

2026 SmartHealth Medical Plan Options

SmartHealth Plan Name	SmartHealth EPO HDHP Plan Option	SmartHealth EPO Plan Option	SmartHealth HDHP Option		SmartHealth PPO Plan Option	
Network	Ascension Network	Ascension Network	Ascension Network	National Network	Ascension Network	National Network
Annual Deductible	<i>All eligible expenses apply toward all deductibles.</i>		<i>All eligible expenses apply toward all deductibles.</i>		<i>All eligible expenses apply towards all deductibles</i>	
Single	\$2,000	\$500	\$2,500	\$7,500	\$1,000	\$4,000
Family	\$4,000	\$1,000	\$5,000	\$15,000	\$2,000	\$8,000
Total Annual OOP max including Deductible	<i>All eligible expenses apply toward all OOP maximums.</i>		<i>All eligible expenses apply toward all OOP maximums.</i>		<i>All eligible expenses apply toward all OOP maximums. Copays do not apply to the deductible</i>	
Single	\$4,000	\$4,500	\$5,000	\$8,500	\$5,000	\$10,600
Family	\$8,000	\$9,000	\$10,000	\$17,000	\$10,000	\$21,200
Inpatient/Outpatient Services	Copay/Coinsurance	Copay/Coinsurance	Copay/Coinsurance		Copay/Coinsurance	
Inpatient Hospital Services	10% after deductible	15% after deductible	15% after deductible	40% after deductible	20% after deductible	40% after deductible
Outpatient Services (i.e. Lab, Radiology)	10% after deductible	15% after deductible	15% after deductible	40% after deductible	20% after deductible	40% after deductible
Urgent Care	10% after deductible	\$50 Copay	15% after deductible	\$200 copay after deductible	\$50 copay	\$75 copay
Emergency Room Visit	10% after deductible	\$500 Copay	15% after deductible	15% after Ascension Network deductible	\$500 copay	\$500 copay
Physician Office Services	Copay/Coinsurance	Copay/Coinsurance	Copay/Coinsurance		Copay/Coinsurance	
Primary Care Visits (Family Practice/General Internal Medicine/Pediatrics)	10% after deductible	\$10 Copay	15% after deductible	40% after deductible	\$30 copay	40% after deductible
Specialist Visits	10% after deductible	\$25 Copay	15% after deductible	40% after deductible	\$60 copay	40% after deductible
Mental Health Visits (Individual therapy/ group therapy)	10% after deductible	\$10 Copay	15% after deductible	15% after Ascension Network deductible	\$30 copay	\$30 copay
Therapy (Physical/Speech/Occupational) Annual max: 60 visits	10% after deductible	15% after deductible	15% after deductible	40% after deductible	20% after deductible	40% after deductible
Chiropractic Office Visit Annual max: 35 visits	10% after deductible	\$30 Copay	15% after deductible	40% after deductible	\$35 copay	40% after deductible
Preventive Health Care Adult/Child & Immunizations	\$0	\$0	\$0	\$0	\$0	\$0
Prescription Drugs	<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>	<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>		<i>Prescription drugs do not count toward deductibles.</i>	
Prescription Drug Plan (applies to all SmartHealth medical plans)						
	ARx 30-day supply	ARx 90-day supply	Retail 30-day supply	ARx Home Delivery 90-day	ARx Specialty 30-day Generic & Preferred	ARx Specialty 30-day Non-Preferred
Generic	Up to \$25.00	Up to \$75.00	Up to \$35.00	Up to \$40.00	N/A	N/A
Preferred Brand name	20% (min \$0/ max \$100)	20% (min \$0/ max \$300)	25% (min \$0/ max \$150)	20% (min \$0/ max \$200)	N/A	N/A
Non-preferred Brand Name	30% (min \$0/ max \$175)	30% (min \$0/ max \$525)	35% (min \$0/ max \$225)	30% (min \$0/ max \$350)	N/A	N/A
Specialty	N/A	N/A	N/A	N/A	40% (max \$200/\$250)	40% (max \$425)

Biweekly Premiums

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Annual Pay Bands	Associate Only	Associate + Spouse	Associate + Child(ren)	Associate + Family	Associate Only	Associate + Spouse	Associate + Child(ren)	Associate + Family	Associate Only	Associate + Spouse	Associate + Child(ren)	Associate + Family	Associate Only	Associate + Spouse	Associate + Child(ren)	Associate + Family
Pay Band 1: Up to \$48,000.00	\$14.00	\$44.00	\$29.00	\$50.00	\$28.00	\$85.00	\$46.00	\$94.00	\$34.00	\$87.00	\$62.00	\$109.00	\$48.00	\$115.00	\$78.00	\$154.00
Pay Band 2: \$48,000.01 to \$112,000.00	\$37.00	\$103.00	\$76.00	\$127.00	\$52.00	\$132.00	\$93.00	\$178.00	\$57.00	\$144.00	\$107.00	\$184.00	\$74.00	\$174.00	\$131.00	\$242.00
Pay Band 3: \$112,000.01 to \$231,000.00	\$52.00	\$142.00	\$108.00	\$191.00	\$62.00	\$163.00	\$118.00	\$244.00	\$73.00	\$182.00	\$139.00	\$247.00	\$95.00	\$225.00	\$177.00	\$318.00
Pay Band 4: \$231,000.01 to \$361,000.00	\$74.00	\$187.00	\$135.00	\$243.00	\$90.00	\$214.00	\$160.00	\$284.00	\$94.00	\$226.00	\$169.00	\$298.00	\$128.00	\$295.00	\$228.00	\$399.00
Pay Band 5: Greater than \$361,000.01	\$97.00	\$251.00	\$177.00	\$326.00	\$107.00	\$261.00	\$187.00	\$349.00	\$127.00	\$298.00	\$228.00	\$379.00	\$152.00	\$350.00	\$267.00	\$459.00
Part Time: No Salary Bands	\$97.00	\$219.00	\$168.00	\$275.00	\$107.00	\$229.00	\$178.00	\$293.00	\$127.00	\$271.00	\$219.00	\$329.00	\$152.00	\$303.00	\$256.00	\$385.00

Note: Tobacco Surcharge: If you or a covered family member use tobacco products, a \$50 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.