

The Dako Group 2018 Benefits and Enrollment Guide

September 1, 2018 to August 31, 2019



Health | Dental | Vision | Life | Disability

Contact Information

Benefit Consultant



General Claims and Benefit Information

Customer Service Hotline: In order to help you with your benefit questions, claim issues, and general inquiries, you and your dependents may contact Sterling Insurance Group. Sterling Insurance Group is a one-source helpline for all of your benefit questions. Please call the toll-free number listed below and speak to a customer service specialist who knows your benefit plan and can help with any questions.

Toll Free: (844) 599-9500

www.sterlingagency.com

Healthcare	ASR Health Benefits	Group Number 1073	(800) 968-2449	www.asrhealthbenefits.com (PPO Networks Michigan) - HAP AHL PPO & Physicians Care (PPO Networks Nationwide) Cigna & MultiPlan
Prescription Drug	EHIM	Group Number 1073	(800) 311-3446	www.ehimrx.com
Mail Order	Walgreens	Group Number 1073	(800) 345-1985	www.walgreens.com/mailservice
Dental	Delta Dental		(800) 524-0149	www.deltadentalmi.com
Vision	VSP		(800) 877-7195	www.vsp.com
Supplemental Life and AD&D	MetLife	Group Number 5999447	(800) 858-6506	www.metlife.com
Voluntary Short Term Disability	MetLife	Group Number 5999447	(800) 858-6506	www.metlife.com
Long Term Disability	MetLife	Group Number 5999447	(800) 858-6506	www.metlife.com
Medical Pre-Certification Requirement	ASR Health Benefits	Group Number 1073	(800) 638-0573	www.asrhealthbenefits.com
Will Preparation Services	Hyatt Legal Plans, Inc.	Group Number 5999447	(800) 821-6400	
Estate Resolution Services	Hyatt Legal Plans, Inc.	Group Number 5999447	(800) 821-6400	
Travel Assistance	AXA Assistance USA, Inc.	Group Number 5999447		http://webcorp.axa-assistance.com

When contacting any of the companies above it is important to have the Insurance card or I.D. number (s) of the subscriber for the coverage you are calling about as well as any appropriate paperwork, i.e. Explanation of Benefits, denial letter, receipts, etc.

2018 Benefits Summary Guide Overview

The Dako Group offers eligible employees a variety of benefits that can provide you and your family with health care coverage and financial protection, tailored to best fit your needs. Our benefits program is an important part of your overall compensation and with the assistance of Sterling Insurance Group, we are regularly assessing the quality and cost of the benefits to ensure we offer the most competitive package possible. Changes and relevant new information are highlighted below, however, we encourage you to review this guide in its entirety.

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Open Enrollment: Enrollment is available in August for a September 1st effective date. This is the only opportunity you will have this year to make changes to your benefit elections. During this period you may add, drop, or modify coverage. You will be locked into the plan selections for one year unless there is a qualifying event (marriage, divorce, birth, adoption or change in custody of a child, death of a dependent, change in employment status). All changes must be made within 30 days of the event or you will need to wait until the next open enrollment period.

- **Healthcare: ASR Health Benefits**
- **Prescription Drugs: EHIM**
- **Mail Order Drugs: Walgreens**
- **Dental: Delta Dental**
- **Vision: VSP**
- **Supplemental Term Life/AD&D: MetLife**
- **Voluntary Short Term Disability: MetLife**
- **Voluntary Long Term Disability: MetLife**

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 20 for more details.

This booklet is intended for illustrative and information purposes only. The plan documents, insurance certificates and policies will serve as the governing documents. In the case of conflict between the information in this booklet and the official plan documents, the plan documents will always govern. The The Dako Group reserves the right to change or terminate at any time, in whole or in part, the employee benefit package, with respect to all or any class of employees, former employees and retirees.

Eligibility Overview

The Dako Group is pleased to offer its employees an excellent benefits program. These health and welfare benefits are designed to protect you and your family while you are an active employee.

- **Medical** - Coverage is offered to employees who work at least 30 hours per week. Coverage begins 1st of the month following 30 days from your date of full-time employment. You may cover your unmarried children up to age 26 regardless of student status. Coverage continues to the end of the year in which they turn 26.
- **Vision** - Coverage is offered to employees who work at least 30 hours per week. Coverage begins first of the month following 30 days from your date of full-time employment. You may cover your unmarried children to the end of the year in which they turn 26.
- **Dental** - Coverage is offered to employees who work at least 30 hours per week. Coverage begins first of the month following 30 days from your date of full-time employment. You may cover your unmarried children to the end of the year in which they turn 26.
- **Supplemental Term Life** - Coverage is offered to employees who work at least 30 hours per week. Coverage begins first of the month following 30 days from your date of full-time employment. If your employment ends from your Employer, you may elect portable coverage. You may cover your unmarried children up to age 19, and 24 if a full-time student.
- **Voluntary STD** - Coverage is offered to employees who work at least 30 hours per week. Coverage begins first of the month following 30 days from your date of full-time employment.
- **Voluntary LTD** - Coverage is offered to employees who work at least 30 hours per week. Coverage begins first of the month following 30 days from your date of full-time employment.
- It is your responsibility to provide Barbara Micakovic with proof of your dependents' eligibility, in the form of: (a) marriage license, (b) Court order specifying your responsibility to provide "group health care coverage" to your dependent children, (c) copy of birth certificate or (d) class schedule if dependent is between the ages of 19-26.

New employees have up to 30 days after their eligibility to enroll. If you do not enroll by that deadline, you will not be eligible for coverage until the following annual open enrollment period.



Annual Elections: It is important that you make your choices carefully, since changes to those elections can generally only be made during the annual open enrollment period. Exceptions will be made for changes in family status during the year, allowing you to make a mid-year benefit change. A family status change includes:

- Marriage
- Divorce
- Birth or adoption
- Death of a dependent
- Change in your spouse's employment or
- Loss of coverage by a spouse

If you have a family status change, you must change your benefit elections within 30 days of the qualifying event, or you will need to wait until the next annual open enrollment period.

COBRA Continuation Coverage: When you or any of your dependents no longer meet the eligibility requirements for health and welfare plans, you may be eligible for continued coverage as required by the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986.

The DAKO Group

Top 10 Need-to-Knows about your Benefit Plans

Employee benefits programs can be complicated. It is easy to overlook important details that can affect your future finances. In an effort to avoid surprises at claim time, we have compiled a list of the Top 10 Need-to-Know items regarding the benefits under The DAKO Group plans.

1. Initial Enrollment

All elections made upon first eligibility as a new hire will become effective on the **first of the month following 30 days** from the date of your full-time employment with DAKO Group. (Note - some amounts of voluntary life insurance may not become effective until approved by the insurance company. See #8 for more information.)

2. Open Enrollment

Open enrollment for DAKO's group medical, dental, and vision coverage occurs in August each year. All elections made during open enrollment go into effect **September 1st**.

3. Deductible and Coinsurance Annual Reset

The medical plan's deductible, coinsurance and out of pocket maximums reset every **September 1st (plan year)**.

The dental plan's deductible, coinsurance and benefit maximums reset every **January 1 (calendar year)** (except ortho for children).

4. Auto Insurance Coordination

The DAKO Group medical plan will pay **secondary** to auto insurance for claims related to an auto accident. Therefore, your auto insurance policy should include primary medical coverage. You should talk to your auto insurance agent about the need for an **'uncoordinated'** policy rider.

5. Motorcycle Insurance Coordination

In the event of claims resulting from a motorcycle accident that does not include an automobile, the DAKO Group medical plan will **exclude** coverage for the first \$50,000 in eligible charges or, if greater, the amount of medical benefits payable by the motorcycle insurance policy. You should talk to your motorcycle insurance agent about the need for an **'uncoordinated'** policy rider.

6. Disability Insurance and Taxation

The DAKO Group Short Term Disability and Long Term Disability insurances are 'voluntary.' This means employees who enroll will pay the entire cost of the premium via payroll deduction. This is a GOOD thing because, if you become disabled, the disability benefits you receive will **not be taxable**. (If DAKO paid the premium, your benefit would be taxed!)

7. Short Term Disability Insurance and Pre-existing Conditions (including pregnancy)

During the first 12 months of enrollment in the DAKO Group Short Term Disability insurance, there is **no coverage** for disabilities due to any condition, **including pregnancy**, for which you received medical treatment, consultation, care, services, or prescribed medications during the 3 months immediately prior to the effective date of your enrollment in the plan.

8. Voluntary Life Insurance and Evidence of Insurability

If you enroll when first eligible (as a new hire), Evidence of Insurability is only required for amounts of coverage requested **in excess of** \$100,000 (employee), or \$25,000 (spouse). After that, **ALL** requests for enrollment, or for increases in coverage amount, such as during an annual enrollment period, will require Evidence of Insurability and will be **subject to insurance company approval or denial**.

9. Voluntary Short Term Disability Insurance and Evidence of Insurability

Evidence of Insurability is not required, however, if you don't enroll when first eligible (as a new hire) your **coverage amount will be limited to** \$100 per week, and coverage increases will be limited to an additional \$50/wk each year.

10. Voluntary Long Term Disability Insurance and Evidence of Insurability

If you enroll when first eligible (as a new hire), Evidence of Insurability is not required. Enrolling later, such as during an annual enrollment period, will require Evidence of Insurability, and your request for coverage will be subject to **insurance company approval or denial**.

Healthcare Benefits Overview

Healthcare benefits are one of the most important and necessary parts of your benefit package. The following is a summary of your benefits offered through ASR Health Benefits. For a more detailed explanation of benefits, please refer to your certificate of coverage. The following networks are included: HAP/Alliance PPO and Physicians Care networks in Michigan, Cigna and Multiplan in all other states. Instructions to access a list of participating providers can be found on page 6 of this guide.

	Platinum PPO Plan		Gold PPO Plan		Silver PPO Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible (Plan Year)						
Individual / Family	\$750 / \$1,500	\$1,000 / \$2,000	\$1,000 / \$2,000	\$1,500 / \$3,000	\$2,500 / \$5,000	\$6,000 / \$12,000
Coinsurance	90%	70%	80%	60%	90%	60%
Annual Coinsurance Maximum (applies to coinsurance but does not apply towards deductible, flat dollar copays, or prescription drugs)						
Individual / Family	\$500 / \$1,000	\$2,500 / \$5,000	\$1,500 / \$3,000	\$3,500 / \$7,000	N/A	
Annual Out-of-Pocket Maximum (applies to deductible, copays, coinsurance and prescription drugs)						
Individual / Family	\$6,350 / \$12,700	\$12,700 / \$25,400	\$6,350 / \$12,700	\$12,700 / \$25,400	\$5,000 / \$10,000	\$15,000 / \$30,000
Office Visit	\$40 copay	70% after deductible	\$30 copay	60% after deductible	90% after deductible	60% after deductible
Online Visit <i>Answer Health On Demand</i>	\$20 copay	n/a	\$15 copay	n/a	90% after deductible	n/a
Specialist Visit	\$60 copay	70% after deductible	\$60 copay	60% after deductible	90% after deductible	60% after deductible
Emergency Room	\$200 copay, then deductible & coinsurance	\$200 copay, then deductible & coinsurance	\$200 copay, then deductible & coinsurance	\$200 copay, then deductible & coinsurance	90% after deductible	60% after deductible
Chiropractic (20 visits per calendar year)	\$40 copay and coinsurance	70% after deductible	\$30 copay and coinsurance	60% after deductible	90% after deductible	60% after deductible
Urgent Care	\$75 copay	70% after deductible	\$75 copay	60% after deductible	90% after deductible	60% after deductible
Prescription Drugs - 30 day supply	\$10 / \$30 / \$50	No Coverage	\$10 / \$30 / \$60	No Coverage	\$10 / \$35 / \$50 after deductible	No Coverage
Mail Order Prescription Drugs - 90 day supply	\$20 / \$60 / \$100	No Coverage	\$20 / \$60 / \$120	No Coverage	\$20 / \$70 / \$100 after deductible	No Coverage

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Provider Search Instructions

IMPORTANT: If you are a Michigan resident, please begin your search with Physicians Care & HAP and continue with Cigna/MultiPlan if the provider does not participate with Physicians Care & HAP. If you are a non-Michigan resident, please begin your search with Cigna/MultiPlan.

Physicians Care & HAP (Michigan)

- Step 1: Visit www.asrhealthbenefits.com
- Step 2: See Exhibit A
- Step 3: Click **Physicians Care & HAP Network**
- Step 4: Enter search criteria

Cigna & MultiPlan (Nationwide)

- Step 1: Visit www.asrhealthbenefits.com
- Step 2: See Exhibit A
- Step 3: Click **Cigna Network and/or MultiPlan Network**
- Step 4: Enter search criteria



Exhibit A

If you are unable to locate your physician on our website, please contact ASR at (888)-262-6401.

Pre-Certification Requirements

You are required to obtain a Pre-Certification prior to any hospital admission or certain outpatient procedures, or within 48 hours after obtaining services listed below by calling (800) 638-0573. Services requiring pre-certification include the following:

1. Inpatient Hospital Confinements
2. Home and Outpatient Rehabilitative Therapy
3. Rental and Purchase of Durable Medical Equipment
4. Home Health Care
5. Purchase of Custom-Made Orthotic or Prosthetic Appliances
6. Oncology Treatment

Auto Insurance Coordination

IMPORTANT! - The Dako Group medical plan is self-funded and will pay secondary to auto insurance for claims related to an auto accident. Additionally, if a covered person is injured in a motorcycle accident that does not involve a motor vehicle, this plan will exclude coverage for the first \$50,000 in eligible charges or, if greater, the amount of health benefits payable by the motorcycle insurance policy. *Be sure to address this with your auto insurance agent as it may affect the riders required for your auto policy.*

Answer Health On Demand (telemedicine/e-visits)



Attention ASR-enrolled members:

See a doctor online anytime!

Enroll now with Answer Health on Demand!

ASR enrolled members, download the Answer Health on Demand app or visit asr.ahondemand.org and sign up now to see a certified provider anytime, anywhere.*

You can use Answer Health on Demand when:

- You need to see a doctor, but can't fit it in your schedule.
- Your doctor's office is closed.
- You feel too sick to leave the house.
- You have the flu, a headache or other common condition.
- You need to care for your children.
- You're traveling and need a doctor.



Download the Answer Health on Demand app or use this QR code.

Sign up for Answer Health on Demand today; it's as easy as 1, 2, 3!

STEP 1: ENROLL

Visit asr.ahondemand.org, enter your name and e-mail address, create a password, and answer a few simple questions. Service Key = ASR

STEP 2: CHOOSE A DOCTOR

Click on the **ASR health benefits** icon, and then click on the green access button (🟢) for a doctor available now or the yellow access button (🟡) to wait in a virtual waiting room. For a therapy (behavioral care) appointment, click the **ASR** icon and choose by Date or by Provider to schedule an appointment.

STEP 3: BEGIN VISIT

Complete the patient questionnaire before your visit. When a doctor is available your visit will begin.

*The amount charged to your credit card (if applicable) will be based on the health plan telemedicine benefit your employer offers. Answer Health on Demand will send confirmation when your payment is processed. Charges will appear on your credit card statement as "Answer Health on Demand."

Visit asr.ahondemand.org when using a computer or mobile device or call 888-230-0774.

ASR health benefits

Health Savings Accounts (HSA)

How does an HSA work?

- You contribute money to the HSA (either a lump sum payment or monthly through payroll deductions)
- You can use HSA dollars to pay your health insurance deductible, along with other qualified medical expenses such as dental or vision services
- Once you meet your deductible, your insurance pays additional covered expenses in accordance with our plan



Who is eligible for an HSA?

Anyone who is:

- Covered by a High Deductible Health Plan (HDHP)
- Not enrolled in Medicare
- Not covered under other health insurance
- Not another person's dependent

What are the benefits of an HSA?

- Triple tax advantage means you save money on your health care expenses (1. deposits are tax-free, 2. any interest earned is tax-free, 3. using the funds to pay for health care expenses is tax-free)
- Funds rollover each year, so you can use your HSA to save tax-free money for retirement
- You own the account, even if you leave the company

How much can I deposit into my HSA?

Each year, the IRS sets contribution limits:

- **2017 limits**
 - \$3,400 for individual coverage
 - \$6,750 for family coverage
- **2018 limits**
 - \$3,400 for individual coverage
 - \$6,900 for family coverage
- Also, individuals age 55 and over may contribute an additional \$1,000 for the year. This 'catch-up contribution' is meant to help you save additional money for retirement.

How may I use my HSA dollars?

The account may be used to pay for qualified medical expenses (as defined by IRS Code Section 213(d))

- This includes all out of pocket expenses for medical, Rx, dental, and vision care
- If you use your HSA to pay for non-qualified expenses, you will be subject to income tax on the amount of the distribution, and an additional 20% penalty
- Beginning at age 65, the 20% penalty rule no longer applies

How do I open a Health Savings Account (HSA)?

- The DAKO Group offers this plan through HSA Bank
- You will need to provide proof of your enrollment in the High Deductible Health Plan option.
- Once your account is open, you can set up pre-tax payroll deductions for direct deposit into your account
- You may also deposit post-tax dollars on your own and take the deduction when filing your taxes

Prescription Drug Money Saving Tips

Medtipster Online Tool

The ultimate pharmacy search engine for discounted generic drug programs available at pharmacies throughout the USA. Simply go to www.medtipster.com and begin saving money.

It's as easy as





The image shows a three-step search process. Step 1: 'drug name' with a dropdown menu showing 'Generic Equivalent: Ranitidine HCl' and 'Drug Category: Acid Reducer (ranitidine)'. Step 2: 'dosage' with a dropdown menu showing 'Dosage Form: 300 mg tablet'. Step 3: 'zip or address' with a text input field containing '98103' and a search button.

Enter the name, dosage, and your zip code to find the best deal for your generic prescription...

You can also find the names of any therapeutic alternatives. .

Finding the **cheapest prescriptions** is as easy as 1-2-3 with Medtipster.com's proprietary technology. You will never again have to wonder which pharmacy's generic program has your prescription drug. Have your healthcare and afford it, too.

Other search types include...

-  Flu Shots
-  Immunizations
-  Health Screenings
-  Mini clinics

Costco Pharmacy



Membership is NOT required to fill prescriptions at Costco!
Simply tell the Costco greeter you are going to the pharmacy.

- Go to www.costco.com to find a Costco warehouse near you, and give their phone number to your doctor for calling in your prescriptions.
- To transfer existing prescriptions with remaining refills, simply take the bottle to Costco's pharmacy. The pharmacist will take care of the rest.
- If you establish a user profile at www.costco.com, you can manage your prescriptions online (check status, order refills, etc.) If you have a Costco membership, you can tie your profile to it, but membership is not required.

	COSTCO	OTHER	SAVINGS
LYRICA 100 MG 30 CAPS	\$229.94	\$552.66	\$322.72
ADVAIR DISKUS 100-50 MCG	\$323.38	\$347.83	\$24.45
JANUMET 50-100MG 30 TABS	\$221.85	\$404.68	\$182.83

Pricing as of 8/1/18; subject to change

To check the Costco price of your medication, go to www.costco.com/pharmacy/drug-directory-main



Did you know you don't have to get your **pet's medications** from your veterinarian?

Ask your veterinarian to fax or call your pet's prescription to the Costco pharmacy - or - ask the Costco pharmacist to request the prescription from your vet for you. If you have a dog or cat that regularly uses a prescription drug, bring the bottle to the Costco. The pharmacy staff will be able to tell you about availability and pricing and can arrange to transfer the prescription from your veterinarian. (You will be asked to join the Costco Member Prescription Program.)

Dental Benefits Overview

Dental coverage is provided by Delta Dental. You may access a list of participating providers through the carriers website listed on page 2 of this guide.

		Delta Dental Gold PPO Dental Plan		
		PPO Network	Premier Network	Non Network
Deductible (Calendar Year)				
	Individual / Family	\$50 / \$150		
Class 1 —Preventative Services: Oral Exams, X-Rays, Cleaning, Sealants		100% Coverage (<i>deductible waived</i>)		
Class 2 —Basic Services: Fillings, Crown Repair, Periodontal Services, Simple Extractions, Root Canals		80% after deductible		
Class 3 —Major Services: Endodontic Services, Crowns, Dentures, Bridges, Implants		50% after deductible		
Class 4 —Orthodontics (up to age 19)		50% after deductible		
Maximum Benefit:				
	Annual Maximum - Class 1, 2, & 3	\$1,500		
	Lifetime Maximum - Class 4	\$1,000		
		Delta Dental Silver PPO Dental Plan		
		PPO Network	Premier Network	Non Network
Deductible (Calendar Year)				
	Individual / Family	None		
Class 1 —Preventative Services: Oral Exams, X-Rays, Cleaning, Sealants		100%		
Class 2 —Basic Services: Fillings, Crown Repair, Periodontal Services, Simple Extractions, Root Canals		80%		
Class 3 —Major Services: Endodontic Services, Crowns, Dentures, Bridges, Implants		50%		
Class 4 —Orthodontics (up to age 19)		50%		
Maximum Benefit:				
	Annual Maximum - Class 1, 2, & 3	\$1,000		
	Lifetime Maximum - Class 4	\$1,000		

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Vision Benefits Overview

Vision coverage is provided by VSP. You may access a list of participating providers through the carrier website listed on page 26 of this guide.

	VSP Vision Plan	
	In-Network	Out-of-Network
Eye Exams <i>Covered Once Every 12 Months</i>	\$10 copay (applies to first service provided, exam or materials)	Reimbursement up to \$45
Lenses (Standard Plastic Lenses) <i>Covered Once Every 12 Months</i>	\$10 copay	Reimbursement up to approved amount
Frames <i>Covered Once Every 12 Months</i>	\$130 allowance	Reimbursement up to \$70
Contact Lenses (in lieu of glasses) <i>Covered Once Every 12 Months</i>	\$130 allowance	Reimbursement up to \$105

Participating Retail Chains

You get the convenience of popular retail chains like these, and more.



Look for this symbol in find a Doctor or doctor locations offering even more great savings.



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Supplemental Term Life Insurance

Employees have the opportunity to elect **Supplemental Life Insurance** provided by MetLife. This will provide an additional Life Insurance benefit for yourself, your spouse and/or your dependent child(ren). Contributions for these premiums are 100% employee paid. *If you waive supplemental life coverage when you are initially eligible you will be required to provide Evidence of Insurability (EOI) when enrolling at a later date.* Please allow 4 to 6 weeks for underwriting review. Claims incurred prior to the approval of your coverage will not be covered. Benefits may be limited and/or denied based on the EOI results. It is important to keep your beneficiary information updated.

Supplemental Life and AD&D Coverage	
Employee Life Insurance	\$10,000 increments to a maximum of \$100,000
Guarantee Issue Amounts	\$100,000
Spouse Life Insurance	\$5,000 increments to a maximum of \$50,000; not to exceed 50% of Employees Life Insurance Benefit
Guarantee Issue Amounts	\$25,000
Dependent Child(ren) Life Insurance	Child from age 15 days to 6 months old \$100; Child 6 months old or older Option \$1,000, \$2,000, \$4,000, \$5,000 or \$10,000; not to exceed the spouse's benefit amount
Guarantee Issue Amounts	\$10,000
Benefit Reduction Schedule	35% at age 65, additional 50% at age 70 and an additional 32% at age 75

If your employment ends, you may elect portable coverage directly with MetLife.

Supplemental Life/AD&D Employee & Spouse	
Rate per \$1,000	
Age Band	
0-29	\$0.08
30-34	\$0.08
35-39	\$0.15
40-44	\$0.22
45-49	\$0.37
50-54	\$0.58
55-59	\$0.94
60-64	\$1.55
65-69	\$2.24
70+	\$4.32

Voluntary Life/AD&D Child
Rate Per \$1,000
Age 0-19 or 24 if student
\$0.291

For Example:

Jane Doe is 35 yrs old and has elected \$50,000 Voluntary Life/AD&D coverage.

To calculate Jane's premium we take her benefit amount (i.e. \$50,000) divide it by \$1,000 and multiply it by the rate that corresponds to her age.

$$\$50,000 / 1,000 = 50$$

$$50 \times \$0.15 = \$7.50 \text{ per month or } \$1.88 \text{ per check.}$$

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Voluntary Short Term Disability Overview

Voluntary Short Term Disability Insurance is provided by MetLife. Short Term Disability Insurance provides income protection in the event you become disabled and are unable to work due to sickness or injury.

	Short Term Disability Coverage
Benefit Amount	60% of Base Weekly Earnings
Maximum Weekly Benefit	\$1,000
Elimination Period	7th day for Accident/Illness
Maximum Benefit Period	Up to 26 weeks

Definition of disability: Insured is unable to earn more than 80% of their pre-disability earnings at their own occupation due to your injury or sickness.

Age Range	Rate
0-39	\$0.385
40-44	\$0.468
45-49	\$0.606
50-54	\$0.771
55-59	\$0.936
60-64	\$1.102
65+	\$1.322

For Example: Jane Doe is 35 yrs old and makes \$14.00 an hour ($\$14.00 \times 2080 \text{ hours} = \$29,120 \text{ annual} / \560 weekly)

Jane's Voluntary Short Term Disability (STD) benefits is 60% of \$560 (her weekly pay) = \$336

STD is paid in \$50 increments - so Jane's STD benefit would be \$300 per week.

To calculate the premium you take the benefit amount \$300 divide it by 10 = \$30

\$30 x Jane's Age Rate which is \$0.385 = \$11.55 per month or \$2.89 per check (out of 4 checks per month)

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Long Term Disability Overview

Long Term Disability Insurance is provided by MetLife. Long Term Disability Insurance provides income protection in the event you become disabled and are unable to work for an extended period of time.

	Long Term Disability Coverage
Benefit Amount	60% of Base Monthly Earnings
Maximum Monthly Benefit	\$10,000
Elimination Period	180 days
Maximum Benefit Period	Your Normal Retirement Age

Definition of disability: Insured is unable to earn more than 80% of their pre-disability earnings at their own occupation for any employer in their local economy, and after such period is unable to earn more than 80% of their pre-disability earnings from any employer in their local economy at any gainful occupation for which they are reasonable qualified taking account their training, prior education and experience.

Voluntary Long Term Disability Rates	
Age Range	Rate
0-34	\$0.15
35-39	\$0.19
40-44	\$0.46
45-49	\$0.60
50-54	\$0.83
55-59	\$1.07
60-64	\$0.86
65-99	\$0.77

For Example: Jane Doe is 35 yrs old and makes \$14.00 an hour ($\$14.00 \times 2080 \text{ hours} = \$29,120 \text{ annual} / \$2,427 \text{ monthly}$)

Jane's Voluntary Long Term Disability (LTD) benefit is based on her covered payroll which is $\$29,120 / \$2,427 \text{ monthly}$

To calculate the premium you take the monthly payroll of $\$2,427$ multiply it by her age rate of $\$0.19 = \461.13 .

Take $\$461.13$ divide by $\$100 = \4.61 per month or $\$1.15$ per check (out of 4 checks per month)

This booklet is intended for illustrative and information purposes only. The plan documents, insurance certificates and policies will serve as the governing documents. In the case of conflict between the information in this booklet and the official plan documents, the plan documents will always govern.

Will Preparation Services

Will Preparation Services are provided by Hyatt Legal Plans, Inc. at no cost to you if you're enrolled in MetLife Supplemental Life insurance. This includes preparation of living wills, power of attorney, and access to network of 13,000 participating attorneys.

MetLife Estate Resolution Services

MetLife Estate Resolution Services are provided by Hyatt Legal Plans, Inc. at no cost to you if you're enrolled in MetLife Supplemental Life insurance. This includes face to face consultation, preparation, representation, correspondence and tax filings, and coverage for attorney fees. Beneficiaries can also use this benefits to consult an attorney to discuss general questions about the probate process.

Travel Assistance Services

Travel Assistance is provided by AXA Assistance USA, Inc. at no cost to you if you're enrolled in MetLife Accidental Death and Dismemberment coverage. This services offers you and your dependents medical, travel, legal, financial, and concierge services 24 hours a day 365 days a year while travelling 100 miles or more from home whether internationally or domestically. Medical assistance includes physician referrals, hospital admission validation, evacuation and repatriation, prescription transfer, transportation to join patient, and return of mortal remains.

Insurance Definitions

ANNUAL MAXIMUM COST: The most you will pay for approved benefits in a benefit year. Also referred to as the annual “out-of-pocket” maximum.

ANNUAL MAXIMUM BENEFIT: The most your plan will pay for approved benefits in a benefit year.

CARRIER: The insurance company (i.e. Delta Dental, VSP).

CLAIM: A bill submitted to your carrier for payment.

COPAY: The amount you pay for a benefit (i.e. prescriptions/office visits - \$6, \$40, \$60).

COINSURANCE: The percentage of costs you pay for a covered service (i.e. 10%, 20% or 30%).

COORDINATION OF BENEFITS: Your insurance combined with another (spouse) insurance company.

DEDUCTIBLE: The amount you pay first before your insurance company pays for your services.

EFFECTIVE DATE: The day and month your benefits are activated.

EOB (Explanation of Benefits): Information you receive explaining how your claim was processed.

HMO (Health Maintenance Organization): A network where you choose one participating doctor.

IN-NETWORK: A group (network) of Doctors, labs, or hospitals that ‘participate’ with network carriers, and agree to accept the payment offered by the insurance carrier.

MAIL ORDER DRUGS: Prescription drugs are received through the mail.

MAINTENANCE DRUGS: Prescription drugs that must be taken regularly (i.e. insulin, high blood pressure).

OUT-OF-NETWORK: Doctors, labs or hospitals that do not ‘participate’ with some insurance carriers.

PCP (Primary Care Physician): A network doctor that you choose ‘participates’ in a network plan.

PPO (Preferred Provider Organization): A network plan of doctors, labs and hospitals.

PROVIDER: The doctor, lab or hospital (i.e. participating providers in HMO, POS or PPO plans).

REIMBURSEMENT: The amount returned to you after a claim form has been submitted for payment.

TRADITIONAL: You can usually choose any doctor, lab or hospital for service.

VOLUNTARY: You agree to pay for the insurance coverage offered through your employer.

Important Disclosure Notices

NOTE TO ALL EMPLOYEES:

Certain State and Federal Regulations require employers to provide disclosures of these regulations to all employees. The remainder of this document provides you with all of the required disclosures related to our employee benefits plan. If you have any questions or need further assistance please contact your Plan Administrator as follows:

The Dako Group
Barbara Micakovic
2966 Industrial Row Drive
Troy, MI 48084

THIS DOCUMENT IS FOR INFORMATION PURPOSES ONLY

This communication is intended for illustrative and information purposes only. The plan documents, insurance certificates, and policies will serve as the governing documents to determine plan eligibility, benefits, and payments.

LIMITATIONS AND EXCLUSIONS

Insurance and benefit plans always contain exclusions and limitations. Please see benefit booklets and/or contracts for complete details of coverage and eligibility.

ALL RIGHTS RESERVED

The Dako Group reserves the right to amend, modify, or terminate its insurance and benefit plans at any time, including during treatment.

NOTICE REGARDING SPECIAL ENROLLMENT RIGHTS

If you do not timely or properly complete the enrollment process, you and your Eligible Dependents generally will not be covered under the applicable Plan, except as described below. Also, if you fail to specifically enroll your Eligible Dependents on the enrollment form, your Eligible Dependents will not be covered under the applicable Plan, except as otherwise provided below. (a.) If you decline enrollment because you or your dependent had other group health plan coverage, either through COBRA or otherwise, you may enroll yourself and Eligible Dependents in the Medical Program within **30 days** of the loss of that coverage. Your enrollment will become effective on the date you enroll in the Medical Program. For this purpose, "loss of coverage" will occur if the other group health plan coverage terminates as a result of: (i) termination of employer contributions for the other coverage; (ii) exhaustion of the maximum COBRA period; (iii) legal separation or divorce; (iv) death; (v) termination of employment; (vi) reduction in hours of employment; or (vii) failure to elect COBRA coverage.

However, a loss of coverage will not be deemed to occur if the other coverage terminates due to a failure to pay premiums or termination for cause. At the time you enroll in the Employer's Plan, you must provide a written statement from the administrator of the other medical plan that you no longer have that coverage.

(b.) You are eligible to enroll yourself and your Eligible Dependent in the Medical Program within **30 days** of the date you acquire a new Eligible Dependent through marriage, birth, adoption or placement for adoption. Your enrollment will become effective on the date of marriage, birth, adoption or placement for adoption.

(c.) You are eligible to enroll yourself and your Eligible Dependent in the Plan within **60 days** after either:

(1.) Your or your Eligible Dependent's Medicaid coverage under

title XIX of the Social Security Act or CHIP coverage through a State child health plan under title XXI of the Social Security Act is terminated as a result of eligibility for such coverage; or (2.) You or your Eligible Dependent is determined to be eligible for employment assistance under Medicaid or CHIP to help pay for coverage under the Plan.

(d.) You are eligible to enroll yourself and your Eligible Dependents in the Plan during an Open Enrollment Period. Your enrollment will become effective on the 1st day of the Plan Year following the Open Enrollment Period.

(e.) You may enroll in the Plan an Eligible Dependent child for whom you are required to provide medical coverage pursuant to a Qualified Medical Child Support Order (as defined under ERISA Section 609). This enrollment of an Eligible Dependent will become effective as of the Plan Administrator's qualification and acceptance of the Qualified Medical Child Support Order.

(f.) You are eligible to enroll yourself and your Eligible Dependents in the Plan under any other special circumstances permitted under the applicable Benefits Guide (and subject to the Cafeteria Plan rules outlined in Section 125 of the Internal Revenue Code).

NOTE: You will not be allowed to enroll yourself and/or Eligible Dependents for coverage in the Plan for a Plan Year unless you timely and affirmatively complete the enrollment process by the deadlines set forth above (i.e. within 30 days for loss of coverage or new dependents; within 60 days for Medicaid or CHIP circumstances; within 30 days of receipt of this notice for a dependent under the age of 26; or within the deadline established by the Plan Administrator for Open Enrollment Period).

Should you have any questions regarding this information or require additional details, please contact the Plan Administrator at the address or phone number below.

The Dako Group
Barbara Micakovic
2966 Industrial Row Drive
Troy, MI 48084
(248) 655-0100

NOTICE REGARDING PRE-EXISTING CONDITIONS

The Dako Group Health Plan (the "Plan") does not impose a pre-existing condition limitation as detailed in the Benefit Guide issued by the insurance carrier. Please review the Benefits Guide carefully (you can obtain another copy of it by contacting the Plan Administrator). The following provides an overview of the pre-existing condition limitation that is allowed under the Health Insurance Portability and Accountability Act (HIPAA) as well as protections provided under the Patient Protection and Affordable Care Act of 2010 (PPACA). If the Plan does not impose a pre-existing condition limitation, much of this information does not apply to you; however, this information is provided to make you aware of this important legislation.

The Plan complies with the changes set forth in the PPACA of 2010 and does not impose pre-existing condition exclusions with respect to eligible dependent children who are under 19 years of age. In accordance with PPACA, this change was effective as of the first day of the Plan Year beginning on or after September 23, 2010; and will apply to all other covered individuals on the first day of the Plan Year beginning on or after January 1, 2014.

Pre-existing condition exclusion means that if you have a medical

Important Disclosure Notices

condition before enrolling in the medical program, you might have to wait a certain period of time before the medical program will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a 6-month look-back period. Generally, this 6-month period ends the day before your coverage becomes effective. However, if you were in a new hire waiting period for coverage, the 6-month period ends on the day before the waiting period begins. The pre-existing condition exclusion does not apply to pregnancy nor to a child who is enrolled in the medical program or who has other creditable coverage within 30 days after birth, adoption, or placement for adoption.

This exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of at least 63 days. **To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you should promptly give the Plan Administrator a copy of any certificate of creditable coverage (HIPAA Certificates) you have.** If you do not have a Certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or insurer. There are also other ways that you can show that you have creditable coverage. Please contact the Plan Administrator if you need help demonstrating creditable coverage.

Each HIPAA Certificate (or other evidence of creditable coverage) will be reviewed by the Plan Administrator (with the assistance of the prior plan administrator or insurer) to determine its authenticity. Submission of a fraudulent HIPAA Certificate would be considered a federal health care crime under HIPAA and may be punishable by fine and/or imprisonment, and may result in a loss of coverage under this Plan and other employment disciplinary action.

HOW TO REQUEST A CERTIFICATION OF CREDITABLE COVERAGE FROM THIS PLAN:

HIPAA also requires any medical program offered by the Employer to provide certificates of creditable coverage to you after you lose coverage under such medical program. This certificate allows you to use your coverage under the medical program to reduce or eliminate any pre-existing condition exclusion period that might otherwise apply to you when you change health care plans. You also may request a certificate of creditable coverage for periods of coverage on and after July 1, 1996, within 24 months of your loss of coverage. To request a HIPAA Certificate of Creditable Coverage, please contact the insurance company customer service department by calling the phone number on your healthcare identification card. If you are unable to obtain the certificate of coverage through the carrier, or have other questions regarding Pre-existing Conditions, please contact the Plan Administrator for assistance at the address or phone number below.

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NOTICE REGARDING WOMEN'S HEALTH AND CANCER RIGHTS ACT (JANET'S LAW)

On October 21, 1998, Congress passed a Federal Law known as the Women's Health and Cancer Rights Act. Under the Women's Health and Cancer Rights Act, group health plans and insurers offering mastectomy coverage must also provide coverage for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymph edemas

These services are payable to a patient who is receiving benefits in connection with a mastectomy and elects reconstruction. The physician and patient determine the manner in which these services are performed.

The plan may apply deductibles and copayments consistent with other coverage within the plan. This notice serves as the official annual notice and disclosure of that the fact that the company's health and welfare plan has been designed to comply with this law. This notification is a requirement of the act.

The Women's Health and Cancer Rights Act (Women's Health Act) was signed into law on October 21, 1998. The law includes important new protections for breast cancer patients who elect breast reconstruction in connection with a mastectomy. The Women's Health Act amended the Employee Retirement Income Security Act of 1974 (ERISA) and the Public Health Services Act (PHS Act) and is administered by the Departments of Labor and Health and Human Services.

NOTICE REGARDING MICHELLE'S LAW

On Thursday, October 9, 2008, President Bush signed into law H.R. 2851, known as Michelle's Law. This law requires employer health plans to continue coverage for employees' dependent children who are college students and need a medically necessary leave of absence. This law applies to both fully insured and self-insured medical plans.

The dependent child's change in college enrollment must meet the following requirements:

- The dependent is suffering from a serious illness or injury.
- The leave is medically necessary.
- The dependent loses student status for purposes of coverage under the terms of the plan or coverage.

Coverage for the dependent child must remain in force until the earlier of:

- One year after the medically necessary leave of absence began.
- The date the coverage would otherwise terminate under the terms of the plan.

A written certification by the treating physician is required. The certification must state that the dependent child is suffering from a serious illness or injury and that the leave is medically necessary. Provisions under this law become effective for plan years beginning on or after October 9, 2009.

NOTICE REGARDING NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

Group health plans and health insurance issuers offering group health insurance may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child for less than 48 hours following normal vaginal delivery, or less than 96 hours following a cesarean

Important Disclosure Notices

section, or require that a provider obtain authorization from the plan or insurance issuer to prescribe a length of stay not in excess of the above periods.

MEDICARE NOTICE

You must notify The Dako Group when you or your dependents become Medicare eligible. The Dako Group is required to contact the insurer to inform them of your Medicare status. Federal law determines whether Medicare or the group health plan is the primary payer. You must also notify Medicare directly that you have group health insurance coverage. Privacy laws prohibit Medicare from discussing coverage with anyone other than the Medicare beneficiary or their legal guardian. The toll free number to Medicare Coordination of Benefits is 1-800-999-1118.

If you have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices in your prescription drug plan. Please see the complete Medicare Part D Non-Creditable Coverage Notice.

Should you have any questions regarding this information or require additional details, please contact the Plan Administrator at the address or phone number below.

The Dako Group
Barbara Micakovic
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(248) 655-0100

NOTICE REGARDING PATIENT PROTECTION RIGHTS

The Dako Group Plan does not require members to designate a Primary Care Physician. The following paragraphs outline certain protections under the PPACA and only apply when the Plan requires the designation of a Primary Care Physician. One of the provisions in the PPACA of 2010 is for plans and insurers that require or allow for the designation of primary care providers by participants to inform the participants of their rights beginning on the first day of the first plan year on or after September 23, 2010.

You will have the right to designate any primary care provider who participates in the Plan's network and who is available to accept you and/or your Eligible Dependents. For children, you may designate a pediatrician as the primary care provider. You also do not need prior authorization from the Plan or from any other person (including your primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Plan's network. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan or procedures for making referrals or notifying primary care provider or Plan of treatment decisions.

If you do not make a provider designation, the Plan may make one for you. For information on how to select or change a primary care provider, and for a list of the participating primary care providers, pediatricians, or obstetrics or gynecology health care professionals, please contact the insurer.

Should you have any questions regarding this information or require additional details, please contact the Plan Administrator at the address or phone number below.

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IMPORTANT INFORMATION ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please note that the following notice only applies to individuals who are eligible for Medicare.

Medicare eligible individuals may include employees, spouses or dependent children who are Medicare eligible for one of the following reasons.

- Due to the attainment of age 65
- Due to certain disabilities as determined by the Social Security Administration
- Due to End Stage Renal Disease (ESRD)

If you are covered by Medicare, please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with The Dako Group and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about Medicare's prescription drug coverage. (Your Plan is Creditable if Covered Under ASR Premier or Value Plan.)

The following paragraphs 1 and 2 apply only to the ASR Platinum and ASR Gold medical plans.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The Dako Group has determined that the prescription drug coverage offered by their carrier's Benefits Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. If your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

The following paragraphs 1, 2 and 3 apply only to the ASR Silver plan.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare

Important Disclosure Notices

Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The Dako Group has determined that the prescription drug coverage offered by your company plan is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan than if you only have prescription drug coverage from the company plan. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.

3. You can keep your current coverage for the The Dako Group Plan. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully—it explains your options.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan? If you decide to join a Medicare drug plan, your current coverage will not be affected. Your current coverage pays for other health expenses in addition to prescription drugs. The prescription drug coverage is part of the Group Health Plan and cannot be separated from the medical coverage. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits. You have the option to waive the coverage provided under the Group Health plan due to your eligibility for Medicare. If you decide to waive coverage under the Group Health Plan due to your Medicare eligibility, you will be entitled to re-enroll in the plan during the next open enrollment period.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan? You should also know that if you drop or lose your current coverage and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium

may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage...

Contact your HR Representative. You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through your company changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information, visit Social Security at www.socialsecurity.gov, or call 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (penalty).

**The Dako Group
Barbara Micakovic
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Important Disclosure Notices

Premium Assistance under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2018. Contact your State for more information on eligibility –

ALABAMA – Medicaid

Website: <http://www.medicaid.alabama.gov>
Phone: 1-855-692-5447

ALASKA – Medicaid

Website: <http://health.hss.state.ak.us/dpa/programs/medicaid/>
Phone (Outside of Anchorage): 1-888-318-8890
Phone (Anchorage): 907-269-6529

ARIZONA – CHIP

Website: <http://www.azahcccs.gov/applicants>
Phone (Outside Maricopa County): 1-877-764-5437
Phone (Maricopa County): 602.417.5437

COLORADO – Medicaid and CHIP

Medicaid Website: <http://www.colorado.gov/>
Medicaid Phone (In state): 1-800-866-3513
Medicaid Phone (Out of state): 1-800-221-3943

FLORIDA – Medicaid

Website: <https://www.flmedicaidprecovery.com/>
Phone: 1-877-357-3268

GEORGIA – Medicaid

Website: <http://dch.georgia.gov/>
Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP)
Phone: 1-800-869-1150

IDAHO – Medicaid and CHIP

Medicaid Website: www.accessstohealthinsurance.idaho.gov
Medicaid Phone: 1-800-926-2588
CHIP Website: www.medicaid.idaho.gov
CHIP Phone: 1-800-926-2588

INDIANA – Medicaid

Website: <http://www.in.gov/fssa>
Phone: 1-800-889-9949

IOWA – Medicaid

Website: www.dhs.state.ia.us/hipp/
Phone: 1-888-346-9562

KANSAS – Medicaid

Website: <http://www.kdheks.gov/hcf/>
Phone: 1-800-792-4884

KENTUCKY – Medicaid

Website: <http://chfs.ky.gov/dms/default.htm>
Phone: 1-800-635-2570

LOUISIANA – Medicaid

Website: <http://www.lahipp.dhh.louisiana.gov>
Phone: 1-888-695-2447

MAINE – Medicaid

Website: <http://www.maine.gov/dhhs/ofi/public-assistance/index.html>
Phone: 1-800-977-6740
TTY 1-800-977-6741

MASSACHUSETTS – Medicaid and CHIP

Website: <http://www.mass.gov/MassHealth>
Phone: 1-800-462-1120

MINNESOTA – Medicaid

Website: <http://www.dhs.state.mn.us/>
Click on Health Care, then Medical Assistance
Phone: 1-800-657-3629

MISSOURI – Medicaid

Website: <http://www.dss.mo.gov/mhd/participants/pages/hipp.htm>
Phone: 573-751-2005

MONTANA – Medicaid

Website: <http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml>
Phone: 1-800-694-3084

Important Disclosure Notices

STATES OFFERING PREMIUM PAYMENT ASSISTANCE PROGRAMS , continued

NEBRASKA – Medicaid

Website: www.ACCESSNebraska.ne.gov
Phone: 1-800-383-4278

NEVADA – Medicaid

Medicaid Website: <http://dwss.nv.gov/>
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: <http://www.dhhs.nh.gov/oii/documents/hippapp.pdf>
Phone: 603-271-5218

NEW JERSEY – Medicaid and CHIP

Medicaid Website: <http://www.state.nj.us/humanservices/dmahs/clients/medicaid/>
Medicaid Phone: 609-631-2392
CHIP Website: <http://www.njfamilycare.org/index.html>
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid

Website: http://www.nyhealth.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: <http://www.ncdhhs.gov/dma>
Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: <http://www.nd.gov/dhs/services/medicalserv/medicaid/>
Phone: 1-800-755-2604

OKLAHOMA – Medicaid

Website: <http://www.insureoklahoma.org>
Phone: 1-888-365-3742

OREGON – Medicaid and CHIP

Website: <http://www.oregonhealthykids.gov>
<http://www.hijosaludablesoregon.gov>
Phone: 1-877-314-5678

PENNSYLVANIA – Medicaid

Website: <http://www.dpw.state.pa.us/hipp>
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid

Website: www.ohhs.ri.gov
Phone: 401-462-5300

SOUTH CAROLINA – Medicaid

Website: <http://www.scdhhs.gov>
Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid

Website: <http://dss.sd.gov>
Phone: 1-888-828-0059

TEXAS – Medicaid

Website: <https://www.gethipptexas.com/>
Phone: 1-800-440-0493

UTAH– Medicaid

Website: <http://health.utah.gov/upp>
Phone: 1-866-435-7414

VERMONT– Medicaid

Website: <http://www.greenmountaincare.org/>
Phone: 1-800-250-8427

VIRGINIA– Medicaid and CHIP

Medicaid Website: <http://www.dmas.virginia.gov/rcp-HIPP.htm>
Medicaid Phone: 1-800-432-5924
CHIP Website: <http://www.famis.org/>
CHIP Phone: 1-866-873-2647

WASHINGTON – Medicaid

Website: <http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm>
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid

Website: www.dhhr.wv.gov/bms/
Phone: 1-877-598-5820, HMS Third Party Liability

WISCONSIN – Medicaid

Website: <http://www.badgercareplus.org/pubs/p-10095.htm>
Phone: 1-800-362-3002

WYOMING – Medicaid

Website: <http://health.wyo.gov/healthcarefin/equalitycare>
Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2018, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 10/31/2017)

Important Disclosure Notices

** Continuation Coverage Rights Under COBRA**

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

Important Disclosure Notices

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Barbara Micakovic.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

**The Dako Group Plan
Barbara Micakovic
2966 Industrial Row Drive
Troy, MI 48084
(248) 655-0100**

Important Disclosure Notices



New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October for coverage starting as early as January 1.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.¹

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact: Barbara Micakovic.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

¹ An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

Important Disclosure Notices

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name: Dako Resources, Inc. dba The Dako Group		4. Employer Identification Number (EIN) 38-3322128	
5. Employer address 2966 Industrial Row Drive		6. Employer phone number (248) 655-0100	
7. City Troy	8. State MI	9. ZIP Code 48084	
10. Who can we contact about employee health coverage at this job? Barbara Micakovic			
11. Phone number (if different from above)		12. Email address bmicakovic@dakogroup.com	

Here is some basic information about health coverage offered by this employer:

As your employer, we offer a health plan to:

- All full-time eligible employees.

With respect to dependents:

- We do offer coverage. Eligible dependents are:
 - Legally married opposite-sex and same-sex spouses
 - Dependent child(ren) as defined by the IRS
 - This coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.
- ** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, [HealthCare.gov](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](https://www.healthcare.gov) to find out if you can get a tax credit to lower your monthly premiums.

Summary of Benefits Coverage



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:
<p>What is the overall <u>deductible</u>?</p>	<p>\$750/individual or \$1,500/family for services rendered by <u>in-network providers</u>, and \$1,000/individual or \$2,000/family for services rendered by <u>out-of-network providers</u>.</p>	<p>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>.</p>
<p>Are there services covered before you meet your <u>deductible</u>?</p>	<p>Yes. <u>In-network preventive care</u>, routine immunizations administered in a pharmacy or at the Department of Community Health, most <u>in-network</u> physician exam charges (primary care, <u>urgent care</u>, <u>specialist</u> visits), physician emergency room fees, <u>in-network</u> chiropractic care, rehabilitative and habilitative therapies, and <u>prescription drug coverage</u> are covered before you meet your <u>deductible</u>.</p>	<p>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 https://www.healthcare.gov/coverage/preventive-care-benefits/.</p>
<p>Are there other <u>deductibles</u> for specific services?</p>	<p>No.</p>	<p>You don't have to meet <u>deductibles</u> for specific services.</p>
<p>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</p>	<p>The <u>out-of-pocket limits</u> for <u>coinsurance</u> only are \$500/individual and \$1,000/family for services rendered by <u>in-network providers</u>, and \$2,500/individual and \$5,000/family for services rendered by <u>out-of-network providers</u>. These figures do not include the <u>deductible</u> or any <u>copayments</u>. The total <u>out-of-pocket limits</u> for services rendered by <u>in-network providers</u> are \$6,350/individual and \$12,700/family, and these figures include the <u>in-network deductibles</u> and <u>coinsurance out-of-pocket limits</u> shown above as well as <u>prescription drug copayments</u> and <u>in-network</u> medical</p>	<p>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.</p>

Important Questions	Answers	Why this Matters:
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?, cont.	<u>copayments</u> . The total <u>out-of-pocket limits</u> for services rendered by <u>out-of-network providers</u> are \$12,700/individual and \$25,400/family, and these figures include the <u>out-of-network deductibles</u> and <u>coinsurance out-of-pocket limits</u> shown above.	
What is not included in the <u>out-of-pocket limit</u> ?	<u>Deductibles</u> and <u>copayments</u> on certain services are not included in the <u>out-of-pocket limits</u> applicable to only <u>coinsurance</u> (but would be included in the total <u>out-of-pocket limits</u> as specified above). In general, <u>out-of-pocket limits</u> do not include penalties; charges that exceed the <u>plan's usual, customary, and reasonable fee allowance</u> 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> .
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 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.
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	\$40 <u>copay</u> /visit; <u>deductible</u> does not apply	30% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$40 <u>copay</u> /day for most chiropractic services; otherwise \$60 <u>copay</u> /visit; <u>deductible</u> does not apply if <u>copay</u> applies	30% <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 <u>provider's office or clinic</u> , cont.	<u>Preventive care/screening/immunization</u>	No charge	No charge for routine immunizations administered in a pharmacy or at the Department of Community Health; otherwise 30% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (X-ray, blood work)	10% <u>coinsurance</u> ; <u>deductible</u> does not apply for chiropractic X-rays	30% <u>coinsurance</u>	None
	<u>Imaging</u> (CT/PET scans, MRIs)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.ehimrx.com	Generic drugs	\$10 <u>copay</u> /prescription (retail) or \$20 <u>copay</u> /prescription (mail order); <u>deductible</u> does not apply		Covers up to a 30-day supply (retail) or up to a 90-day supply (mail order). Specific criteria may have to be met in order for some brand-name medications to be covered.
	Preferred brand drugs	\$30 <u>copay</u> /prescription (retail) or \$60 <u>copay</u> /prescription (mail order); <u>deductible</u> does not apply		
	Non-preferred brand drugs	\$50 <u>copay</u> /prescription (retail) or \$100 <u>copay</u> /prescription (mail order); <u>deductible</u> does not apply		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	\$200 <u>copay</u> /visit and 10% <u>coinsurance</u>	\$200 <u>copay</u> /visit and 10% <u>coinsurance</u> for certain services rendered at an out-of-network hospital; otherwise 30% <u>coinsurance</u>	<u>Copay</u> may be waived if admitted inpatient.
	<u>Emergency medical transportation</u>	No charge after <u>deductible</u>	No charge after <u>deductible</u>	None
	<u>Urgent care</u>	\$75 <u>copay</u> /visit; <u>deductible</u> does not apply	30% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Certification (sometimes called <u>preauthorization</u>) is required. \$500 penalty applies if not certified.
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <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 need mental health, behavioral health, or substance abuse services	Outpatient services	\$40 <u>copay</u> /office visit (<u>deductible</u> does not apply) and 10% <u>coinsurance</u> for other outpatient services	30% <u>coinsurance</u>	None
	Inpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Certification (sometimes called <u>preauthorization</u>) is required. \$500 penalty applies if not certified.
If you are pregnant	Office visits	10% <u>coinsurance</u>	30% <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).
	Childbirth/delivery professional services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	
	Childbirth/delivery facility services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Certification (sometimes called <u>preauthorization</u>) is required.
	<u>Rehabilitation services</u>	\$40 <u>copay</u> /visit; <u>deductible</u> does not apply	30% <u>coinsurance</u>	
	<u>Habilitation services</u>	\$40 <u>copay</u> /visit; <u>deductible</u> does not apply	30% <u>coinsurance</u>	
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Certification (sometimes called <u>preauthorization</u>) is required. Vehicle and home modifications are excluded.
	<u>Hospice services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	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 <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
- 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.)

- Chiropractic care up to 20 chiropractic 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 Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit their website at www.dol.gov/ebsa/healthreform. 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.

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>	\$750
■ <u>Specialist coinsurance</u>	10%
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	10%

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$750
Copayments	\$30
Coinsurance	\$500
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,340

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>	\$750
■ <u>Specialist copayment</u>	\$60
■ Hospital (facility) <u>coinsurance</u>	10%
■ 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	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$600
Copayments	\$1,300
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$1,930

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$750
■ <u>Specialist copayment</u>	\$200
■ Hospital (facility) <u>coinsurance</u>	10%
■ 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	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$750
Copayments	\$500
Coinsurance	\$70
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,320

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



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:
<p>What is the overall <u>deductible</u>?</p>	<p>\$1,000/individual or \$2,000/family for services rendered by <u>in-network providers</u>, and \$1,500/individual or \$3,000/family for services rendered by <u>out-of-network providers</u>.</p>	<p>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>.</p>
<p>Are there services covered before you meet your <u>deductible</u>?</p>	<p>Yes. <u>In-network preventive care</u>, routine immunizations administered in a pharmacy or at the Department of Community Health, most <u>in-network</u> physician exam charges (primary care, <u>urgent care</u>, <u>specialist</u> visits), physician emergency room fees, <u>in-network</u> chiropractic care, rehabilitative and habilitative therapies, and <u>prescription drug coverage</u> are covered before you meet your <u>deductible</u>.</p>	<p>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 https://www.healthcare.gov/coverage/preventive-care-benefits/.</p>
<p>Are there other <u>deductibles</u> for specific services?</p>	<p>No.</p>	<p>You don't have to meet <u>deductibles</u> for specific services.</p>
<p>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</p>	<p>The <u>out-of-pocket limits</u> for <u>coinsurance</u> only are \$1,500/individual and \$3,000/family for services rendered by <u>in-network providers</u>, and \$3,500/individual and \$7,000/family for services rendered by <u>out-of-network providers</u>. These figures do not include the <u>deductible</u> or any <u>copayments</u>. The total <u>out-of-pocket limits</u> for services rendered by <u>in-network providers</u> are \$6,350/individual and \$12,700/family, and these figures include the <u>in-network deductibles</u> and <u>coinsurance out-of-pocket limits</u> shown above as well as <u>prescription drug copayments</u> and <u>in-network</u> medical</p>	<p>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.</p>

Important Questions	Answers	Why this Matters:
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?, cont.	<u>copayments</u> . The total <u>out-of-pocket limits</u> for services rendered by <u>out-of-network providers</u> are \$12,700/individual and \$25,400/family, and these figures include the <u>out-of-network deductibles</u> and <u>coinsurance out-of-pocket limits</u> shown above.	
What is not included in the <u>out-of-pocket limit</u> ?	<u>Deductibles</u> and <u>copayments</u> on certain services are not included in the <u>out-of-pocket limits</u> applicable to only <u>coinsurance</u> (but would be included in the total <u>out-of-pocket limits</u> as specified above). In general, <u>out-of-pocket limits</u> do not include penalties; charges that exceed the <u>plan's usual, customary, and reasonable fee allowance</u> 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> .
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 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.
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	\$30 <u>copay</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$30 <u>copay</u> /day for most chiropractic services; otherwise \$60 <u>copay</u> /visit; <u>deductible</u> does not apply if <u>copay</u> applies	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 <u>provider's office or clinic</u> , cont.	<u>Preventive care/screening/immunization</u>	No charge	No charge for routine immunizations administered in a pharmacy or at the Department of Community Health; otherwise 40% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (X-ray, blood work)	20% <u>coinsurance</u> ; <u>deductible</u> does not apply for chiropractic X-rays	40% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.ehimrx.com	Generic drugs	\$10 <u>copay</u> /prescription (retail) or \$20 <u>copay</u> /prescription (mail order); <u>deductible</u> does not apply		Covers up to a 30-day supply (retail) or up to a 90-day supply (mail order). Specific criteria may have to be met in order for some brand-name medications to be covered.
	Preferred brand drugs	\$30 <u>copay</u> /prescription (retail) or \$60 <u>copay</u> /prescription (mail order); <u>deductible</u> does not apply		
	Non-preferred brand drugs	\$60 <u>copay</u> /prescription (retail) or \$120 <u>copay</u> /prescription (mail order); <u>deductible</u> does not apply		
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>	None
If you need immediate medical attention	<u>Emergency room care</u>	\$200 <u>copay</u> /visit and 20% <u>coinsurance</u>	\$200 <u>copay</u> /visit and 20% <u>coinsurance</u> for certain services rendered at an out-of-network hospital; otherwise 40% <u>coinsurance</u>	<u>Copay</u> may be waived if admitted inpatient.
	<u>Emergency medical transportation</u>	No charge after <u>deductible</u>	No charge after <u>deductible</u>	None
	<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. \$500 penalty applies if not certified.
	Physician/surgeon fees	20% <u>coinsurance</u>	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 need mental health, behavioral health, or substance abuse services	Outpatient services	\$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. \$500 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).
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Certification (sometimes called <u>preauthorization</u>) is required.
	<u>Rehabilitation services</u>	\$30 <u>copay</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u>	
	<u>Habilitation services</u>	\$30 <u>copay</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u>	
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Certification (sometimes called <u>preauthorization</u>) is required. Vehicle and home modifications are excluded.
	<u>Hospice services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	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 <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
- 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.)

- Chiropractic care up to 20 chiropractic 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 Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit their website at www.dol.gov/ebsa/healthreform. 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.

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>	\$1,000
■ <u>Specialist coinsurance</u>	20%
■ 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*)

Total Example Cost	\$12,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$30
Coinsurance	\$1,500
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,590

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>	\$1,000
■ <u>Specialist copayment</u>	\$60
■ 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*)

Total Example Cost	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$570
Copayments	\$1,200
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$1,830

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$1,000
■ <u>Specialist copayment</u>	\$200
■ Hospital (facility) <u>coinsurance</u>	20%
■ 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*)

Total Example Cost	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$400
Coinsurance	\$60
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,460


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



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> ?	\$2,500/individual or \$5,000/family for services rendered by <u>in-network providers</u> , and \$6,000/individual or \$12,000/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> , the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>In-network preventive care</u> , routine immunizations administered in a pharmacy or at the Department of Community Health, and certain preventive <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 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> ?	\$5,000/individual and \$10,000/family for services rendered by <u>in-network providers</u> , and \$15,000/individual and \$30,000/family for services rendered by <u>out-of-network providers</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.
What is not included in the <u>out-of-pocket limit</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; 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> .

Important Questions	Answers	Why this Matters:
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 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.
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	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Specialist</u> visit	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No charge	No charge for routine immunizations administered in a pharmacy or at the Department of Community Health; otherwise 40% <u>coinsurance</u> not covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (X-ray, blood work)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.ehimrx.com	Generic drugs	\$10 <u>copay</u> /prescription (retail) or \$20 <u>copay</u> /prescription (mail order); <u>deductible</u> does not apply to certain preventive drugs		Covers up to a 30-day supply (retail) or up to a 90-day supply (mail order). Specific criteria may have to be met in order for some brand-name medications to be covered.
	Preferred brand drugs	\$35 <u>copay</u> /prescription (retail) or \$70 <u>copay</u> /prescription (mail order); <u>deductible</u> does not apply to certain preventive drugs		
	Non-preferred brand drugs	\$50 <u>copay</u> /prescription (retail) or \$100 <u>copay</u> /prescription (mail order); <u>deductible</u> does not apply to certain preventive drugs		

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)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Physician/surgeon fees	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u> for certain services rendered at an out-of-network hospital; otherwise 40% <u>coinsurance</u>	None
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	None
	<u>Urgent care</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Certification (sometimes called <u>preauthorization</u>) is required. \$500 penalty applies if not certified.
	Physician/surgeon fees	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Inpatient services	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Certification (sometimes called <u>preauthorization</u>) is required. \$500 penalty applies if not certified.
If you are pregnant	Office visits	10% <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).
	Childbirth/delivery professional services	10% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	10% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Certification (sometimes called <u>preauthorization</u>) is required.
	<u>Rehabilitation services</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	
	<u>Habilitation services</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Certification (sometimes called <u>preauthorization</u>) is required. Vehicle and home modifications are excluded.
	<u>Hospice services</u>	10% <u>coinsurance</u>	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 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 <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 <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"> • Acupuncture • Bariatric surgery • Cosmetic surgery • Dental care (except to the extent required to be covered by Health Care Reform) 	<ul style="list-style-type: none"> • Glasses • Hearing aids • Infertility treatment • Long-term care 	<ul style="list-style-type: none"> • 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 <u>plan</u> document.)	
<ul style="list-style-type: none"> • Chiropractic care up to 20 chiropractic visits allowed annually 	<ul style="list-style-type: none"> • 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 Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit their website at www.dol.gov/ebsa/healthreform. 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.

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>	\$2,500
■ <u>Specialist coinsurance</u>	10%
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	10%

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,500
Copayments	\$30
Coinsurance	\$1,000
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,590

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>	\$2,500
■ <u>Specialist coinsurance</u>	10%
■ Hospital (facility) <u>coinsurance</u>	10%
■ 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	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,500
Copayments	\$800
Coinsurance	\$60
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$3,420

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$2,500
■ <u>Specialist coinsurance</u>	10%
■ Hospital (facility) <u>coinsurance</u>	10%
■ 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	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,900
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,900

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.