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, www.cap-rx.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.dol.gov/ebsa/healthreform or call 1-800-797-9791 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers
Are there services covered before you meet your deductible?	No.	
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$5,550 person/ $11,100 family.	If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.cap-rx.com or call 1-844-532-2779 for a list of network providers	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing).
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Not covered	Not covered	No coverage for primary care visit
	Specialist visit	Not covered	Not covered	No coverage for specialist visit
	Preventive care/screening/ immunization	Not covered	Not covered	No coverage for preventive care / screening / immunization
If you have a test	Diagnostic test (x-ray, blood work)	Not covered	Not covered	No coverage for diagnostic tests
	Imaging (CT/PET scans, MRIs)	Not covered	Not covered	No coverage for imaging
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.cap-rx.com	Generic drugs	$15 copay/ prescription retail; $30 copay/ prescription mail order. $0 copay for Anti-Diabetic medications and supplies. $0 copay for Anti-Hypertensive medications	Reimbursed the submitted cost less the $15 copay	Covers up to a 90-day supply (retail prescription); 34-90 day supply (mail order prescription) Growth and biosynthetic hormones require prior authorization Contraceptive medication subject to PPACA regulations covered at 100%
	Preferred brand drugs	$25 copay/ prescription retail; $50 copay/ prescription mail order.	Reimbursed the submitted cost less the $25 copay	Covers up to a 90-day supply (retail prescription); 34-90 day supply (mail order prescription) Growth and biosynthetic hormones require prior authorization
	Non-preferred brand drugs	$45 copay/ prescription retail; $90 copay/ prescription mail order	Reimbursed the submitted cost less the $45 copay	Covers up to a 90-day supply (retail prescription); 34-90 day supply (mail order prescription) Growth and biosynthetic hormones require prior authorization. Step Therapy may apply.
	Specialty drugs	$15 Generic, $25 Preferred, $45 Non-preferred	35% coinsurance	——————none——————
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered	Not covered	No coverage for facility fee
	Physician/surgeon fees	Not covered	Not covered	No coverage for outpatient surgery

[* For more information about limitations and exceptions, see the plan or policy document at [www.cap-rx.com].]

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	Not covered	Not covered	No coverage for emergency room services
	Emergency medical transportation	Not covered	Not covered	No coverage for emergency medical transportation
	Urgent care	Not covered	Not covered	No coverage for urgent care
If you have a hospital stay	Facility fee (e.g., hospital room)	Not covered	Not covered	No coverage for facility fee
	Physician/surgeon fees	Not covered	Not covered	No coverage for physician / surgeon fee
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not covered	Not covered	No coverage for mental / behavioral health outpatient services
	Inpatient services	Not covered	Not covered	No coverage for mental / behavioral health inpatient services
If you are pregnant	Office visits	Not covered	Not covered	No coverage for prenatal / postnatal office visits
	Childbirth/delivery professional services	Not covered	Not covered	No coverage for childbirth / delivery professional services
	Childbirth/delivery facility services	Not covered	Not covered	No coverage for childbirth / delivery facility services
If you need help recovering or have other special health needs	Home health care	Not covered	Not covered	No coverage for home health care
	Rehabilitation services	Not covered	Not covered	No coverage for rehabilitation services
	Habilitation services	Not covered	Not covered	No coverage for habilitation services
	Skilled nursing care	Not covered	Not covered	No coverage for skilled nursing care
	Durable medical equipment	Not covered	Not covered	No coverage for durable medical equipment
	Hospice services	Not covered	Not covered	No coverage for hospice care
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	No coverage for eye exam
	Children's glasses	Not covered	Not covered	No coverage for glasses
	Children's dental check-up	Not covered	Not covered	No coverage for dental check-up

[* For more information about limitations and exceptions, see the plan or policy document at [www.cap-rx.com].]

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
- Chiropractic care
- Cosmetic surgery
- Dental care (Adult/child)
- Diagnostic test (x-ray, blood work)
- Durable medical equipment
- Emergency medical transportation
- Emergency room services
- Eye Exam (Adult/child)
- Eye care – glasses (Adult/child)
- Habilitation services
- Hospice service
- Hospital stay – facility fee
- Hospital stay – physician / surgeon fee
- Imaging (CT / PET scans, MRIs)
- Infertility treatment
- Long term care
- Mental / behavioral health outpatient services
- Mental / behavioral health inpatient services
- Non-emergency care when traveling outside the U.S.
- Other practitioner office or clinic visit
- Outpatient surgery – facility fee
- Outpatient surgery – physician / surgeon fee
- Pregnancy – prenatal and postnatal care
- Pregnancy – delivery and all inpatient services
- Preventive care / screening / immunizations in a health care provider's office or clinic
- Primary care office or clinic visits
- Private-duty nursing
- Rehabilitation services
- Routine eye care (Adult)
- Routine foot care
- Skilled nursing care
- Specialist office or clinic visits
- Substance use disorder outpatient services
- Substance use disorder inpatient services
- Urgent care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Most coverage provided outside the United States. See www.cap-rx.com

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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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: Capital Rx, 228 Park Avenue S, Suite 87234, New York, NY 1003-1502, Attention: Grievance Department; Kent County: Attention Human Resources 300 Monroe NW Grand Rapids, MI 49503-2222. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? No

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 the Minimum Value Standards? No

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:

To get help reading in your language call the customer service number on the back of your ID card.

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

[* For more information about limitations and exceptions, see the plan or policy document at [www.cap-rx.com].]

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$300
Specialist copayment	$25
Hospital (facility) *[cost sharing]*	15%
Other *[cost sharing]*	15%

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	$12,755

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$60
Coinsurance	$0
What isn't covered	
Limits or exclusions	$12,695
The total Peg would pay is	$12,755

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

The plan's overall deductible	$300
Specialist copayment	$25
Hospital (facility) *[cost sharing]*	15%
Other *[cost sharing]*	15%

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	$3,922

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$790
Coinsurance	$0
What isn't covered	
Limits or exclusions	$3,132
The total Joe would pay is	$3,922

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

The plan's overall deductible	$300
Specialist *[cost sharing]*	$25
Hospital (facility) *[cost sharing]*	15%
Other *[cost sharing]*	15%

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	$1,925

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$1,925
The total Mia would pay is	$1,925

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