This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.asrhealthbenefits.com** or **www.physicianscare.com** or by calling **616-957-1751** or **1-800-968-2449**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$400** per covered person and **$800** per family for services rendered by in-network providers, and **$3,000** per covered person and **$6,000** per family for services rendered by out-of-network providers. The overall **deductible** does not apply to most in-network physician exam fees, in-network routine preventive care services, chiropractic care, in-network hearing exams, or prescription drugs. **Copayments, coinsurance,** penalties, charges that exceed the plan's usual and customary fee allowance or are in excess of stated maximums, premiums, balance-billed charges (unless balance billing is prohibited), and health care this plan doesn't cover don't count toward the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. This plan's **deductible** starts over on July 1st. See the chart starting on page 3 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 3 for other costs for services that this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$3,250** per covered person and **$6,500** per family for services rendered by in-network providers, and **$8,000** per covered person and **$16,000** per family for services rendered by out-of-network providers.	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.
What is not included in the out–of–pocket limit?	**Copayments**, penalties, charges that exceed the plan's usual and customary fee allowance or are in excess of stated maximums, premiums, balance-billed charges (unless balance billing is prohibited), 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 an overall annual limit on what the plan pays?	Yes, **$2,000,000** per covered person.	This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above this limit. The chart starting on page 3 describes specific coverage limits.

Questions: Call **616-957-1751 or 1-800-968-2449** or visit **www.asrhealthbenefits.com** or **www.physicianscare.com**.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at the websites above or by calling the phone numbers above to request a copy.

Important Questions	Answers	Why this Matters:
Does this plan use a network of providers?	Yes. For more information, visit one of the websites or call one of the phone numbers shown at the bottom of page 1.	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 for different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts you pay for covered health care, usually when you receive the service.
- **Coinsurance** 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 **coinsurance** 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 in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit	40% coinsurance	--none--
	Specialist visit	$20 copay/visit	40% coinsurance	--none--
	Other practitioner office visit	$20 copay/visit for chiropractic services and hearing exams, 50% coinsurance for massage therapy services, 40% coinsurance for infertility treatment, and 10% coinsurance for hearing tests and other services	$20 copay/visit for chiropractic services and 50% coinsurance for massage therapy; otherwise 40% coinsurance. Infertility treatment, hearing exams, and hearting tests are not covered.	Covers up to $500 annually for all chiropractic and massage therapy services combined).
	Preventive care/screening/ immunization	No charge	Not covered	--none--
If you have a test	Diagnostic test (x-ray, blood work)	No charge after deductible	40% coinsurance	--none--
	Imaging (CT/PET scans, MRIs)	No charge after deductible	40% coinsurance	--none--
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.asrhealthbenefits.com** or **www.physicianscare.com**.	Eligible over-the-counter drug	$-0- copay/prescription (retail or mail order)		Covers up to a 30-day supply (retail) or up to a 90-day supply (mail order). A greater day supply of a maintenance medication may be purchased at a retail pharmacy for an increased copay. Covers only one 60-day supply of infertility medications.
	Generic or brand drugs	25% of the purchase price ($-0- minimum or $60 maximum) copay/prescription (retail) or 25% of the purchase price ($-0- minimum or $120 maximum) copay/prescription (mail order)		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	*Surgeries performed in a physician's office:* 10% coinsurance *Surgeries performed elsewhere:* $250 copay/surgery, then 10% coinsurance	*Surgeries performed in a physician's office:* 40% coinsurance *Surgeries performed elsewhere:* $500 copay/ surgery, then 40% coinsurance	Copay may be waived if covered person receives treatment at Spectrum Health or Lakeland Regional Health System.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you have outpatient surgery, cont.	Physician/surgeon fees	10% coinsurance	40% coinsurance	--none--
If you need immediate medical attention	Emergency room services	$100 copay/visit and 10% coinsurance	$100 copay/visit and 10% coinsurance if treated at an in-network hospital and for certain services rendered at an out-of-network hospital; otherwise 40% coinsurance	Copay may be waived if admitted inpatient.
	Emergency medical transportation	10% coinsurance	10% coinsurance if delivered to an in-network facility; otherwise 40% coinsurance	--none--
	Urgent care	$20 copay/visit	40% coinsurance	--none--
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copay/admission, then 10% coinsurance	$500 copay/ admission, then 40% coinsurance	$250 penalty if not certified. Copay may be waived if covered person receives treatment at Spectrum Health or Lakeland Regional Health System.
	Physician/surgeon fee	10% coinsurance	40% coinsurance	--none--
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 copay/office visit and 10% coinsurance for other services	40% coinsurance	--none--
	Mental/Behavioral health inpatient services	10% coinsurance	40% coinsurance	$250 penalty if not certified.
	Substance use disorder outpatient services	$20 copay/office visit and 10% coinsurance for other services	40% coinsurance	--none--
	Substance use disorder inpatient services	10% coinsurance	40% coinsurance	$250 penalty if not certified.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	10% coinsurance	40% coinsurance	No coverage for dependent child maternity except as may be required by Health Care Reform.
	Delivery and all inpatient services	$250 copay/admission, then 10% coinsurance	$500 copay/ admission, then 40% coinsurance	$250 penalty if not certified. Copay may be waived if covered person receives treatment at Spectrum Health or Lakeland Regional Health System. Separate copays will not be charged to both the mother and newborn.
If you need help recovering or have other special health needs	Home health care	10% coinsurance	40% coinsurance	$250 penalty if not certified.
	Rehabilitation services	10% coinsurance	40% coinsurance	$250 penalty if not certified.
	Habilitation services	10% coinsurance	40% coinsurance	$250 penalty if not certified.
	Skilled nursing care	10% coinsurance	40% coinsurance	--none--
	Durable medical equipment	25% coinsurance for hearing aids; otherwise 10% coinsurance	40% coinsurance. Hearing aids are not covered.	$250 penalty if not certified.
	Hospice service	10% coinsurance	40% coinsurance	--none--
If your child needs dental or eye care	Eye exam	Not covered (except to the extent required by law)	Not covered	No coverage for routine eye care under the medical plan, except as required by Health Care Reform.
	Glasses	Not covered	Not covered	No coverage for glasses under the medical plan.
	Dental check-up	Not covered (except to the extent required by law)	Not covered	No coverage for routine dental care under the medical plan, except as required by Health Care Reform.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Acupuncture • Bariatric surgery • Cosmetic surgery • Dental care (except to the extent required to be covered by Health Care Reform)	• Glasses • Most dependent child maternity 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 (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Chiropractic care up to $500 paid annually for chiropractic care and massage therapy services combined • Hearing aids	• Infertility treatment up to $3,000 paid in a lifetime plus one 60-day supply of infertility medications • Long-term care	• Private-duty nursing

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at 616-957-1751 or 1-800-968-2449. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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 ASR Health Benefits at 616-957-1751 or 1-800-968-2449 or visit them at www.asrhealthbenefits.com or www.physicianscare.com. Additionally, a Consumer Assistance Program may be able to help you file your appeal. Visit http://www.healthcare.gov/law/features/rights/consumer-assistance-program/index.html to see if your state has a Consumer Assistance Program that may be able to help you file your appeal.

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 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:** $7,540
- **Plan pays** $6,140
- **Patient pays** $1,400

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$400
Copays	$260
Coinsurance	$590
Limits or exclusions	$150
Total	**$1,400**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,010
- **Patient pays** $1,390

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$400
Copays	$790
Coinsurance	$120
Limits or exclusions	$80
Total	**$1,390**

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**, **copayments**, and **coinsurance** 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 **copayments**, **deductibles**, and **coinsurance**. 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.

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