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?	$0/individual or family for services rendered by in-network providers, and $500/individual or $1,000/family for services rendered by out-of-network providers.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Routine immunizations administered in a pharmacy or at the Department of Community Health, emergency room care, emergency medical transportation, applied behavior analysis (ABA) treatment, and prescription drug coverage are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	The out-of-pocket limits for coinsurance only are $1,500/individual and $3,000/family for services rendered by out-of-network providers. These figures do not include the deductible or any copayments. The total out-of-pocket limits are $7,150/individual and $14,300/family, and they apply to services rendered by in-network providers only. These figures include the deductibles and the coinsurance out-of-pocket limits shown above as well as prescription drug copayments and in-network medical copayments.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.

Important Questions	Answers	Why this Matters:
What is not included in the out-of-pocket limit?	Deductibles and copayments on certain services are not included in the out-of-pocket limits applicable to only coinsurance (but would be included in the total out-of-pocket limits as specified above). Services rendered by out-of-network providers are not included in the above total out-of-pocket limits. In general, out-of-pocket limits do not include penalties; charges that exceed the plan's usual, customary, and reasonable fee allowance or are in excess of stated maximums; premiums; balance-billing charges; and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.asrhealthbenefits.com or call 616-957-1751 or 1-800-968-2449 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

- All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.
- 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) 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 $10 copay/visit	20% coinsurance	None
	Specialist visit	$10 copay/visit (or copay/day for most chiropractic care); no charge for chiropractic X-rays	50% coinsurance for most chiropractic care; 20% coinsurance	Certification (sometimes called preauthorization) is required for infusion or injection of select products.

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, cont.	Preventive care/screening/ immunization	No charge	No charge for routine immunizations administered in a pharmacy or at the Department of Community Health; otherwise 20% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (X-ray, blood work)	No charge	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.ascendpbm.com	Eligible over-the-counter and generic drugs	$10 copay/prescription (retail) or $20 copay/prescription (mail order); deductible 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 copay. Specific criteria may have to be met in order for some brand-name medications to be covered.
	Brand drugs	$20 copay/prescription (retail) or $40 copay/prescription (mail order); deductible does not apply		
	Specialty drugs	$20 copay/prescription (retail or mail order); deductible does not apply		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance	None
	Physician/surgeon fees	No charge	20% coinsurance	
If you need immediate medical attention	Emergency room care	$150 copay/visit	$150 copay/visit	Copay may be waived if admitted inpatient.
	Emergency medical transportation	No charge	No charge	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 emergency medical transportation is appropriate.
	Urgent care	$10 copay/visit	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% coinsurance	Certification (sometimes called preauthorization) is required.
	Physician/surgeon fees	No charge	20% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge for telemedicine e-visit or $10 copay/office visit and for ABA therapy and no charge for other outpatient services	$10 copay/visit for ABA therapy; otherwise 20% coinsurance	None
	Inpatient services	No charge	20% coinsurance	Certification (sometimes called preauthorization) is required.
If you are pregnant	Office visits	No charge	20% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or a deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	20% coinsurance	
	Childbirth/delivery facility services	No charge	20% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	Certification (sometimes called preauthorization) is required.
	Rehabilitation services	$10 copay/day	50% coinsurance	Certification (sometimes called preauthorization) is required. 50 outpatient visits/year for physical, speech, and occupational therapies.
	Habilitation services	$10 copay/day with an eligible diagnosis (e.g., autism spectrum disorder); otherwise not covered	$10 copay/day with an eligible diagnosis (e.g., autism spectrum disorder); otherwise not covered	
	Skilled nursing care	No charge	20% coinsurance	Certification (sometimes called preauthorization) is required for infusion or injection of select products.
	Durable medical equipment	No charge	20% coinsurance for hearing aids; otherwise 50% coinsurance	Certification (sometimes called preauthorization) is required. Vehicle and home modifications are excluded.
	Hospice services	No charge	20% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not covered (except to the extent required by law)	Not covered (except to the extent required by law)	No coverage for routine eye care under the medical plan, except as required by Health Care Reform.
	Children's glasses	Not covered	Not covered	No coverage for glasses under the medical plan.
	Children's dental check-up	Not covered (except to the extent required by law)	Not covered (except to the extent required by law)	No coverage for routine dental care under the medical plan, except as required by Health Care Reform.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- 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 on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: ASR Health Benefits at 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**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes.**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Para obtener asistencia en Español, llame al 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.

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About these Coverage Examples:

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

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

The plan's overall deductible	**$0**
Specialist coinsurance	**0%**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$70**

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

The plan's overall deductible	**$0**
Specialist copayment	**$10**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$720**

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

The plan's overall deductible	**$0**
Specialist copayment	**$150**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(X-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$200**

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