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, see www.ascensionpersonalizedcare.com or call 833-600-1311. 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 https://www.ascensionpersonalizedcare.com/ or call 833-600-1311 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0** at Indian Health Care Provider (IHCP); or **$0** Individual / **$0** Family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. **$5,000** Individual / **$10,000** Family for prescription drug coverage.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers **$9,100** individual / **$18,200** family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out–of–pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, penalties for failure to obtain preauthorization for services, 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. See www.ascensionpersonalizedcare.com or call 833-600-1311 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP Provider In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge	$50 copay/visit	Not covered	——————none——————
	Specialist visit	No charge	$100 copay/visit	Not covered	——————none——————
	Preventive care/screening/ immunization	No charge	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	$100 copay/service	Not covered	Some services may require prior authorization, or no benefits will be paid. See your policy for more details.
	Imaging (CT/PET scans, MRIs)	No charge	$200 copay/service	Not covered	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.ascensionpers	Generic drugs	No charge	$30 copay/prescription	Not covered	Coverage is limited up to 30-day supply (retail) and 90-day supply (home delivery); up to a 30-day supply (retail and home delivery) for Specialty drugs. Certain limitations may apply including, for example: prior authorization, step therapy, quantity limits.
	Preferred brand drugs	No charge	$150 copay/prescription	Not covered	

* For more information about limitations and exceptions, see the plan or policy document at www.ascensionpersonalizedcare.com.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP Provider In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	
onalizedcare.com/pharmacy/2023_drug_formulary	Non-preferred brand drugs	No charge	$250 copay/prescription	Not covered	For drugs in the Cigna Patient Assurance Program you may pay less than the noted retail or home delivery cost share amounts. In-network Federally required preventive drugs will be provided at no charge. Some services may require prior authorization, or no benefits will be paid. See your policy for more details.
	Specialty drugs	No charge	Rx deductible + 50% coinsurance	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	$1,000 copay/procedure	Not covered	Some services may require prior authorization, or no benefits will be paid. See your policy for more details.
	Physician/surgeon fees	No charge	$200 copay/procedure	Not covered	See Above.
If you need immediate medical attention	Emergency room care	No charge	$1,000 copay/visit	$1,000 copay/visit	Emergency hospital admissions require authorization within 48 hours following admission.
	Emergency medical transportation	No charge	$1,000 copay/visit	$1,000 copay/visit	Non-emergent Ambulance not covered Out-of-Network.
	Urgent care	No charge	50% coinsurance	Not covered	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	$2,000 copay/day	Not covered	Prior authorization is required, or no benefits will be paid.
	Physician/surgeon fees	No charge	No charge	Not covered	Physician/surgeon fees included in Facility fee copayment. Prior authorization is required, or no benefits will be paid.

* For more information about limitations and exceptions, see the plan or policy document at www.ascensionpersonalizedcare.com.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP Provider In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	$50 copay/visit	Not covered	None
	Inpatient services	No charge	$2,000 copay/day	Not covered	
If you are pregnant	Office visits	No charge	$50 copay/visit	Not covered	Depending on the type of service a copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	$2,000 copay	Not covered	Childbirth/delivery professional services included in facility services copayment.
	Childbirth/delivery facility services	No charge	$2,000 copay	Not covered	Prior authorization is required for vaginal deliveries requiring more than a 48 hour stay, and for cesarean section deliveries requiring more than a 96 hour stay, or no benefits will be paid.
If you need help recovering or have other special health needs	Home health care	No charge	50% coinsurance	Not covered	Limited to 60 visits per member per year. Some services may require prior authorization, or no benefits will be paid. See your policy for more details.
	Rehabilitation services	No charge	$100 copay/visit	Not covered	Limited to 20 visits per year. The limit on the number of visits for therapy applies to all visits for that therapy, whether received in a Practitioner's office, outpatient facility or home health setting. Cardiac and pulmonary therapy limited to 36 visits per year.

* For more information about limitations and exceptions, see the plan or policy document at www.ascensionpersonalizedcare.com.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP Provider In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	
	Habilitation services	No charge	$100 copay/visit	Not covered	Limited to 20 visits per year. The limit on the number of visits for therapy applies to all visits for that therapy, whether received in a Practitioner's office, outpatient facility or home health setting. Cardiac and pulmonary therapy limited to 36 visits per year.
	Skilled nursing care	No charge	$2,000 copay/day	Not covered	Skilled Nursing and Rehabilitation Facility limited to 60 days/year combined.
	Durable medical equipment	No charge	50% coinsurance	Not covered	Durable medical equipment over $500 requires prior authorization. See your policy for more details.
	Hospice services	No charge	$2,000 copay	Not covered	Prior Authorization required for Inpatient Hospice.
If your child needs dental or eye care	Children's eye exam	No charge	$50 copay/visit	Not covered	Limited to 1 exam per Benefit Period
	Children's glasses	No charge	50% coinsurance	Not covered	Limited to 1 item per Benefit Period
	Children's dental check-up	Not covered	Not covered	Not covered	Not covered.

* For more information about limitations and exceptions, see the plan or policy document at www.ascensionpersonalizedcare.com.

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.)

- Abortion (except when the life of the mother is endangered)
- Acupuncture
- Bariatric surgery
- Children's dental check-up
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

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

- Chiropractic care
- Tobacco cessation

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: the plan, administered by US Health and Life, at 833-600-1311 or http://www.ascensionpersonalizedcare.com, the Tennessee Department of Commerce & Insurance, 500 James Robertson Pkwy, Nashville, TN 37243 at 615-741-2241 or https://www.tn.gov/commerce/insurance-division.html, the U.S. Department of Health and Human Services at 1-877-696-6775 or https://www.hhs.gov/. 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: Tennessee Department of Commerce & Insurance at https://www.tn.gov/commerce/insurance-division.html.

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? Not Applicable.
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 833-600-1311.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 833-600-1311.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 833-600-1311.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 833-600-1311.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see the plan or policy document at www.ascensionpersonalizedcare.com.

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	**$100**
Hospital (facility) copayment	**$2,000**
Other coinsurance	**50%**

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	$3,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,060**

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	**$100**
Hospital (facility) copayment	**$2,000**
Other coinsurance	**50%**

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	$4,000
Coinsurance	$400
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$4,420**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$0**
Specialist copayment	**$100**
Hospital (facility) copayment	**$2,000**
Other coinsurance	**50%**

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	$2,000
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,100**

Note: These numbers assume the patient received care from an IHCP provider or with IHCP referral at a non-IHCP. If you receive care from a non-IHCP provider without a referral from an IHCP your costs may be higher.

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

Spanish	Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de US Health and Life Insurance Company, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-833-600-1311.
Arabic	صوصخب ةلئسأ هدعاست صخش ىدل وأ كيدل ناك نإ ،US Health and Life Insurance Company إن قحلا كيدلف .1-833-600-1311 بـ لصتا مجرتم عم ثدحتلل .ةفلكت ةيا نود نم كتغلب ةيرورضلا تامولعملاو ةدعاسملا بلع لوصحلا يف
Chinese	如果您，或您正在幫助的人，有關於US Health and Life Insurance Company方面的問 題，您有權利免費以您的母語得到幫助和訊息。想要跟一位翻譯員通話，請致電1-833-600-1311。
Vietnamese	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về US Health and Life, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình hoàn toàn miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-833-600-1311.
Albanian	Nëse ju, ose dikush që po ndihmoni, ka pyetje për US Health and Life, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin 1-833-600-1311.
Korean	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 US Health and Life에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-833-600-1311로 전화하십시오.
Bengali	যদি আপদি, অথবা আপদি অিয কাউকক সহায়তা করকেি, সম্পককে প্রশ্ন আকে US Health and Life, আপিার অদিকার আকে দবিা খরকে আপিার দিজস্ব ভাষাকত সাহাযয পাবার এবং তথয জাি্বার। অিুবাি্ককর সাকথ কথা বলার জিয, কল করুি 1-833-600-1311.
Polish	Jeśli Ty lub osoba, której pomagasz ,macie pytania odnośnie US Health and Life, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku .Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-833-600-1311.
German	Falls Sie oder jemand, dem Sie helfen, Fragen zumUS Health and Life Insurance Company haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-833-600-1311 an.
Italian	Se tu o qualcuno che stai aiutando avete domande su US Health and Life Insurance Company, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-833-600-1311.
Japanese	ご本人様、またはお客様の身の回りの方でも、US Health and Life Insurance Company についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-833-600-1311までお電話ください。
Russian	Если у вас или лица, которому вы помогаете, имеются вопросы по поводу US Health and Life Insurance Company, то вы имеете право на бесплатное получение помощи иинформации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-833-600-1311.
Serbo-Croatian	Ukoliko Vi ili neko kome Vi pomažete ima pitanje o US Health and Life Insurance Company, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, nazovite 1-833-600-1311.
Tagalog	Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa US Health and Life Insurance Company, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-833-600-1311.
Swahili	Kama wewe, au mtu unaye mpa usaidizi ana maswali kuhusu US Health and Life Insurance Company, Una haki ya kupata habari hii na msaada kwa lugha yako bila gharama. Kuzungumza na mkalimani, piga nambari hii: 1-833-600-1311.