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:** $375 Deductible per ind/ $750 Deductible per fam. **National Network:** $3,000 Deductible per ind/$6,000 Deductible per fam. **Out-of-Network:** $5,000 Deductible per ind/ $10,000 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 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 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:** $2,000 OOP per ind/$4,000 OOP per fam. **National Network:** $9,450 OOP per ind/$18,900 OOP per fam. **Out-of- Network:** $12,500 OOP per ind/$25,000 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 or National Network 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	National Network 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/pharmacy**	Generic drugs	$0 Copay (30 days)	$0 Copay (30 days)	N/A	Some prescription drugs are subject to prior authorization, or no benefits will be paid.
	Preferred brand drugs	$15 Copay (30 days)	$15 Copay (30 days)	N/A	See above.
	Non-preferred brand drugs	$25 Copay (30 days)	$25 Copay (30 days)	N/A	See above.
	Specialty drugs	$25 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	National Network Provider	Out-of-Network Provider	
	Urgent care	$37 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)	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	10% after Ascension Network Deductible	50% after Deductible	Some services require prior authorization or no benefits are paid
	Childbirth/delivery professional services	10% after Deductible	10% after Ascension Network Deductible	50% after Deductible	See above
	Childbirth/delivery facility services	10% after Deductible	10% after Ascension Network 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.

* 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	National Network 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
- Cosmetic Surgery
- Dental Care
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S., its protectorates, Canada or Mexico
- Private Duty Nursing
- Routine Eye Care
- 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
- Chiropractic Care up to 35 visits per plan year
- Hearing aids, up to $2,000/ 3 plan years
- Services in Canada, Mexico and U.S. protectorates covered same as in U.S.
- Weight loss programs

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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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.

* For more information about limitations and exceptions, see the plan or policy document at 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, kwiijigo holne' Language Assistance | Ascension

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** **$375**
- **Specialist *copayment*** **$30**
- **Hospital (facility) *copayment*** **$**
- **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	$375
Copayments	$1,200
Coinsurance	$
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,635**

Managing Joe's Type 2 Diabetes

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

- **The plan's overall deductible** **$375**
- **Specialist *copayment*** **$30**
- **Hospital (facility) *copayment*** **$**
- **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	$600
Coinsurance	$
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** **$375**
- **Specialist *copayment*** **$30**
- **Hospital (facility) *copayment*** **$**
- **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	$375
Copayments	$300
Coinsurance	$100
What isn't covered	
Limits or exclusions	$
The total Mia would pay is	**$775**

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