



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](http://www.mysmarthealth.org) 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.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<p><b>Ascension Network:</b> \$750 Deductible per ind/ \$1,500 Deductible per fam. <b>National Network:</b> \$3,000 Deductible per ind/\$6,000 Deductible per fam. <b>Out-of-Network:</b> \$5,000 Deductible per ind/ \$10,000 Deductible per fam. (Does not apply to some in-network benefits.)</p>	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 and National Network providers) Routine Physical, Well Baby/Child Care, Routine Immunizations, Annual Gynecological Exam/Annual Mammogram, Screening Colonoscopy (Ascension Network and National 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> ?	<p><b>Ascension Network:</b> \$4,000 OOP per ind/\$8,000 OOP per fam. <b>National Network:</b> \$9,450 OOP per ind/\$18,900 OOP per fam. <b>Out-of- Network:</b> \$12,500 OOP per ind/\$25,000 OOP per fam.</p>	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, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <b>out- of-pocket limit</b> .

<p><b>Will you pay less if you use a <a href="#">network provider</a>?</b></p>	<p>Yes. For a list of Ascension Network or National Network providers, see <a href="http://www.mysmarthealth.org">www.mysmarthealth.org</a>.</p>	<p>If you use an in-network doctor or other health care <b>provider</b>, 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 different kinds of <b>providers</b>.</p>
<p><b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b></p>	<p>No. You do not need a referral to see a specialist.</p>	<p>You can see the <b>specialist</b> you choose without permission from this plan</p>



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	Out-of-Network Provider	
If you visit a health care <a href="#">provider's office or clinic</a>	Primary care visit to treat an injury or illness	\$30 Copay	40% after Deductible	50% after Deductible	Some services require prior authorization, or no benefits are paid.
	<a href="#">Specialist</a> visit	\$60 Copay	40% after Deductible	50% after Deductible	See above.
	<a href="#">Preventive care/screening/immunization</a>	\$0	\$0	50% after Deductible	Limited to recommended age, frequency, and other guidelines.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% after Deductible	40% after Deductible	50% after Deductible	Some services require prior authorization, or no benefits are paid.
	Imaging (CT scans, PET scans, MRIs)	20% after Deductible	40% after Deductible	50% after Deductible	Some services require prior authorization, or no benefits are paid.
If you need drugs to treat your illness or condition  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	Up to \$20 (30 days)	Up to \$25 (30 days)	N/A	Some prescription drugs are subject to prior authorization, or no benefits will be paid.
	Preferred brand drugs	20% (Min \$0/ Max \$50) (30 days)	25% (Min \$0/ Max \$100) (30 days)	N/A	See above.
	Non-preferred brand drugs	30% (Min \$0/ Max \$150) (30 days)	35% (Min \$0/ Max \$150) (30 days)	N/A	See above.
	<a href="#">Specialty drugs</a>	40% (Max \$200 - Generic & Preferred) 40% (Max \$350 - Non-Preferred) (30 days)	N/A	N/A	See above.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% after Deductible	40% after Deductible	50% after Deductible	Some services require prior authorization, or no benefits are paid.
	Physician/surgeon fees	20% after Deductible	40% after Deductible	50% after Deductible	See above.
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$500 Copay	\$500 Copay	\$500 Copay	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](http://www.mysmarthealth.org).

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Ascension Network Provider	National Network Provider	Out-of-Network Provider	
If you need immediate medical attention	<a href="#">Emergency medical transportation</a>	20% after Deductible	20% after Ascension Network Deductible	20% after Ascension Network Deductible	Prior authorization required for non-emergency medical transfer/transport (any kind), or no benefits will be paid.
	<a href="#">Urgent care</a>	\$75 Copay	\$200 Copay after Deductible	\$200 Copay after National Network Deductible	Some services require prior authorization or no benefits will be paid.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% after Deductible	40% after Deductible	50% after Deductible	Prior authorization required
	Physician/surgeon fees	20% after Deductible	40% after Deductible	50% after Deductible	Prior authorization required
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 copay (Individual/ Group Therapy/ E-Visits)	\$30 copay (Individual/ Group Therapy/ E-Visits)	50% after Deductible (Individual/ Group Therapy/ E-Visits)	Some services require prior authorization or no benefits are paid
	Inpatient services	20% after Deductible (Partial day treatment/ Intensive Outpatient Therapy/Inpatient Admission/ Acute Inpatient Care)	20% after Ascension Network Deductible (Partial day treatment/ Intensive Outpatient Therapy/Inpatient Admission/ Acute Inpatient Care)	50% after Deductible (Partial day treatment/ Intensive Outpatient Therapy/Inpatient Admission/ Acute Inpatient Care)	Some services require prior authorization or no benefits are paid
If you are pregnant	Office visits	20% after Deductible	40% after Deductible	50% after Deductible	Some services require prior authorization or no benefits are paid
	Childbirth/delivery professional services	20% after Deductible	40% after Deductible	50% after Deductible	See above
	Childbirth/delivery facility services	20% after Deductible	40% after Deductible	50% after Deductible	See above
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% after Deductible	40% after Deductible	50% after Deductible	Up to 100 visits/plan year. Some visits require prior authorization or no benefits are paid.

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Ascension Network Provider	National Network Provider	Out-of-Network Provider	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Rehabilitation services</a>	20% after Deductible (Occupational/ Physical/ Speech Therapy)	40% after Deductible	50% after Deductible	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="#">Habilitation services</a>	20% after Deductible (Occupational/ Physical/ Speech Therapy)	40% after Deductible	50% after Deductible	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>	20% after Deductible	40% after Deductible	50% after Deductible	Up to 120 days/plan year. Some services require prior authorization, or no benefits are paid.
	<a href="#">Durable medical equipment</a>	20% after Deductible (Annual out of pocket maximum \$250)	40% after Deductible	50% after Deductible	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>	20% after Deductible	40% after Deductible	50% after Deductible	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	Not covered	Not covered	
	Children's glasses	Not covered	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	Not covered	

**Excluded Services & Other Covered Services:**

<b>Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a>.)</b>		
<ul style="list-style-type: none"> <li>● Acupuncture</li> <li>● Cosmetic Surgery</li> <li>● Dental Care</li> </ul>	<ul style="list-style-type: none"> <li>● Infertility Treatment</li> <li>● Long Term Care</li> <li>● Non-emergency care when traveling outside the U.S., its protectorates, Canada or Mexico</li> </ul>	<ul style="list-style-type: none"> <li>● Private Duty Nursing</li> <li>● Routine Eye Care</li> <li>● Routine Foot Care</li> </ul>

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**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.

**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 [Language Assistance | Ascension](#)

[Tagalog (Tagalog): Para sa tulong sa Tagalog, pumunta sa [Language Assistance | Ascension](#)

[Chinese (中文): 如需中文帮助, 请访问 [Language Assistance | Ascension](#)

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' [Language Assistance | Ascension](#)

*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](#) \$750
- [Specialist](#) copayment \$60
- Hospital (facility) copayment \$
- Other [[cost sharing](#)] 20%

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>	\$750
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$2,400
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,220</b>

**Managing Joe's Type 2 Diabetes**

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$750
- [Specialist](#) copayment \$60
- Hospital (facility) copayment \$
- 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>	\$100
<a href="#">Copayments</a>	\$900
<a href="#">Coinsurance</a>	\$
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,020</b>

**Mia's Simple Fracture**

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

- The [plan's](#) overall [deductible](#) \$750
- [Specialist](#) copayment \$60
- Hospital (facility) copayment \$
- Other [[cost sharing](#)] 20%

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>	\$750
<a href="#">Copayments</a>	\$500
<a href="#">Coinsurance</a>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$
<b>The total Mia would pay is</b>	<b>\$1,450</b>

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