

## 2025 SmartHealth Medical Plan Options

SmartHealth PPO Copay Plan Option							SmartHealth HDHP Option					
	Ascension Network		BlueChoice Options Network (IL)		Out-of-Network		Ascension Network		BlueChoice Options Network (IL)		Out-of-Network	
<b>Annual Deductible</b>	<i>All eligible expenses apply toward all deductibles.</i>						<i>All eligible expenses apply toward all deductibles.</i>					
Single	\$1,000		\$4,000		\$6,000		\$2,500		\$7,500		\$10,000	
Family	\$2,000		\$8,000		\$12,000		\$5,000		\$15,000		\$20,000	
<b>Total Annual OOP max including Deductible</b>	<i>All eligible expenses apply toward all OOP maximums. Copays do not apply to the deductible.</i>						<i>All eligible expenses apply toward all OOP maximums.</i>					
Single	\$4,500		\$9,200		\$12,500		\$4,500		\$9,200		\$13,000	
Family	\$9,000		\$18,400		\$25,000		\$9,000		\$18,400		\$26,000	
<b>Inpatient/Outpatient Services</b>	<b>Copay/Coinsurance</b>						<b>Copay/Coinsurance</b>					
Inpatient Hospital Services	20% after deductible		40% after deductible		50% after deductible		15% after deductible		40% after deductible		50% after deductible	
Outpatient Services (i.e. Lab, Radiology)	20% after deductible		40% after deductible		50% after deductible		15% after deductible		40% after deductible		50% after deductible	
Urgent Care	\$50 copay		\$75 copay		\$200 copay after BlueChoice Options Network (IL) deductible		15% after deductible		\$200 copay after deductible		\$200 copay after Blue Choice Options Network (IL) deductible	
Emergency Room Visit	\$500 copay		\$500 copay		\$500 copay		15% after deductible		15% after Ascension Network deductible		15% after Ascension Network deductible	
<b>Physician Office Services</b>	<b>Copay/Coinsurance</b>						<b>Copay/Coinsurance</b>					
Primary Care Visits (Family Practice/General Internal Medicine/Pediatrics)	\$30 copay		40% after deductible		50% after deductible		15% after deductible		40% after deductible		50% after deductible	
Specialist Visits	\$60 copay		40% after deductible		50% after deductible		15% after deductible		40% after deductible		50% after deductible	
Mental Health Visits (Individual therapy/ group therapy/ e-visits)	\$30 copay		\$30 copay		50% after deductible		15% after deductible		15% after Ascension Network deductible		50% after deductible	
<b>Therapy</b> (Physical/Speech/Occupational) Annual max: 60 visits	20% after deductible		40% after deductible		50% after deductible		15% after deductible		40% after deductible		50% after deductible	
<b>Chiropractic Office Visit</b> Annual max: 35 visits	\$35 copay		40% after deductible		50% after deductible		15% after deductible		40% after deductible		50% after deductible	
<b>Preventive Health Care</b> Adult/Child & Immunizations	\$0		\$0		50% after deductible		\$0		\$0		50% after deductible	
<b>Prescription Drugs</b>	<i>Prescription drugs do not count toward deductibles.</i>						<i>Before satisfying the deductible, the full cost of prescription drugs count toward the deductible. After satisfying the deductible, you pay these co-pays until you reach your OOP maximum.</i>					
	<b>ARx 30-day</b>	<b>ARx 90-day</b>	<b>Retail 30-day</b>	<b>ARx Home Delivery 90-day</b>	<b>ARx Specialty 30-day Generic &amp; Preferred</b>	<b>ARx Specialty 30-day Non-Preferred</b>	<b>ARx 30-day</b>	<b>ARx 90-day</b>	<b>Retail 30-day</b>	<b>ARx Home Delivery 90-day</b>	<b>ARx Specialty 30-day Generic &amp; Preferred</b>	<b>ARx Specialty 30-day Non-Preferred</b>
Generic	Up to \$25.00	Up to \$75.00	Up to \$30.00	Up to \$40.00	N/A	N/A	Up to \$25.00	Up to \$75.00	Up to \$30.00	Up to \$40.00	N/A	N/A
Preferred Brand name	20% (min \$0/ max \$65)	20% (min \$0/ max \$200)	25% (min \$0/ max \$125)	20% (min \$0/ max \$100)	N/A	N/A	20% (min \$0/ max \$65)	20% (min \$0/ max \$200)	25% (min \$0/ max \$125)	20% (min \$0/ max \$100)	N/A	N/A
Non-preferred Brand Name	30% (min \$0/ max \$165)	30% (min \$0/ max \$500)	35% (min \$0/ max \$175)	30% (min \$0/ max \$250)	N/A	N/A	30% (min \$0/ max \$165)	30% (min \$0/ max \$500)	35% (min \$0/ max \$175)	30% (min \$0/ max \$250)	N/A	N/A
Specialty	N/A	N/A	N/A	N/A	40% (max \$200) 40% (max \$250)	40% (max \$400)	N/A	N/A	N/A	N/A	40% (max \$200) 40% (max \$250)	40% (max \$400)
<b>Biweekly Premiums</b>												
<b>Annual Pay Band</b>	\$46,000.00 or less	\$44,000.01 - \$108,000.00	\$108,000.01 - \$223,000.00	\$223,000.01 - \$349,000.00	\$349,000.01 or more	Part-time (all bands)	\$46,000.00 or less	\$44,000.01 - \$108,000.00	\$108,000.01 - \$223,000.00	\$223,000.01 - \$349,000.00	\$349,000.01 or more	Part-time (all bands)
Associate	\$68.92	\$76.61	\$81.73	\$99.00	\$139.00	\$131.70	\$52.52	\$60.09	\$65.13	\$80.00	\$114.00	\$114.33
Associate Plus Spouse or Associate Plus LDB	\$138.59	\$158.56	\$171.88	\$230.20	\$260.20	\$242.26	\$102.41	\$121.90	\$134.90	\$192.89	\$222.89	\$203.56
Associate Plus Child(ren)	\$129.88	\$148.32	\$159.94	\$176.00	\$235.96	\$216.11	\$101.77	\$120.12	\$131.68	\$145.00	\$202.00	\$187.56
Associate Plus Family or Associate Plus Children/LDB	\$199.54	\$230.28	\$250.76	\$316.25	\$346.25	\$356.01	\$142.08	\$171.20	\$190.61	\$255.03	\$285.03	\$290.33

**Notes:** Tobacco Surcharge: If you or a covered family member use tobacco products, a \$50 surcharge will be deducted biweekly from your paycheck.