SmartHealth

2024 Schedule of Benefits: Exclusive Provider Organization (EPO) Plan

Benefits	Ascension Network
Deductible • Individual • Family *All eligible expenses apply toward all OOP Maximums.	$0 $0
Coinsurance • Plan Pays • You Pay	100% 0%
Total Out-Of-Pocket Maximum • Individual • Family *All eligible expenses apply toward all OOP Maximums.	$3,000 $6,000
Lifetime Maximum	Unlimited

Services	Ascension Network	National Network
Preventive Services Routine Physicals, Well Baby/Child Care, Routine Immunizations, Annual Gynecological Exam/ Mammogram Screening, Colonoscopy See: mysmarthealth.org/member-resources/preventive-care	$0	No coverage without an approved referral
Facility Outpatient/ Diagnostic Services (per provider/per day) Radiology, CT Scans, Radiation & Chemotherapy, Diagnostic Infertility Testing, Labs, Ultrasounds (non-Maternity)	$75 Copay	No coverage without an approved referral
Medical Specialty (Physician administered or infusion therapy) • Physician office/home • Outpatient	Prior Authorization Required $150 Copay(2) $300 Copay(2)	No coverage without an approved referral
Outpatient Surgery/Facility Charge Anesthesia, Ancillary Services, Pathology, Physician Charges & Surgery	$400 Copay	No coverage without an approved referral
Outpatient Surgery/Physician's Office	$75 Copay	No coverage without an approved referral
Physical/Occupational/Speech Therapy (Annual maximum for PT, OT, ST - 60 visits combined) • Occupational & Speech Therapy • Physical Therapy	$25 Copay (OT and ST) $10 Copay (PT)	No coverage without an approved referral
Dialysis (per treatment)	$25 Copay	Referral not required $25 Copay
Chiropractic Visit (Annual maximum - 35 visits) Note: Includes manipulation and therapy; x-rays excluded	$30 Copay	No coverage without an approved referral
Facility High Tech Radiology (non-emergent) (per visit unless otherwise noted) Example: MRI and PET scans)	Prior Authorization Required $400 Copay (2)	No coverage without an approved referral

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Office Visits (per visit unless otherwise noted) Primary Care (Family Practice/ General Internal Medicine/ Pediatrics)	$10 Copay	No coverage without an approved referral
Specialist (including OB/GYN)	$25 Copay	No coverage without an approved referral
Amwell Online Care • Behavioral Health Online Visit • Urgent Care Online	$10 Copay $10 Copay	N/A N/A
All other E-Visits • Primary Care • Specialist	$10 Copay $25 Copay	No coverage without an approved referral
Pre/Postnatal Care & Delivery	$50 Copay (Once per pregnancy)	No coverage without an approved referral
• Maternity Imaging (Ultrasound)	$75 Copay to maximum of $150 Copay (per pregnancy)	No coverage without an approved referral
Mental Health[5] (per visit unless otherwise noted) • Individual Therapy/ Group Therapy[5] • E-Visits[5] • Partial Day Treatment/ Intensive Outpatient Therapy[5] • Inpatient Admission[5]	$10 Copay $10 Copay $200 Copay $200 Copay	Referral not required $10 Copay $10 Copay $200 Copay $200 Copay
Substance Use Disorder[5] (per visit unless otherwise noted) • Individual Therapy/ Group Therapy[5] • E-Visits[5] • Partial Day Treatment/ Intensive Outpatient Therapy[5] • Acute Inpatient Care[5]	$10 Copay $10 Copay $200 Copay $200 Copay	Referral not required $10 Copay $10 Copay $200 Copay $200 Copay
Emergency Care[5] (per visit unless otherwise noted) • ER Visit[5]	$500 Copay (Waived if admitted)	Referral not required $500 Copay (Waived if admitted)
• Urgent Care[5]	$75 Copay	Referral not required $75 Copay
• Ambulance[5]	$200 Copay	Referral not required $200 Copay
• Medical Transfer/ Transport[5] (non-emergent)	Prior Authorization Required $200 Copay(2)	Referral not required Prior Authorization Required $200 Copay(2)
Inpatient Services (per admission) Room and Board, Ancillary Services, Surgery, Anesthesia, Physician Charges	Prior Authorization Required $600 Copay (2)	No coverage without an approved referral
Inpatient Admission through Emergency Room (Note: Authorization required upon admission.)	$600 Copay	Referral not required $600 Copay
Allergy Testing & Treatment	$25 Copay (per visit)	No coverage without an approved referral
Extended Care Facility (per admission) (Annual maximum - 120 days)	$500 Copay	No coverage without an approved referral

Home Health Care (Annual maximum - 100 visits)	$50 Copay (per day)	No coverage without an approved referral
Hospice	$500 Copay	No coverage without an approved referral
Other Services (per provider/ per day) • Durable Medical Equipment (DME)	Prior Authorization Required 10% Copay (Annual out of pocket maximum $250) (2)	No coverage without an approved referral
Prosthetics & Orthotics (P&O) (Per provider/per day)	$200 Copay	No coverage without an approved referral
Foot Orthotics (2 pairs every 3 years)	$100 Copay (per pair)	No coverage without an approved referral
Hearing Aid (3-year maximum - $2,000)	$200 Copay	No coverage without an approved referral
Bariatric Surgery	Prior Authorization Required See Inpatient Services (2)	No coverage without an approved referral(2)
Organ/Bone Marrow/Other Transplants	Prior Authorization Required See Inpatient Services (2)	No coverage without an approved referral
Wellness/ Disease Management (Diabetic Education per Medicare guidelines)	$0	No coverage without an approved referral
Smoking Cessation Intervention (Counseling)	$0	No coverage without an approved referral

***Notes: (1) Only care received within the Ascension Network (Tier 1) will be covered, unless you have an EPO Approved Referral or in the event of a medical emergency. If you receive care outside of the Ascension Network (Tier 1) without an EPO Approved Referral, you will pay the full cost of care. (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 those services which require Prior Authorization, go to www.mysmarthealth.org. (3) The Ascension network includes all Health Ministries of Ascension - including hospitals, clinics, affiliated providers and senior living facilities. (4) Any claim incurred through a non-Ascension Network provider could result in balance billing and/or additional charges to the member. (5) An EPO Approved Referral is required when using National Network providers (http://provider.bcbs.com) and Out-of-Network providers except under certain limited circumstances (Emergency Care or Mental Health and Substance Abuse services). All other services received from a non-Ascension Network provider require an EPO Approved Referral.**

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 review the official Summary Plan Description, available online at www.mysmarthealth.org.

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2024 Schedule of Benefits: Rx

Prior Authorization Required?	Yes - when applicable. Refer to current formulary.
Quantity Level Limits	Yes
Out of Pocket Limits	Applies to EPO Plan Participants $3,000 per individual/ $6,000 per family
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 generic 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 $20 copay Preferred Brand: 20% (no minimum/ maximum $50) Non-Preferred Brand: 30% (no minimum/ maximum $150) Ascension Preferred Diabetic Supplies (Strips/Lancets)/ Insulin: $10 copay
Ascension Rx **(90 day supply)**	Generic: Up to $60 copay Preferred Brand: 20% (no minimum/ maximum $150) Non-Preferred Brand: 30% (no minimum/ maximum $450) Ascension Preferred Diabetic Supplies (Strips/Lancets)/ Insulin: $30 copay
Retail Benefit (30 day supply)	Generic: Up to $25 copay Preferred Brand: 25% (no minimum/ maximum $100) Non-Preferred Brand: 35% (no minimum/ maximum $150)
Ascension Rx Home Delivery (90 day supply)	Generic: Up to $30 copay Preferred Brand: 20% (no minimum/ maximum $75) Non-Preferred Brand: 30% (no minimum/ maximum $225) Ascension Preferred Diabetic Supplies (Strips/Lancets)/ Insulin: $25 copay
Ascension Rx Specialty Pharmacy **(30 day supply)**	Specialized Generic: 40% (maximum $200) Preferred Specialty: 40% (maximum $200) Non-Preferred Speciality: 40% (maximum $350)
Pharmacy Benefit Manager (PBM)	MaxorPlus
Mail Order Benefit Manager	Ascension Rx Home Delivery
Specialty Drug Benefit Manager	Ascension Rx Specialty Pharmacy