



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.mysmarthealth.org/EPO](http://www.mysmarthealth.org/EPO) or call 1-888-492-6811. 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](http://www.dol.gov/ebsa/healthreform) or call 1-800-318-2596. **Only care received within the Ascension Network (Tier 1) will be covered, unless you have an Approved Referral or in the event of a medical emergency.**

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<b>Ascension Network:</b> \$0 Deductible per ind/ \$0 Deductible per fam. (Does not apply to some in-network benefits.)	Generally you must pay all the costs up to the <b>deductible</b> amount before this plan begins to pay. Check your policy to see when the <b>deductible</b> starts over. See the Common Medical Event chart for how much you pay for covered services after the <b>deductible</b> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes	Preventative care limited to recommended age, frequency, and other guidelines (Ascension Network providers). Routine Physical, Well Baby/Child Care, Routine Immunizations, Annual Gynecological Exam/Annual Mammogram, Screening Colonoscopy (Ascension Network providers).
Are there other <a href="#">deductibles</a> for specific services?	No	You don't have to meet <b>deductibles</b> for specific services, but see the chart starting on page 3 for other costs for services this plan covers.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<b>Ascension Network:</b> \$2,500 OOP per ind/\$5,000 OOP per fam.	The <b>out-of-pocket limit</b> 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 <a href="#">out-of-pocket limit</a> ?	Premiums, balance-billed charges, health care this plan doesn't cover, and pre-authorization penalties.	Even though you pay these expenses, they don't count toward the <b>out- of-pocket limit</b> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. For a list of Ascension Network, see <a href="http://www.mysmarthealth.org/EPO">www.mysmarthealth.org/EPO</a> .	If you use an in-network doctor, 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 <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 3 for how this plan pays.

Do you need a [referral](#) to see a [specialist](#)?

No. You do not need a referral to see a specialist.

You can see the [specialist](#) you choose without permission from this plan



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
		Ascension Network Provider	National Network Provider	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$10 Copay	No coverage without an approved referral	Some services require prior auth, or no benefits are paid.
	<a href="#">Specialist</a> visit	\$25 Copay	No coverage without an approved referral	See above.
	<a href="#">Preventive care/screening</a> /immunization	\$0	No coverage without an approved referral	Limited to recommended age, frequency, and other guidelines.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$75 Copay	No coverage without an approved referral	Some services require prior authorization, or no benefits are paid.
	Imaging (CT scans, PET scans, MRIs)	\$75 Copay CT Scan \$400 Copay PET & MRI	No coverage without an approved referral	Some services require prior authorization, or no benefits are paid.
<b>If you need drugs to treat your illness or condition</b>  More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.mysmarthealth.org/pharmacy">www.mysmarthealth.org/pharmacy</a>	Generic drugs	<a href="#">Ascension Rx</a> Up to \$15 (30 days)	<a href="#">Retail Pharmacy</a> Up to \$15 (30 days)	Some prescription drugs are subject to prior authorization, or no benefits will be paid.
	Preferred brand drugs	20% (Min \$30/ Max \$50) (30 days)	25% (Min \$50/ Max \$100) (30 days)	See above.
	Non-preferred brand drugs	30% (Min \$50/ Max \$100) (30 days)	35% (Min \$60/ Max \$120) (30 days)	See above.
	<a href="#">Specialty drugs</a>	\$200 (30 days)	N/A	See above.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$400 Copay	No coverage without an approved referral	Some services require prior authorization, or no benefits are paid.
	Physician/surgeon fees	Included in facility fee	No coverage without an approved referral	See above.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$500 Copay	Referral not required \$500 Copay	Some services require prior authorization or no benefits are paid.
	<a href="#">Emergency medical transportation</a>	\$200 Copay	Referral not required \$200 Copay	Prior authorization required for non-emergency medical transfer/transport (any kind), or no benefits will be paid.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.mysmarthealth.org/EPO](http://www.mysmarthealth.org/EPO).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Ascension Network Provider	National Network Provider	
<b>If you need immediate medical attention</b>	<a href="#">Urgent care</a>	\$75 Copay	Referral not required \$75 Copay	Some services require prior authorization or no benefits will be paid.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$600 Copay	No coverage without an approved referral	Prior authorization required.
	Physician/surgeon fees	Included in facility fee	No coverage without an approved referral	Prior authorization required.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$10 Copay (Individual/ Group Therapy/E-Visits)	Referral not required \$10 Copay (Individual/ Group Therapy/E-Visits)	Some services require prior authorization or no benefits are paid.
	Inpatient services	\$200 Copay (Partial day treatment/ Intensive Outpatient Therapy/Inpatient Admission/ Acute Inpatient Care)	Referral not required \$200 Copay (Partial day treatment/ Intensive Outpatient Therapy/Inpatient Admission/ Acute Inpatient Care)	Up to 120 days per plan year (Inpatient Admission and Acute Inpatient Care) Some services require prior authorization or no benefits are paid.
<b>If you are pregnant</b>	Office visits	\$50 Copay (once per pregnancy)	No coverage without an approved referral	Some services require prior authorization or no benefits are paid.
	Childbirth/delivery professional services	\$50 Copay	No coverage without an approved referral	See above.
	Childbirth/delivery facility services	Included above	No coverage without an approved referral	See above.
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	\$50 Copay (per day)	No coverage without an approved referral	Up to 100 visits/plan year. Some visits require prior authorization or no benefits are paid.
	<a href="#">Rehabilitation services</a>	\$10 Copay (Physical Therapy) \$25 Copay (Occupational/ Speech Therapy)	No coverage without an approved referral	Up to 60 visits/plan year for physical therapy, occupational therapy, and speech therapy combined. Pulm rehab up to 36 visits/conditions. Some services require prior authorization, or no benefits are paid.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.mysmarthealth.org/EPO](http://www.mysmarthealth.org/EPO).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Ascension Network Provider	National Network Provider	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Habilitation services</a>	\$10 Copay (Physical Therapy) \$25 Copay (Occupational/Speech Therapy)	No coverage without an approved referral	Up to 60 visits/plan year for physical therapy, occupational therapy, and speech therapy combined. Pulm rehab up to 36 visits/conditions. Some services require prior authorization, or no benefits are paid.
	<a href="#">Skilled nursing care</a>	\$500 Copay	No coverage without an approved referral	Up to 120 days/plan year. Some services require prior authorization, or no benefits are paid.
	<a href="#">Durable medical equipment</a>	10% Copay (Annual out of pocket maximum \$250)	No coverage without an approved referral	Some services require prior authorization, or no benefits are paid. Prescription support stockings are limited to 4 pairs/plan year. Hearing aids up to \$2,000/3 plan years.
	<a href="#">Hospice services</a>	\$500 Copay	No coverage without an approved referral	Some services require prior authorization or no benefits are paid.
<b>If your child needs dental or eye care</b>	Children's eye exam	Not covered		
	Children's glasses	Not covered		
	Children's dental check-up	Not covered		

**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      | • Infertility Treatment   | • Private Duty Nursing |
| • Cosmetic Surgery | • Long Term Care  | • Routine Eye Care     |
| • Dental Care      | • Non-emergency care when traveling outside the U.S., its protectorates, Canada or Mexico | • Routine Foot Care    |

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

- |   |   |                        |
|---|---|------------------------|
| • Bariatric surgery                               | • Hearing aids, up to \$2,000/ 3 plan years                                 | • Weight loss programs |
| • Chiropractic Care up to 35 visits per plan year | • Services in Canada, Mexico and U.S. protectorates covered same as in U.S. |                        |

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.mysmarthealth.org/EPO](http://www.mysmarthealth.org/EPO).

**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](http://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](http://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: plan administrator at 1-888-492-6811 or [www.mysmarthealth.org](http://www.mysmarthealth.org).

### 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:

[Spanish (Español): Para obtener ayuda en español, vaya a <https://healthcare.ascension.org/language-assistance>.

[Tagalog (Tagalog): Para sa tulong sa Tagalog, pumunta sa <https://healthcare.ascension.org/language-assistance>.

[Chinese (中文): 如需中文帮助, 请访问 <https://healthcare.ascension.org/language-assistance>.

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' <https://healthcare.ascension.org/language-assistance>.

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*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 [plan's](#) overall [deductible](#) \$0
- [Specialist](#) copayment \$25
- Hospital (facility) copayment \$600
- Other [[cost sharing](#)] 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$2,000
<a href="#">Coinsurance</a>	\$
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,060</b>

### 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 \$25
- Hospital (facility) copayment \$600
- Other [[cost sharing](#)] 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$500
<a href="#">Coinsurance</a>	\$
<i>What isn't covered</i>	
Limits or exclusions	\$800
<b>The total Joe would pay is</b>	<b>\$1,300</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist](#) copayment \$25
- Hospital (facility) copayment \$500
- Other [[cost sharing](#)] 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$1,300
<a href="#">Coinsurance</a>	\$20
<i>What isn't covered</i>	
Limits or exclusions	\$
<b>The total Mia would pay is</b>	<b>\$1,320</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.