



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to www.asrhealthbenefits.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 616-957-1751 or 1-800-968-2449 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	<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>The employer's Medical Reimbursement Account may reimburse up to \$750/individual or \$1,500/family for services rendered by <u>in-network providers</u> and up to \$0/individual or \$0/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>
Are there services covered before you meet your deductible?	<p>Yes. <u>In-network preventive care</u>, most <u>in-network</u> physician exam charges (primary care, telemedicine e-visits, <u>urgent care</u>, <u>specialist</u> visits), routine immunizations administered in a pharmacy or at the Department of Community Health, <u>emergency room care</u>, <u>emergency medical transportation</u>, <u>in-network</u> advanced types of X-rays, imaging services, and nuclear radiology services, <u>in-network</u> allergy services, most <u>in-network</u> chiropractic care services, <u>in-network</u> outpatient rehabilitative therapy services, applied behavior analysis (ABA) treatment, 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>
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.

Important Questions	Answers	Why this Matters:
<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 \$1,000/individual and \$2,000/family for services rendered by <u>in-network providers</u>, and \$1,500/individual and \$3,000/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> are \$7,150/individual and \$14,300/family, and they apply to services rendered by <u>in-network providers</u> only. These figures include the <u>deductibles</u> and the <u>coinsurance out-of-pocket limits</u> shown above as well as <u>prescription drug copayments</u> and <u>in-network medical copayments</u>.</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>
<p>What is not included in the <u>out-of-pocket limit</u>?</p>	<p><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). Services rendered by <u>out-of-network providers</u> are not included in the above total <u>out-of-pocket limits</u>. 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.</p>	<p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.</p>
<p>Will you pay less if you use a <u>network provider</u>?</p>	<p>Yes. See www.asrhealthbenefits.com or call 616-957-1751 or 1-800-968-2449 for a list of <u>network providers</u>.</p>	<p>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.</p>
<p>Do you need a <u>referral</u> to see a <u>specialist</u>?</p>	<p>No.</p>	<p>You can see the <u>specialist</u> you choose without a <u>referral</u>.</p>



- All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.
- Eligible charges for outpatient miscellaneous medical supplies, anesthesia, surgery, infusion/injection therapy, diagnostic X-rays, and diagnostic lab tests performed by an in-network provider and billed with a place of service code “11” (physician’s office) or “20” (urgent care center) will be paid at 100% and all applicable deductible amounts will be waived. Any copayment applicable to the physician’s exam will still be assessed.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider’s office or clinic	Primary care visit to treat an injury or illness	No charge for telemedicine e-visit; otherwise \$20 <u>copay/visit</u> (<u>deductible</u> does not apply)	30% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$35 <u>copay/visit</u> and \$20 <u>copay/ day</u> for most chiropractic care (10% <u>coinsurance</u> for chiropractic X-rays); <u>deductible</u> does not apply if <u>copay</u> applies	50% <u>coinsurance</u> for most chiropractic care; otherwise 30% <u>coinsurance</u>	Certification (sometimes called <u>preauthorization</u>) is required for infusion or injection of select products.
	<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>	30% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	\$150 <u>copay/service</u> for most advanced types of X-rays, imaging services, and nuclear radiology services; otherwise 10% <u>coinsurance</u>	30% <u>coinsurance</u>	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.ascendpbm.com	Eligible over-the-counter and generic drugs	\$10 <u>copay/prescription</u> (retail) or \$20 <u>copay/prescription</u> (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). A greater day supply of a maintenance medication may be purchased at a retail pharmacy for an increased <u>copay</u> .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition, cont.	Brand drugs	\$20 <u>copay</u> /prescription (retail) or \$40 <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). A greater day supply of a maintenance medication may be purchased at a retail pharmacy for an increased <u>copay</u> . Specific criteria may have to be met in order for some brand-name medications to be covered.
	<u>Specialty drugs</u>	\$20 <u>copay</u> /prescription (retail or 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>	
If you need immediate medical attention	<u>Emergency room care</u>	\$100 <u>copay</u> /visit; <u>deductible</u> does not apply	\$100 <u>copay</u> /visit; <u>deductible</u> does not apply	<u>Copay</u> may be waived if admitted inpatient.
	<u>Emergency medical transportation</u>	\$50 <u>copay</u> /trip; <u>deductible</u> does not apply	\$50 <u>copay</u> /trip; <u>deductible</u> does not apply	Air ambulance transport is covered only when the patient is taken to the nearest facility that can treat him or her and no other method of <u>emergency medical transportation</u> is appropriate.
	<u>Urgent care</u>	\$50 <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.
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge for telemedicine e-visit, \$20 <u>copay</u> /office visit and for ABA therapy (<u>deductible</u> does not apply), and 10% <u>coinsurance</u> for other outpatient services	\$20 <u>copay</u> /visit for ABA therapy (<u>deductible</u> does not apply); otherwise 30% <u>coinsurance</u>	None
	Inpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Certification (sometimes called <u>preauthorization</u>) is required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	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>	\$20 <u>copay/day</u> ; <u>deductible</u> does not apply	50% <u>coinsurance</u>	Certification (sometimes called <u>preauthorization</u>) is required. 50 outpatient visits/year for physical, speech, and occupational therapies.
	<u>Habilitation services</u>	\$20 <u>copay/day</u> (<u>deductible</u> does not apply) with an eligible diagnosis (e.g., autism spectrum disorder); otherwise not covered	\$20 <u>copay/day</u> (<u>deductible</u> does not apply) with an eligible diagnosis (e.g., autism spectrum disorder); otherwise not covered	
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Certification (sometimes called <u>preauthorization</u>) is required for infusion or injection of select products.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u> for hearing aids; otherwise 50% <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
- Cosmetic surgery
- Dental care (except to the extent required to be covered by Health Care Reform)
- Glasses
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (except to the extent required to be covered by Health Care Reform)
- Routine foot care
- Weight loss programs

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

- Bariatric surgery
- Chiropractic care up to 30 chiropractic visits allowed annually
- Hearing aids up to \$500 paid in any 36-consecutive-month period
- 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>	10%
■ <u>Hospital (facility) coinsurance</u>	10%
■ <u>Other 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:

Cost Sharing	
Deductibles	\$1,000
Copayments	\$30
Coinsurance	\$1,000
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$2,090

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>	\$35
■ <u>Hospital (facility) coinsurance</u>	10%
■ <u>Other 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:

Cost Sharing	
Deductibles	\$600
Copayments	\$1,000
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Joe would pay is	\$1,660

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>	\$100
■ <u>Hospital (facility) coinsurance</u>	0%
■ <u>Other 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:

Cost Sharing	
Deductibles	\$300
Copayments	\$300
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$ 600

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