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 deductible?	$650/individual or $1,300/family for services rendered by in-network providers, and $3,000/individual or $6,000/family for services rendered by out-of-network providers.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-network preventive care, most in-network physician exam charges (primary care, urgent care, specialist visits, telemedicine e-visits), a hospital's fee for the use of an emergency room, chiropractic care, In-network hearing exams, and prescription drug coverage are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/ coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	The out-of-pocket limits for medical coinsurance are $3,700/individual and $7,400/family for services rendered by in-network providers, and $5,000/individual and $10,000/family for services rendered by out-of-network providers. The total out-of-pocket limits for medical services are $5,350/individual and $10,700/family, and they apply to services rendered by in-network providers only. These figures include the deductibles and the coinsurance out-of-pocket limits shown above as well as in-network medical copayments.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.

Important Questions	Answers	Why this Matters:
What is the out-of-pocket limit for this plan?, cont.	The out-of-pocket limits for prescription costs are $1,800/individual and $3,600/family.	
What is not included in the out-of-pocket limit?	Deductibles and copayments on certain services are not included in the above out–of–pocket limits applicable to medical coinsurance. Services rendered by out-of-network providers are not included in the above total out–of–pocket limits for medical services. Amounts attributed to the above total out–of–pocket limits for medical services are not included in the out-of-pocket limits for prescription costs. In general, out–of–pocket limits do not include penalties; charges that exceed the plan's usual, customary, and reasonable fee allowance or are in excess of stated maximums; premiums; balance-billing charges; and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.asrhealthbenefits.com or call 616-957-1751 or 1-800-968-2449 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

- 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 provider's office or clinic	Primary care visit to treat an injury or illness	No charge for telemedicine e-visits, otherwise $30 copay/office visit (deductible does not apply)	40% coinsurance	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 to massage therapy & infertility treatment, but not to 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) 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 and special rules may apply in order for specialty drugs to be covered.
	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		

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	$250 copay/visit and 20% coinsurance	$250 copay/visit and 20% coinsurance	Copay may be waived if admitted inpatient.
	Emergency medical transportation	20% coinsurance	20% coinsurance	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 emergency medical transportation is appropriate.
	Urgent care	$75 copay/visit; deductible does not apply	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Certification (sometimes called preauthorization) is required. $250 penalty applies if not certified.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge for telemedicine e-visits or $30 copay/office visit (deductible does not apply) and 20% coinsurance for other outpatient services	40% coinsurance	None
	Inpatient services	20% coinsurance	40% coinsurance	Certification (sometimes called preauthorization) is required. $250 penalty applies if not certified.

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 are pregnant	Office visits	20% coinsurance	40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or a deductible 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	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Certification (sometimes called preauthorization) is required. $250 penalty applies if not certified.
	Rehabilitation services	20% coinsurance	40% coinsurance	
	Habilitation services	Not covered	Not covered	Habilitation services are excluded.
	Skilled nursing care	20% coinsurance	40% coinsurance	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.
	Durable medical equipment	25% coinsurance for hearing aids; otherwise 20% coinsurance	25% coinsurance for hearing aids; otherwise 40% coinsurance	Certification (sometimes called preauthorization) is required if the item costs $2,500 or more. $250 penalty applies if not certified.
	Hospice services	20% coinsurance	40% coinsurance	None
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 plan, except as required by Health Care Reform.
	Children's glasses	Not covered	Not covered	No coverage for glasses under the medical plan.

Common Medical Event	Services You May Need	What You Will Pay: In-Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If your child needs dental or eye care, cont.	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 plan, 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
- Habilitation services
- 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 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. 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.

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 plan's overall deductible** **$650**
- **Specialist copayment** **$30**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **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)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$650
Copayments	$40
Coinsurance	$2,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,250**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$650**
- **Specialist copayment** **$30**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **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)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

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

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$650**
- **Specialist coinsurance** **20%**
- **Hospital (facility) copayment** **$250**
- **Other coinsurance** **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)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

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

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.

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