	\$5,600
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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
The total Joe would pay is	\$ 620

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> <u>copayment</u>	\$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*)

Total Example Cost	\$2,800
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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
The total Mia would pay is	\$ 360