SmartHealth

2026 Schedule of Benefits: PPO OLP Gold Plan

Benefits	Ascension Network Tier 1	National Network Tier 2	Out-of-Network[1] Tier 3
Deductible • Individual • Family All eligible expenses apply toward all Deductibles	N/A N/A	N/A N/A	$500 $1,000
Coinsurance • Plan Pays • You Pay	100% 0%	100% 0%	70% after Deductible 30% after Deductible
Annual Out-Of-Pocket Maximum (Deductible plus coinsurance and copays) Not combined with Rx • Individual • Family All eligible expenses apply toward all OOP Maximums	$3,000 $6,000	$3,000 $6,000	$3,000 $6,000
Lifetime Maximum	Unlimited	Unlimited	Unlimited

Services	Ascension Network Tier 1	National Network Tier 2	Out-of-Network[1] Tier 3
*** Services with an asterisk (*) may require Prior Authorization. For a list of services see: https://mysmarthealth.org/provider-resources/prior-authorization**			
Preventative Services Routine Physicals, Well Baby/Child Care, Routine Immunizations, Annual Gynecological Exam/ Mammogram Screening, Colonoscopy See:mysmarthealth.org/member-resources/preventive-care	$0	$0	Not Covered
Outpatient/ Diagnostic Services Pathology, CT Scans, Diagnostic Infertility Testing, Physical/ Occupational/ Speech Therapy (Annual Maximum for PT, OT, ST - 60 visits combined)	$0 Copay	$0 Copay	30% after Deductible
• Outpatient Surgery (facility fee)*	$0 Copay[2]	$10 Copay[2]	30% after Deductible[2]
• Anesthesia	$0 Copay	$0 Copay	$0 Copay
• Lab	$0 Copay	$0 Copay	30% after Deductible
• Chemotherapy & Radiation • Radiology/X-Ray	$0 Copay $0 Copay	$10 Copay $10 Copay	30% after Deductible
• Dialysis (per treatment)	$0 Copay	$10 Copay	30% after Deductible
High Tech Radiology (non-emergent)* (per visit unless otherwise noted) • MRI and PET scans	$0 Copay [2]	$15 Copay[2]	30% after Deductible[2]

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Office Visits (per visit unless otherwise noted) Primary Care (Family Practice/ General Internal Medicine/ Pediatrics)	$10 Copay	$10 Copay	30% after Deductible
Specialist (including OB/GYN)	$10 Copay	$10 Copay	30% after Deductible
LiveHealth Online Care • Behavioral Health Online Visit • Urgent Care Online Visit	$10 Copay $10 Copay	N/A N/A	N/A N/A
All other E-Visits • Primary Care	$0 Copay	$10 Copay	30% after Deductible
• Specialist	$0 Copay	$10 Copay	30% after Deductible
Pre/Postnatal Care	$0 Copay (Once per pregnancy)	$10 Copay (Once per pregnancy)	30% after Deductible
Chiropractic Visit (Annual maximum - 35 visits) Ancillary services are subject to deductible/ coinsurance	$10 Copay	$10 Copay	$10 Copay
Mental Health (per visit unless otherwise noted) • Individual Therapy/ Group Therapy	$10 Copay	$10 Copay	30% after Deductible
• E-Visits	$10 Copay	$10 Copay	30% after Deductible
• Partial Day Treatment, Intensive Outpatient Therapy	$0 Copay	$0 Copay	30% after Deductible
• Inpatient Admission*	$0 Copay(2)	$0 Copay(2)	30% after Deductible(2)
Substance Use Disorder (per visit unless otherwise noted) • Individual Therapy/ Group Therapy	$10 Copay	$10 Copay	30% after Deductible
• E-Visits	$10 Copay	$10 Copay	30% after Deductible
• Partial Day Treatment/ Intensive Outpatient Therapy	$0 Copay	$0 Copay	30% after Deductible
• Acute Inpatient Care*	$0 Copay(2)	$0 Copay(2)	30% after Deductible(2)
Emergency Care (per visit unless otherwise noted) • ER Visit	$150 Copay (Waived if admitted)	$150 Copay (Waived if admitted)	$150 Copay (Waived if admitted)
• Urgent Care	$0 Copay	$35 Copay	30% after Deductible
• Ambulance	$0 Copay	$50 Copay	$50 Copay
• Medical Transfer/ Transport (non-emergent)*	$0 Copay(2)	$50 Copay(2)	$50 Copay(2)
Inpatient Services (per admission)* Room and Board, Ancillary Services, Surgery, Physician Charges	$0 Copay(2)	$250 Copay(2)	30% after Deductible(2)
• Anesthesia	$0 Copay	$0 Copay	$0 Copay

Inpatient Admission through Emergency Room (Note: Authorization required upon admission.)	$0 Copay	$250 Copay (Maximum of 2 copays per family/per year)	30% after Deductible
Allergy Testing & Treatment	50%(5)	50%(5)	50% after Deductible
Extended Care Facility (per admission)	$0 Copay	$0 Copay	30% after Deductible
Home Health Care (Annual maximum - 100 visits)	$0 Copay	30%(5)	30% after Deductible
Hospice	$0 Copay	30%(5)	30% after Deductible
Other Services* (per provider/ per day) • Durable Medical Equipment (DME)*	$0 Copay(2)	20%(2)(5	30% after Deductible(2)
Prosthetics & Orthotics (P&O)* (Per provider/per day)	$0 Copay(2)	20%(2)(5)	30% after Deductible(2)
Foot Orthotics (2 pairs every 3 years)*	50%(2)(5)	50%(2)(5)	50% after Deductible(2)
Hearing Aid (3-year maximum - $2,000)	50% (5)	50% (5)	50% after Deductible
Bariatric Surgery*	50%(2)(5)	50%(2)(5)	50% after Deductible(2)
Organ/Bone Marrow/Other Transplants*	50%(2)(5)	50%(2)(5)	50% after Deductible(2)
Wellness/ Disease Management (Diabetic Education per Medicare guidelines)	$0 Copay	$0 Copay	Not Covered
Smoking Cessation Intervention (Counseling)	$0 Copay	$0 Copay	50% after Deductible

***Notes: (1) Any claim incurred through an Out-of-Network provider could result in balance billing and/or additional charges to the member. (2) Prior Authorization Required - failure to secure a Prior Authorization for certain services will result in no coverage/benefit paid under the Plan. To review a complete and up-to-date list of the services which require Prior Authorization, go to https://mysmarthealth.org/provider-resources/prior-authorization.. (3) The Ascension network includes all Health Ministries of Ascension - including hospitals, clinics, affiliated providers and senior living facilities. (4) In some instances when services are unavailable from an Ascension Network provider, members may obtain services from a National Network provider and such services will be processed at the Ascension Network benefit level. Benefit Elevation is required in order to obtain such National Network benefits at the Ascension Network benefit level. For more information on the required Benefit Elevation process, go to www.mysmarthealth.org. (5) Unless otherwise noted.**

Exclusions - See the SmartHealth Medical Summary Plan Description at www.mysmarthealth.org for complete information regarding exclusions.

Prescription Drugs - Go to www.mysmarthealth.org/plan-coverage/pharmacy for details about your Health Ministry's prescription drug benefits.

The U.S. Department of Health and Human Services, the Department of Labor, and the Internal Revenue Service have jointly released final regulations regarding women's preventative services under the Affordable Care Act ("ACA"). The ACA requires group health plans to provide coverage for "contraceptive services" as part of an array of women's preventative services that must be included in health plans without cost sharing to covered participants. The regulations contain an accommodation for eligible non-profit religious organizations that oppose providing contraceptive coverage. As a health ministry of the Catholic Church, Ascension Health Alliance d/b/a Ascension does not promote or condone contraceptive practices and objects to providing such coverage. Therefore, as the Plan Sponsor of the self-funded Ascension SmartHealth Medical Plan ("Plan"), which includes prescription drug benefits, Ascension qualifies as an eligible organization that is entitled to the accommodation. As a result, the Plan does not provide coverage for contraceptive benefits that are in conflict with our Catholic Identity and the Ethical and Religious Directives for Catholic Health Care Services. As part of the accommodation, third party administrators of the Plan are required to provide this coverage to covered members at no cost, independently of Ascension and consistent with the authority given them by the final regulations. You will receive information directly from those administrators about the coverage that may be available to you for those "preventative services."

This is a brief summary of benefits, which is subject to change. To resolve any conflict between this summary and the Summary Plan Description, you should consult the Plan document, which will prevail over both this summary and the Summary Plan Description. For further details about Plan benefits, please contact Customer Service at the number shown on the back of your ID card, or view the official Summary Plan Description at www.mysmarthealth.org.

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2026 Schedule of Benefits: Rx - Our Lady of Peace

Prior Authorization Required?	Yes - when applicable. Refer to current formulary.
Quantity Level Limits	Yes
Annual Out-of-Pocket Maximums	Applies to Rx only, not combined with medical $7,600 per individual/ $15,200 per family (Gold Plan)
Mandatory Generic Provision	Yes. If you choose to receive a brand drug when a generic drug is available, your costs will be equal to the brand copayment plus the difference between the generic and the brand drug.
Mandatory Specialty Provision	For more information, please visit www.mysmarthealth.org/plan-coverage/pharmacy
Ascension Rx (30 day supply)	Generic: Up to $0 copay Preferred Brand: $0 copay Non-Preferred Brand: $0 copay
Ascension Rx **(90 day supply)**	Generic: Up to $10 copay Preferred Brand: $37.50 copay Non-Preferred Brand: $75 copay
Retail Benefit (30 day supply)	Generic: Up to $4 copay Preferred Brand: $15 copay Non-Preferred Brand: $30 copay
Ascension Rx Home Delivery (90 day supply)	Generic: Up to $10 copay Preferred Brand: $37.50 copay Non-Preferred Brand: $75 copay
Ascension Rx Specialty Pharmacy **(30 day supply)**	Preferred Brand: $0 copay Non-Preferred Brand: $0 copay
Pharmacy Benefit Manager (PBM)	MaxorPlus (MaxorPlus will become VytlOne effective 01/01/2026)
Mail Order Benefit Manager	Ascension Rx Home Delivery
Specialty Drug Benefit Manager	Ascension Rx Specialty Pharmacy