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.healthcare.gov/sbc-glossary or call 833-600-1311 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0 Individual / $0 Family Network providers.	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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$1,900 Individual / $3,800 Family for Network providers.	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
		Network Provider (You will pay the least)	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	$25 copay/visit	Not covered	——————none——————
	Specialist visit	$50 copay/visit	Not covered	——————none——————
	Preventive care/screening/ immunization	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)	$200 copay/visit	Not covered	X-ray services covered at $200 copayment; Laboratory services covered at $100 copayment.
	Imaging (CT/PET scans, MRIs)	$200 copay/visit	Not covered	Some services may require prior authorization, or no benefits will be paid. See your policy for more details.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.ascensionpersonalizedcare.com/-/media/project/aca/aca/pharmacy/2024_drug_formulary.pdf	Generic drugs	$25 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. Some services may require prior authorization, or no benefits will be paid. See your policy for more details.
	Preferred brand drugs	$50 copay/prescription	Not covered	
	Non-preferred brand drugs	40% coinsurance	Not covered	
	Specialty drugs	40% coinsurance	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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$1,000 copay/visit	Not covered	Some services may require prior authorization, or no benefits will be paid. See your policy for more details.
	Physician/surgeon fees	$100 copay/visit	Not covered	See Above.
If you need immediate medical attention	Emergency room care	$1,000 copay/visit	$1,000 copay/visit	Emergency hospital admissions require authorization within 48 hours following admission.
	Emergency medical transportation	$1,000 copay/visit	$1,000 copay/visit	Non-emergent Ambulance not covered Out-of-Network.
	Urgent care	$100 copay/visit	Not covered	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	40% coinsurance	Not covered	Prior authorization is required, or no benefits will be paid.
	Physician/surgeon fees	40% coinsurance	Not covered	Prior authorization is required, or no benefits will be paid.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/visit	Not covered	Prior authorization is required, or no benefits will be paid.
	Inpatient services	40% coinsurance	Not covered	Prior authorization is required, or no benefits will be paid.
If you are pregnant	Office visits	$25 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	40% coinsurance	Not covered	——————none——————
	Childbirth/delivery facility services	40% coinsurance	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.

* 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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	40% coinsurance	Not covered	Limited to 100 visits per benefit period. Some services may require prior authorization, or no benefits will be paid. See your policy for more details.
	Rehabilitation services	$100 copay/visit	Not covered	Speech Therapy limited to 20 services per benefit period. Outpatient rehabilitation services limited to 20 visits per benefit period for P.T. and 20 visits per benefit period for O.T. Some services may require prior authorization, or no benefits will be paid. See your policy for more details.
	Habilitation services	$100 copay/visit	Not covered	Speech Therapy limited to 20 services per benefit period. Outpatient rehabilitation services limited to 20 visits per benefit period for P.T. and 20 visits per benefit period for O.T. Some services may require prior authorization, or no benefits will be paid. See your policy for more details.
	Skilled nursing care	40% coinsurance	Not covered	Limited to 90 days per plan year. Prior authorization is required, or no benefits will be paid.
	Durable medical equipment	40% coinsurance	Not covered	Limited to one wig per member per benefit period. Some services may require prior authorization, or no benefits will be paid. See your policy for more details.
	Hospice services	40% coinsurance	Not covered	——————none——————
If your child needs dental or eye care	Children's eye exam	$30 copay	Not covered	Limited to 1 exam per year.
	Children's glasses	40% coinsurance	Not covered	Limited to 1 item per year.
	Children's dental check-up	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
- Acupuncture
- Bariatric surgery
- Children's dental check-up
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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 (limited to 12 visits per year)
- Private-duty nursing

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 Indiana Department of Insurance, 311 W. Washington Street Suite 100, Indianapolis, IN 46204 at 1-800-622-4461 or https://www.in.gov/idoi/, 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: Indiana Department of Insurance at https://www.in.gov/idoi/.

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.

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	**$50**
Hospital (facility) coinsurance	**40%**
Other coinsurance	**40%**

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	$1,000
Coinsurance	$900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,960**

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	**$50**
Hospital (facility) coinsurance	**40%**
Other coinsurance	**40%**

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	$500
Coinsurance	$1,400
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,920**

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

The plan's overall deductible	**$0**
Specialist copayment	**$50**
Hospital (facility) coinsurance	**40%**
Other coinsurance	**40%**

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	$1,600
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

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 بدل وأ كيدل ناك نإ US Health and Life Insurance Company، إن قحلا كيدلف ـب لصتا مجرتم عم ثدحتلل .ةفلكت ةيا نود نم كتغلب ةيرورضلا تاموللعملاو ةدعاسملا بلع لوصحلا يف 1-833-600-1311.
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 namkalimani, piga nambari hii: 1-833-600-1311.