

## 2024 SmartHealth Medical Plan Options

SmartHealth PPO Copay Plan Option							SmartHealth HDHP Option					
	Ascension Network		National Network		Out-of-Network		Ascension Network		National Network		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	\$750		\$3,000		\$5,000		\$2,000		\$6,000		\$10,000	
Family	\$1,500		\$6,000		\$10,000		\$4,000		\$12,000		\$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	\$4,000		\$9,450		\$12,500		\$3,500		\$8,050		\$12,000	
Family	\$8,000		\$18,900		\$25,000		\$7,000		\$16,100		\$24,000	
<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	\$75 copay		\$200 copay after deductible		\$200 copay after National Network deductible		15% after deductible		\$200 copay after deductible		\$200 copay after National Network 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 \$20.00	Up to \$60.00	Up to \$25.00	Up to \$30.00	N/A	N/A	Up to \$20.00	Up to \$60.00	Up to \$25.00	Up to \$30.00	N/A	N/A
Preferred Brand name	20% (min \$0/ max \$50)	20% (min \$0/ max \$150)	25% (min \$0/ max \$100)	20% (min \$0/ max \$75)	N/A	N/A	20% (min \$0/ max \$50)	20% (min \$0/ max \$150)	25% (min \$0/ max \$100)	20% (min \$0/ max \$75)	N/A	N/A
Non-preferred Brand Name	30% (min \$0/ max \$150)	30% (min \$0/ max \$450)	35% (min \$0/ max \$150)	30% (min \$0/ max \$225)	N/A	N/A	30% (min \$0/ max \$150)	30% (min \$0/ max \$450)	35% (min \$0/ max \$150)	30% (min \$0/ max \$225)	N/A	N/A
Specialty	N/A	N/A	N/A	N/A	40% (max \$200)	40% (max \$350)	N/A	N/A	N/A	N/A	40% (max \$200)	40% (max \$350)
<b>Biweekly Premiums</b>												
<b>Annual Pay Band</b>	\$44,000.00 or less	\$44,000.01 - \$104,000.00	\$104,000.01 - \$215,000.00	\$215,000.01 - \$337,000.00	\$337,000.01 or more	Part-time (all bands)	\$44,000.00 or less	\$44,000.01 - \$104,000.00	\$104,000.01 - \$215,000.00	\$215,000.01 - \$337,000.00	\$337,000.01 or more	Part-time (all bands)
Associate	\$45.00	\$66.00	\$81.00	\$99.00	\$139.00	\$139.00	\$31.00	\$52.00	\$65.00	\$80.00	\$114.00	\$114.00
Associate Plus Spouse or Associate Plus LDB	\$109.76	\$163.00	\$203.00	\$243.00	\$290.00	\$270.00	\$77.81	\$134.00	\$167.00	\$201.00	\$268.58	\$233.58
Associate Plus Child(ren)	\$73.00	\$119.00	\$151.00	\$176.00	\$231.00	\$211.00	\$52.52	\$97.00	\$123.00	\$147.55	\$202.00	\$187.55
Associate Plus Family or Associate Plus Children/LDB	\$148.99	\$227.81	\$286.00	\$350.00	\$380.00	\$353.87	\$101.52	\$182.11	\$230.37	\$299.00	\$329.30	\$294.30

**Notes:** Tobacco Surcharge: If you or a covered family member use tobacco products, a \$30 surcharge will be deducted biweekly from your paycheck.  
 Spousal Surcharge: If your spouse or legally-domiciled beneficiary (LDB) has access to employer-sponsored medical insurance coverage outside of Ascension, a spousal surcharge will be deducted biweekly from your paycheck.