




**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>	\$650/individual or \$1,300/family for services rendered by in- <u>network providers</u> , and \$3,000/individual or \$6,000/family for services rendered by <u>out-of-network providers</u> .	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. In- <u>network preventive care</u> , most in- <u>network</u> physician exam charges (primary care, <u>urgent care</u> , <u>specialist</u> visits, telemedicine e-visits), a hospital's fee for the use of an emergency room, chiropractic care, In- <u>network</u> hearing exams, 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 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> .
<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 limits</u> for medical <u>coinsurance</u> are \$3,700/individual and \$7,400/family for services rendered by in- <u>network providers</u> , and \$5,000/individual and \$10,000/family for services rendered by <u>out-of-network providers</u> . The total <u>out-of-pocket limits</u> for medical services are \$5,350/individual and \$10,700/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 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.

Important Questions	Answers	Why this Matters:
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?, cont.</b>	The <u>out-of-pocket</u> limits for prescription costs are \$1,800/individual and \$3,600/family.	
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<u>Deductibles</u> and <u>copayments</u> on certain services are not included in the above <u>out-of-pocket limits</u> applicable to medical <u>coinsurance</u> . Services rendered by out-of- <u>network providers</u> are not included in the above total <u>out-of-pocket limits</u> for medical services. 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 penalties; charges that exceed the <u>plan's usual, customary, and reasonable fee</u> 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 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.
<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> .

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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-visits, otherwise \$30 <u>copay</u> /office visit ( <u>deductible</u> does not apply)	40% <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.	Specialist visit	50% coinsurance for massage therapy, 40% coinsurance for infertility treatment; otherwise \$30 copay/visit; deductible applies for massage therapy and infertility treatment, but deductible does not apply for other services	50% coinsurance for massage therapy; otherwise 40% coinsurance  Infertility treatment is not covered	Certification (sometimes called preauthorization) is required for infusion or injection of select products. \$250 penalty applies if not certified. No coverage for the infusion or injection of select products if provider/site of service is not approved.
	Preventive care/screening/immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance; hearing testing is not covered	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.navitus.com	Eligible OTC drug	\$0 copay/prescription (retail or mail order); deductible does not apply		Covers up to a 30-day supply (retail and specialty pharmacy) 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.  No charge for syringes dispensed at the same time as insulin; deductible does not apply.  Coverage for medications filled at the retail/pharmacy level will be limited to purchases made at eligible retail network pharmacies. Specialty drugs can be filled through the specialty pharmacy only.
	Formulary preferred generic drugs	\$10 copay/prescription (retail) or \$25 copay/prescription (mail order); deductible does not apply		
	Formulary non-preferred generic drugs	\$20 copay/prescription (retail) or \$50 copay/prescription (mail order); deductible does not apply		
	Formulary preferred brand drugs	\$60 copay/prescription (retail) or \$150 copay/prescription (mail order); deductible does not apply		
	Formulary non-preferred brand drugs	\$80 copay/prescription (retail) or \$200 copay/prescription (mail order); deductible does not apply		
	Specialty drugs (generic)	\$400 copay/prescription (specialty pharmacy); deductible 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 drugs to treat your illness or condition, cont.	<u>Specialty drugs</u> (preferred)	\$1,000 <u>copay</u> /prescription (specialty pharmacy); <u>deductible</u> does not apply		Covers up to a 30-day supply (specialty pharmacy).
	<u>Specialty drugs</u> (non-preferred)	\$1,500 <u>copay</u> /prescription (specialty pharmacy); <u>deductible</u> does not apply		<u>Specialty drugs</u> can be filled through the specialty pharmacy only.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need immediate medical attention	<u>Emergency room care</u>	\$250 <u>copay</u> /visit and 20% <u>coinsurance</u>	\$250 <u>copay</u> /visit and 20% <u>coinsurance</u>	<u>Copay</u> may be waived if admitted inpatient.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	
	<u>Urgent care</u>	\$75 <u>copay</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Certification (sometimes called <u>preauthorization</u> ) is required. \$250 penalty applies if not certified.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge for telemedicine e-visits or \$30 <u>copay</u> /office visit ( <u>deductible</u> does not apply) and 20% <u>coinsurance</u> for other outpatient services	40% <u>coinsurance</u>	None
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Certification (sometimes called <u>preauthorization</u> ) is required. \$250 penalty applies if not certified.
If you are pregnant	Office visits	20% <u>coinsurance</u>	40% <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
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	

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 are pregnant, cont.</b>	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	as may be required by Health Care Reform.
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Certification (sometimes called <u>preauthorization</u> ) is required. \$250 penalty applies if not certified.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	<u>Habilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Certification (sometimes called <u>preauthorization</u> ) is required for infusion or injection of select products. \$250 penalty applies if not certified. No coverage for the infusion or injection of select products if provider/site of service is not approved.
	<u>Durable medical equipment</u>	25% <u>coinsurance</u> for hearing aids; otherwise 20% <u>coinsurance</u>	25% <u>coinsurance</u> for hearing aids; otherwise 40% <u>coinsurance</u>	Certification (sometimes called <u>preauthorization</u> ) is required if the item costs \$2,500 or more. \$250 penalty applies if not certified.
	<u>Hospice services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
<b>If your child needs dental or eye care</b>	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
- Bariatric surgery
- 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.)

- Chiropractic care up to \$500 paid annually for chiropractic care and massage therapy combined
- Hearing aids, up to \$2,500 paid in any two-benefit-year period
- Infertility treatment up to \$3,000 paid in a lifetime plus one 60-day lifetime supply of infertility medications
- Private-duty nursing

**Your Rights to Continue Coverage:** If you want to continue your coverage after it ends and need help, contact Andrews University. 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.

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



## 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>	\$650
■ <u>Specialist copayment</u>	\$30
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

#### 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:

Cost Sharing	
Deductibles	\$650
Copayments	\$40
Coinsurance	\$2,500
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,250</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>	\$650
■ <u>Specialist copayment</u>	\$30
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

#### 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:

Cost Sharing	
Deductibles	\$650
Copayments	\$1,500
Coinsurance	\$200
What isn't covered	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$2,410</b>

### Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$650
■ <u>Specialist coinsurance</u>	20%
■ Hospital (facility) <u>copayment</u>	\$250
■ Other <u>coinsurance</u>	20%

#### 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:

Cost Sharing	
Deductibles	\$650
Copayments	\$300
Coinsurance	\$300
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,250</b>

Note: These numbers assume the patient has obtained all prescription drugs from an eligible retail network pharmacy. If you purchase prescription drugs from an ineligible retail pharmacy, your costs will be higher.