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 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. **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 deductible?	**Ascension Network:** $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 **deductible** amount before this plan begins to pay. Check your policy to see when the **deductible** starts over. See the Common Medical Event chart for how much you pay for covered services after the **deductible**.
Are there services covered before you meet your deductible?	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 deductibles for specific services?	No	You don't have to meet **deductibles** 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:** $3,000 OOP per ind/$6,000 OOP per fam.	The **out-of-pocket limit** 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 out-of-pocket limit?	Premiums, balance-billed 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. For a list of Ascension Network, see www.mysmarthealth.org/EPO	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 **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.

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	
If you visit a health care provider's office or clinic	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.
	Specialist visit	$25 Copay	No coverage without an approved referral	See above.
	Preventive care/ screening/immunization	$0	No coverage without an approved referral	Limited to recommended age, frequency, and other guidelines.
If you have a test	Diagnostic test (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.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.mysmarthealth.org/pharmacy**	Generic drugs	Ascension Rx Up to $20 (30 days)	Retail Pharmacy Up to $25 (30 days)	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)	See above.
	Non-preferred brand drugs	30% (Min $0/ Max $150) (30 days)	35% (Min $0/ Max $150) (30 days)	See above.
	Specialty drugs	40% (Max $200 - Generic & Preferred) 40% (Max $350 - Non-Preferred) (30 days)	N/A	See above.
If you have outpatient surgery	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.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Ascension Network Provider	National Network Provider	
If you need immediate medical attention	Emergency room care	$500 Copay	Referral not required $500 Copay	Some services require prior authorization or no benefits are paid.
	Emergency medical transportation	$200 Copay	Referral not required $200 Copay	Prior authorization required for non-emergency medical transfer/ transport (any kind), or no benefits will be paid.
If you need immediate medical attention	Urgent care	$75 Copay	Referral not required $75 Copay	Some services require prior authorization or no benefits will be paid.
If you have a hospital stay	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.
If you need mental health, behavioral health, or substance abuse services	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)	Some services require prior authorization or no benefits are paid.
If you are pregnant	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.
If you need help recovering or have other special health needs	Home health care	$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.

* For more information about limitations and exceptions, see the plan or policy document at 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	
If you need help recovering or have other special health needs	Rehabilitation services	$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.
	Habilitation services	$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.
	Skilled nursing care	$500 Copay	No coverage without an approved referral	Up to 120 days/plan year. Some services require prior authorization, or no benefits are paid.
	Durable medical equipment	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.
	Hospice services	$500 Copay	No coverage without an approved referral	Some services require prior authorization or no benefits are paid.
If your child needs dental or eye care	Children's eye exam	Not covered		
	Children's glasses	Not covered		
	Children's dental check-up	Not covered		

Excluded Services & Other Covered Services:

* For more information about limitations and exceptions, see the plan or policy document at www.mysmarthealth.org/EPO.

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 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.

* For more information about limitations and exceptions, see the plan or policy document at www.mysmarthealth.org/EPO.

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, kwiijigo holne' Language Assistance | Ascension

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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)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$1,400
Coinsurance	$
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,460**

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]*** **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	$800
Coinsurance	$
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** **$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)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$1,000
Coinsurance	$20
What isn't covered	
Limits or exclusions	$
The total Mia would pay is	**$1,020**

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