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2024 Schedule of Benefits: PPO Plan

Benefits	Ascension Network Tier 1	BlueChoice Options Network (IL) Tier 2	Out-of-Network [1] Tier 3
Deductible • Individual • Family *All eligible expenses apply toward all Deductibles	$750 $1,500	$3,000 $6,000	$5,000 $10,000
Coinsurance • Plan Pays • You Pay	80% after Deductible 20% after Deductible	60% after Deductible 40% after Deductible	50% after Deductible 50% after Deductible
Total Out-Of-Pocket Maximum (Deductible plus coinsurance and copays) • Individual • Family *All eligible expenses apply toward all OOP Maximums	$4,000 $8,000	$9,450 $18,900	$12,500 $25,000
Lifetime Maximum	Unlimited	Unlimited	Unlimited

Services	Ascension Network Tier 1	BlueChoice Options Network (IL) Tier 2	Out-of-Network [1] Tier 3
Preventive Services Routine Physicals, Well Baby/Child Care, Routine Immunizations, Annual Gynecological Exam/ Mammogram Screening, Colonoscopy See:mysmarthealth.org/member-resources/preventive-care	$0	$0	50% after Deductible
Facility Outpatient/ Diagnostic Services Radiology, CT Scans, Radiation & Chemotherapy, Diagnostic Infertility Testing, Labs, Ultrasounds (non-Maternity)	20% after Deductible	40% after Deductible	50% after Deductible
Medical Specialty (Physician administered or infusion therapy) • Physician office/home • Outpatient	Prior Authorization Required 20% after Deductible[2] 20% after Deductible[2]	Prior Authorization Required 40% after Deductible [2] 40% after Deductible [2]	Prior Authorization Required 50% after Deductible [2] 50% after Deductible [2]
Outpatient Surgery/Facility Charge Anesthesia, Ancillary Services, Pathology, Physician Charges & Surgery	20% after Deductible	40% after Deductible	50% after Deductible
Outpatient Surgery/Physician's Office	20% after Deductible	40% after Deductible	50% after Deductible
Physical/Occupational/Speech Therapy (Annual maximum for PT, OT, ST - 60 visits combined) • Occupational & Speech Therapy • Physical Therapy	20% after Deductible 20% after Deductible	40% after Deductible 40% after Deductible	50% after Deductible 50% after Deductible
Dialysis (per treatment)	$25 Copay	$25 Copay	50% after Deductible

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Chiropractic Visit (Annual maximum - 35 visits) Note: Includes manipulation and therapy; x-rays excluded	$35 Copay	40% after Deductible	50% after Deductible
Facility High Tech Radiology (non-emergent) (per visit unless otherwise noted) Example: MRI and PET scans)	Prior Authorization Required 20% after Deductible [2]	Prior Authorization Required 40% after Deductible[2]	Prior Authorization Required 50% after Deductible[2]
Office Visits (per visit unless otherwise noted) Primary Care (Family Practice/ General Internal Medicine/ Pediatrics)	$30 Copay	40% after Deductible	50% after Deductible
Specialist (including OB/GYN)	$60 Copay	40% after Deductible	50% after Deductible
Amwell Online Care • Behavioral Health Online Visit • Urgent Care Online Visit	$30 Copay $30 Copay	N/A N/A	N/A N/A
All other E-Visits • Primary Care • Specialist	$30 Copay $60 Copay	40% after Deductible 40% after Deductible	50% after Deductible 50% after Deductible
Pre/Postnatal Care & Delivery	20% after Deductible	40% after Deductible	50% after Deductible
• Maternity Imaging (Ultrasound)	20% after Deductible	40% after Deductible	50% after Deductible
Mental Health (per visit unless otherwise noted) • Individual Therapy/ Group Therapy • E-Visits • Partial Day Treatment/ Intensive Outpatient Therapy • Inpatient Admission	$30 Copay $30 Copay 20% after Deductible 20% after Deductible	$30 Copay $30 Copay 20% after Ascension Network Deductible 20% after Ascension Network Deductible	50% after Deductible
Substance Use Disorder (per visit unless otherwise noted) • Individual Therapy/ Group Therapy • E-Visits • Partial Day Treatment/ Intensive Outpatient Therapy • Acute Inpatient Care	$30 Copay $30 Copay 20% after Deductible 20% after Deductible	$30 Copay $30 Copay 20% after Ascension Network Deductible 20% after Ascension Network Deductible	50% after Deductible
Emergency Care (per visit unless otherwise noted) • ER Visit	$500 Copay (Waived if admitted)	$500 Copay (Waived if admitted)	$500 Copay (Waived if admitted)
• Urgent Care	$75 Copay	$200 Copay after Deductible	$200 Copay after BlueChoice Options Network (IL) Deductible
• Ambulance	20% after Deductible	20% after Ascension Network Deductible	20% after Ascension Network Deductible
• Medical Transfer/ Transport (non-emergent)	Prior Authorization Required 20% after Deductible[2]	Prior Authorization Required 20% after Ascension Network Deductible[2]	Prior Authorization Required 20% after Ascension Network Deductible[2]
Inpatient Services (per admission) Room and Board, Ancillary Services, Surgery, Anesthesia, Physician Charges	Prior Authorization Required 20% after Deductible [2]	Prior Authorization Required 40% after Deductible[2]	Prior Authorization Required 50% after Deductible[2]

Inpatient Admission through Emergency Room (Note: Authorization required upon admission.)	20% after Deductible	40% after Deductible	40% after BlueChoice Options Network (IL) Deductible
Allergy Testing & Treatment	$25 Copay (per visit)	40% after Deductible (per visit)	50% after Deductible (per visit)
Extended Care Facility (per admission) (Annual maximum - 120 days)	20% after Deductible	40% after Deductible	50% after Deductible
Home Health Care (Annual maximum - 100 visits)	20% after Deductible	40% after Deductible	50% after Deductible
Hospice	20% after Deductible	40% after Deductible	50% after Deductible
Other Services • Durable Medical Equipment (DME)	Prior Authorization Required 20% Copay after Deductible (Annual out of pocket maximum $250) (2)	Prior Authorization Required 40% after Deductible(2)	Prior Authorization Required 50% after Deductible(2)
Prosthetics & Orthotics (P&O)	20% after Deductible	40% after Deductible	50% after Deductible
Foot Orthotics (2 pairs every 3 years)	20% after Deductible (per pair)	50% after Deductible (per pair)	50% after Deductible (per pair)
Hearing Aid (3-year maximum - $2,000)	20% after Deductible	40% after Deductible	50% after Deductible
Bariatric Surgery	Prior Authorization Required See Inpatient Services (2)	Prior Authorization Required See Inpatient Services(2)	Prior Authorization Required See Inpatient Services(2)
Organ/Bone Marrow/Other Transplants	Prior Authorization Required See Inpatient Services (2)	Prior Authorization Required See Inpatient Services(2)	Prior Authorization Required See Inpatient Services(2)
Wellness/ Disease Management (Diabetic Education per Medicare guidelines)	$0	$0	50% after Deductible
Smoking Cessation Intervention (Counseling)	$0	$0	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 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) In some instances when services are unavailable from an Ascension Network provider, members may obtain services from a BlueChoice Options Network (IL) (i.e. National Network) provider and such services will be processed at the Ascension Network benefit level. Benefit Elevation is required in order to obtain such BlueChoice Options Network (IL) (i.e National Network) benefits at the Ascension Network benefit level. For more information on the required Benefit Elevation process, go to www.mysmarthealth.org.**

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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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 PPO Plan Participants $4,000 per individual/ $8,000 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