



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 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 or call 1-800-318-2596.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	Ascension Network: \$500 Deductible per ind/ \$1,000 Deductible per fam. BlueChoice Options Network (IL): \$4,000 Deductible per ind/\$8,000 Deductible per fam. Out-of-Network: \$10,000 Deductible per ind/\$20,000 Deductible per fam. (Does not apply to some in-network benefits.)	Generally you must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay. Check your policy to see when the <u>deductible</u> starts over. See the Common Medical Event chart for how much you pay for covered services after the <u>deductible</u> .
Are there services covered before you meet your deductible ?	Yes	Preventative care limited to recommended age, frequency, and other guidelines (Ascension Network and BlueChoice Options Network (IL) providers) Routine Physical, Well Baby/Child Care, Routine Immunizations, Annual Gynecological Exam/Mammogram Screening, Colonoscopy (Ascension Network and BlueChoice Options Network (IL) providers) See: mysmarthealth.org/member-resources/preventive-care
Are there other deductibles for specific services?	No	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 3 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan ?	Ascension Network: \$2,500 OOP per ind/\$5,000 OOP per fam. BlueChoice Options Network (IL): \$10,600 OOP per ind/\$21,200 OOP per fam. Out-of- Network: \$13,000 OOP per ind/\$26,000 OOP per fam.	The <u>out-of-pocket limit</u> 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	Premiums, balance-billed charges, and	Even though you pay these expenses, they don't count toward the <u>out- of-pocket limit</u> .

the out-of-pocket limit ?	health care this plan doesn't cover.	
Will you pay less if you use a network provider ?	Yes. For a list of Ascension Network or BlueChoice Options Network (IL) providers, see www.mysmarthealth.org .	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 3 for how this plan pays different kinds of providers .
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	BlueChoice Options Network (IL) Provider	Out-of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$15 Copay	40% after Deductible	50% after Deductible	Some services require prior auth, or no benefits are paid.
	Specialist visit	\$30 Copay	40% after Deductible	50% after Deductible	See above.
	Preventive care/screening / immunization	\$0	\$0	50% after Deductible	Limited to recommended age, frequency, and other guidelines.
If you have a test	Diagnostic test (x-ray, blood work)	10% after Deductible	40% after Deductible	50% after Deductible	Some services require prior authorization, or no benefits are paid.
	Imaging (Ct scans, PET scans, MRIs)	10% 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 prescription drug coverage is available at www.mysmarthealth.org/plan-coverage/pharmacy	Generic drugs	\$5 Copay (30 days)	\$5 Copay (30 days)	N/A	Some prescription drugs are subject to prior authorization, or no benefits will be paid.
	Preferred brand drugs	\$25 Copay (30 days)	\$25 Copay (30 days)	N/A	See above.
	Non-preferred brand drugs	\$35 Copay (30 days)	\$35 Copay (30 days)	N/A	See above.
	Specialty drugs	\$35 Copay (30 days)	N/A	N/A	See above.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% after Deductible	40% after Deductible	50% after Deductible	Some services require prior authorization, or no benefits are paid.
	Physician/surgeon fees	10% after Deductible	40% after Deductible	50% after Deductible	See above.
If you need immediate medical attention	Emergency room care	\$250 Copay	\$250 Copay	\$250 Copay	Some services require prior authorization or no benefits are paid
	Emergency medical transportation	10% after Deductible	10% after Ascension Network Deductible	10% after Ascension Network Deductible	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.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Ascension Network Provider	BlueChoice Options Network (IL) Provider	Out-of-Network Provider	
	Urgent care	\$25 Copay	\$75 Copay	\$200 Copay after Deductible	Some services require prior authorization or no benefits will be paid.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% after Deductible	40% after Deductible	50% after Deductible	Prior authorization required
	Physician/surgeon fees	10% after Deductible	40% after Deductible	50% after Deductible	Prior authorization required
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$15 copay (Individual/ Group Therapy/ E-Visits)	\$15 copay (Individual/ Group Therapy/ E-Visits)	50% after Deductible	Some services require prior authorization or no benefits are paid
	Inpatient services	10% after Deductible	10% after Ascension Network Deductible	50% after Deductible	Some services require prior authorization or no benefits are paid
If you are pregnant	Office visits	10% after Deductible	40% after Deductible	50% after Deductible	Some services require prior authorization or no benefits are paid
	Childbirth/delivery professional services	10% after Deductible	40% after Deductible	50% after Deductible	See above
	Childbirth/delivery facility services	10% after Deductible	40% after Deductible	50% after Deductible	See above
If you need help recovering or have other special health needs	Home health care	10% after Deductible	40% after Deductible	50% after Deductible	Up to 100 visits/plan year. Some visits require prior authorization or no benefits are paid.
	Rehabilitation services	10% after Deductible	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.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Ascension Network Provider	BlueChoice Options Network (IL) Provider	Out-of-Network Provider	
If you need help recovering or have other special health needs	Habilitation services	10% after Deductible	40% after Deductible	50% after Deductible	See above
	Skilled nursing care	10% after Deductible	40% after Deductible	50% after Deductible	Up to 120 days/plan year. Some services require prior authorization, or no benefits are paid.
	Durable medical equipment	10% after Deductible (Annual out of pocket maximum \$125)	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.
	Hospice services	10% after Deductible	40% after Deductible	50% after Deductible	Some services require prior authorization or no benefits are paid
If your child needs dental or eye care	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:

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. | |

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

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

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.

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 asistencia en Español, llame al [Language Assistance | Ascension](#)

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [Language Assistance | Ascension](#)

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 [Language Assistance | Ascension](#)

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

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.02** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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](#) \$500
- [Specialist copayment](#) \$30
- Hospital (facility) [\[cost sharing\]](#) 10%
- Other

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	\$500
Copayments	\$10
Coinsurance	\$1,200
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$1,770

Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$500
- [Specialist copayment](#) \$30
- Hospital (facility) [\[cost sharing\]](#) 10%
- Other

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	\$100
Copayments	\$700
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$820

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$500
- [Specialist copayment](#) \$30
- Hospital (facility) [copayment](#) \$250
- Other

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	\$500
Copayments	\$300
Coinsurance	\$100
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$900

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