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

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | $3,500/individual or $7,000/family for services rendered by in-network providers, and $7,000/individual or $14,000/family for services rendered by out-of-network providers. Amounts applied toward the deductible for in-network services will also accrue toward the deductible for out-of-network services, and vice versa. | 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, the overall family deductible must be met before the plan begins to pay. |
| **Are there services covered before you meet your deductible?** | Yes. In-network preventive care, routine immunizations administered in a pharmacy or at the Department of Community Health, and certain preventive 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?** | $6,000/individual and $12,000/family for services rendered by in-network providers, and $12,000/individual and $24,000/family for services rendered by out-of-network providers. Amounts applied toward the out-of-pocket limit for in-network services will also accrue toward the out-of-pocket limit for out-of-network services, and vice versa. | 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, the overall family out-of-pocket limit must be met. |
| **What is not included in the out-of-pocket limit?** | 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. |

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **Will you pay less if you use a network provider?** | Yes. See www.asrhealthbenefits.com or call 1-616-957-1751 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 after deductible for telemedicine e-visits; otherwise 20% coinsurance | 40% coinsurance | None |
| | Specialist visit | 20% coinsurance | 40% coinsurance | Certification (sometimes called preauthorization) is required for infusion or injection of select products. |
| | Preventive care/screening/ immunization | No charge | No charge for routine immunizations administered in a pharmacy or at the Department of Community Health; otherwise 40% coinsurance | You may have to pay for services that aren't preventive. Ask your provider if the services needed 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 | None |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 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 need drugs to treat your illness or condition** More information about prescription drug coverage is available at www.transparentrx.com | Generic drugs, preferred brand drugs, non-preferred brand drugs, specialty drugs, and eligible OTC drugs | 20% coinsurance; deductible does not apply to certain preventive drugs | | Covers up to a 90-day supply (retail or mail order).<br>Non-formulary drugs are generally excluded.<br>Specific criteria may have to be met in order for some brand-name medications to be covered.<br>Special rules may apply in order for specialty drugs to be covered. Such drugs are limited to a 30-day supply and specialty drugs must generally be purchased through the designated specialty pharmacy or from the manufacturer. |
| **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 | 20% coinsurance | 20% coinsurance after in-network deductible | None |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance after in-network deductible | Emergency medical transportation 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. |
| | Urgent care | 20% coinsurance | 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. |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | No charge after deductible for telemedicine e-visits; otherwise 20% coinsurance | 40% coinsurance | No coverage for autism spectrum disorder services. |
| | Inpatient services | 20% coinsurance | 40% coinsurance | Certification (sometimes called preauthorization) is required. No coverage for autism spectrum disorder services. |

| 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 in-network 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). |
| | 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. |
| | Rehabilitation services | 20% coinsurance | 40% coinsurance | 60 outpatient visits/year for all physical, speech, and occupational therapies combined. |
| | 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. |
| | Durable medical equipment | 20% coinsurance | 40% coinsurance | Certification (sometimes called preauthorization) is required if the item costs $2,500 or more. Vehicle and home modifications are excluded. |
| | 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. |
| | 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
- Autism spectrum disorder services
- Cosmetic surgery
- Dental care (except to the extent required to be covered by Health Care Reform)
- Glasses
- Habilitation services
- Hearing aids
- Infertility treatment
- 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.)**

- Bariatric surgery, limited to one surgery per covered person in a lifetime
- Chiropractic care up to 24 chiropractic visits allowed annually
- Private-duty nursing

**Your Rights to Continue Coverage:** If you want to continue your coverage after it ends and need help, contact Albion College. 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 1-616-957-1751 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 1-616-957-1751 o 1-800-968-2449.

如果需要中文的幫助, 請撥打這個號碼 1-800-968-2449.

Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-968-2449.

Fer Hilf griege in Deitsch, ruf 1-800-968-2449 uff.

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 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 plan's overall deductible** | **$3,500** |
| **Specialist coinsurance** | **20%** |
| **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** | **$12,700** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $3,500 |
| Copayments | $0 |
| Coinsurance | $1,800 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$5,360** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$3,500** |
| **Specialist coinsurance** | **20%** |
| **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** | **$5,600** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $3,500 |
| Copayments | $400 |
| Coinsurance | $60 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$3,980** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$3,500** |
| **Specialist coinsurance** | **20%** |
| **Hospital (facility) coinsurance** | **20%** |
| **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** | **$2,800** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $2,800 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2,800** |

Note: These numbers assume the patient has not been reimbursed by the Health Savings Account. If you are eligible for reimbursement under the Health Savings Account, your costs may be lower.

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