This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or in the plan document at www.ifraonline.com or by calling 248-356-1682.

Important Questions	Answers	Why this Matters:
What is the overall deductible:	$500 person $1,000 family After which the Plan pays 90% In Network/60% Non Network unless otherwise stated.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. The deductible starts over January 1st and provides a year-end deductible carry-over to the following year. See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	Dental $50 per person $100 per family	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. Dental coverage is free-standing and optional. If individuals do not elect dental, there is no dental provided and this deductible does NOT apply.
Is there an out-of-pocket limit on my expenses?	Yes. $5,000 per family	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, the deductible**,** and health care this plan doesn't cover	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. Cofinity**.** See www.cofinity.net for participating providers or call 1-248-356-1682	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your Summary Plan Document ("SPD") for additional information about excluded services.

- Co-payments are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- Co-insurance is *your* share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is $1,000, your co-insurance payment of 20% would be $200. This may change if you haven't met your deductible.
- The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges, $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing).
- This plan may encourage you to use participating providers by charging you lower deductibles, co-payments and co-insurance amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Participating Provider	Non-Participating Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 co-pay/visit 100% after deductible waived	40% co-insurance	_____none_____
	Specialist visit	$15 co-pay/visit 100% after deductible waived	40% co-insurance	_____none_____
	Other practitioner office visit	$15 co-insurance 100% after deductible waived	40% co-insurance	Manual manipulation limited to $500 calendar year for x-rays.
	Preventive care/screening/immunization	None, deductible waived	40% co-insurance	Up to $200 adult and $500 child/year, remaining balance after the deductible: your cost is 10% of the balance, In network/40% Non Network
	Mammography Screenings	No charge	No charge	_____none_____
If you have a test	Diagnostic test (x-ray, blood work) Imaging (CT/PET scans, MRIs)	10% coinsurance	40% co-insurance	Ultrasound testing is limited to $750/calendar year.

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Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition	Retail payment limited to a copay using a prescription ID card.	**YOUR COPAY FOR EACH FILL:** CareMark (PharmaCare) Pharmacy: Generic Drug $15.00 Copay Preferred Brand Name $30.00 Copay Non-Preferred Brand $60.00 Copay		Specific drugs named by the Caremark formulary -available at www.ifraonline
	Maintenance drugs by mail	**Mail order for Maintenance Drugs:** Generic Drugs $30.00 - 3 month supply Preferred Brand Name $60.00 - 3 month supply Non-Preferred Brand $120.00 - 3 month supply		
	Medicare Part D Coverage	**Coordinating with Medicare Part D Coverage** If you are covered as an active employee, your REBT prescription coverage will be primary (pay first) to any election under Medicare Part D.		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% co-insurance	40% co-insurance	Preauthorization required for in excess of $500
	Physician/surgeon fees	10% co-insurance	20% co-insurance	Preauthorization required for in excess of $500
If you need immediate medical attention	Emergency room services	10% co-insurance	40% co-insurance	----------none----------
	Emergency medical transportation	10% co-insurance	40% co-insurance	----------none----------
	Urgent care	100% after $15 office visit co-pay	40% co-insurance	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room, intensive care unit, nursery)	10% co-insurance	40% co-insurance	----------none----------
	Physician visit	10% co-insurance	40% co-insurance	Limited to 1 visit/day

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	100% after $15 co-pay/office visit, deductible waived	40% co-insurance	----------none----------
	Mental/Behavioral health inpatient services	10% co-insurance	40% co-insurance	----------none----------
	Substance use disorder outpatient services	$15 co-pay/office visit, deductible waived	40% co-insurance	----------none----------
	Substance use disorder inpatient services	10% co-insurance	40% co-insurance	----------none----------
If you are pregnant	Prenatal and postnatal care	100% after $15 office visit. Copay / deductible waived	40% co-insurance	----------none----------
	Delivery and all inpatient services	10% co-insurance	40% co-insurance	----------none----------
If you need help recovering or have other special health needs	Home health care.	10% co-insurance	40% co-insurance	Limit $50/visit, 100 visits/year
	Rehabilitation services	10% co-insurance	40% co-insurance	----------none----------
	Habilitation services / Physical Therapy	10% co-insurance	40% co-insurance	----------none----------
	Skilled nursing care	10% co-insurance	40% co-insurance	----------none---------- 120 days/calendar year
	Durable medical equipment	10% co-insurance	40% co-insurance	----------none----------
	Hospice service	10% co-insurance	40% co-insurance	----------none----------
If you or your covered child needs dental or eye care	Eye exam	Balance after plan pays $35	Balance after plan pays $35	Limited to one exam per year. Vision is a free-standing option and coverage must be elected
	Glasses	Balance after plan pays $50 for contact lens; $30 for other lens; $40 for frames	Balance after plan pays $50 for contact lens; $30 for other lens; $40 for frames	Limited to one pair of glasses per year and if you have elected the free-standing vision coverage.
	Dental check-up	None	None	**If you have elected the free-standing dental coverage.** *Other dental services:* after $50 annual dental deductible include fillings (you pay 20% coinsurance), crowns, bridges and dentures, (you pay 50% coinsurance; full Xrays subject to frequency limits (you pay 20% co-insurance). Dentamax network use decreases your cost for basic dental to 0%, following dental deductible

Excluded Services & Other Services:

Services Your Plan Does NOT Cover (**This isn't a complete list. Check your policy or plan document for other** excluded services.)

- Cosmetic surgery
- Dental Care (unless elected by employer)
- Infertility treatment
- Experimental Procedures
- Pre employment or physical not covered by Plan
- Injuries from automobiles or other motor craft and from any farm equipment used in a business including farm equipment
- Claims submitted more than 365 days from date of service
- Certain drug, dental and vision benefits
- Acupuncture (if prescribed for rehabilitation purposes)
- Charges outside the scope of the provider's license
- Long-term facility care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Weight loss and smoking cessation programs
- Outpatient family counseling
- Routine eye vision correction (unless elected by employer)
- Routine foot care
- Illness or injury covered by workers comp or
- Charges for more than usual and customary amounts

Other Covered Services (**This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services**.)

- Bariatric surgery
- Outpatient hemodialysys
- Organ transplants
- Chiropractic care
- Hearing tests (not hearing aids)
- Infertility testing
- Most coverage provided Emergency services outside the United States. See www.ifraonline.com

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Your Rights to Continue Coverage:

****Individual health insurance sample--**

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 248-356-1682. You may also contact your state insurance department at Office of Financial and Insurance Regulation at 1-877-999-6442.

OR

****Group health coverage sample--**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay While covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 248-356-1682. You may also contact your state insurance department, the 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.

Your Grievance ad Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact Gail Edwards-Bryant, Plan Coordinator at 1-248-356-1682.

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

Does this Coverage Provide Minimum Essential Coverage?
The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This Plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?
The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

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Having a baby (normal delivery)

- **Amount owed to providers: $7,540**
- **Plan pays $6,385**
- **Patient pays $1,155**

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays (In Network):

Deductibles	$500
Co-pays	$135
Co-insurance	$520
Limits or exclusions	$0
Total	**$1,155**

Managing Type II diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers: $4,100**
- **Plan pays $2,580**
- **Patient pays $1,520**

Sample care costs:

Prescriptions	$1,500
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$730
Education	$290
Laboratory tests	$140
Vaccines, other preventive	$140
Total	**$4,100**

Patient pays (In Network):

Deductibles	$500
Co-pays	$600
Co-insurance	$130
Limits or exclusions	$290
Total	**$1,520**

Note: These numbers assume you elected prescription coverage.

You can view the Glossary at www.ifraonline.com or call 1-248-356-1682.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples:

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

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What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles. Co-payments, and co-insurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses:

No. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as co-payments, deductibles, and co-insurance. You should also consider contributions to Accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.