

2025 Schedule of Benefits: PPO Plan

Benefits	Ascension Network Tier 1	National Network Tier 2	Out-of-Network <sup>(1)</sup> Tier 3
<b>Deductible</b> <ul style="list-style-type: none"> <li>Individual</li> <li>Family</li> </ul> All eligible expenses apply toward all Deductibles	\$1,000 \$2,000	\$4,000 \$8,000	\$6,000 \$12,000
<b>Coinsurance</b> <ul style="list-style-type: none"> <li>Plan Pays</li> <li>You Pay</li> </ul>	80% after Deductible 20% after Deductible	60% after Deductible 40% after Deductible	50% after Deductible 50% after Deductible
<b>Annual Out-Of-Pocket Maximum</b> (Deductible plus coinsurance and copays) <ul style="list-style-type: none"> <li>Individual</li> <li>Family</li> </ul> All eligible expenses apply toward all OOP Maximums	\$4,500 \$9,000	\$9,200 \$18,400	\$12,500 \$25,000
<b>Lifetime Maximum</b>	Unlimited	Unlimited	Unlimited

Services	Ascension Network Tier 1	National Network Tier 2	Out-of-Network <sup>(1)</sup> Tier 3
* Services with an asterisk (*) may require Prior Authorization. For a list of services see: <a href="https://mysmarthealth.org/provider-resources/prior-authorization">https://mysmarthealth.org/provider-resources/prior-authorization</a>			
<b>Preventive Services</b> Routine Physicals, Well Baby/Child Care, Routine Immunizations, Annual Gynecological Exam/Mammogram Screening, Colonoscopy See: <a href="https://mysmarthealth.org/member-resources/preventive-care">mysmarthealth.org/member-resources/preventive-care</a>	\$0	\$0	50% after Deductible
<b>Facility Outpatient/Diagnostic Services</b> Radiology, CT Scans, Radiation & Chemotherapy, Diagnostic Infertility Testing, Labs, Ultrasounds (non-Maternity)	20% after Deductible	40% after Deductible	50% after Deductible
<b>Medical Specialty</b> (Physician administered or infusion therapy)* <ul style="list-style-type: none"> <li>Physician office/home</li> <li>Outpatient</li> </ul>	20% after Deductible <sup>(2)</sup> 20% after Deductible <sup>(2)</sup>	40% after Deductible <sup>(2)</sup> 40% after Deductible <sup>(2)</sup>	50% after Deductible <sup>(2)</sup> 50% after Deductible <sup>(2)</sup>
<b>Outpatient Surgery/Facility Charge*</b> Anesthesia, Ancillary Services, Pathology, Physician Charges & Surgery	20% after Deductible <sup>(2)</sup>	40% after Deductible <sup>(2)</sup>	50% after Deductible <sup>(2)</sup>
<b>Outpatient Surgery/Physician's Office*</b>	20% after Deductible <sup>(2)</sup>	40% after Deductible <sup>(2)</sup>	50% after Deductible <sup>(2)</sup>
<b>Physical/Occupational/Speech Therapy</b> (Annual maximum for PT, OT, ST - 60 visits combined) <ul style="list-style-type: none"> <li>Occupational &amp; Speech Therapy</li> <li>Physical Therapy</li> </ul>	20% after Deductible 20% after Deductible	40% after Deductible 40% after Deductible	50% after Deductible 50% after Deductible
<b>Dialysis</b> (per treatment)	\$25 Copay	\$25 Copay	50% after Deductible

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<b>Chiropractic Visit</b> (Annual maximum - 35 visits) (Note: Includes manipulation and therapy; x-rays excluded.)	\$35 Copay	40% after Deductible	50% after Deductible
<b>Facility High Tech Radiology</b> (non-emergent)* (per visit unless otherwise noted) (Example: MRI and PET scans)	20% after Deductible <sup>(2)</sup>	40% after Deductible <sup>(2)</sup>	50% after Deductible <sup>(2)</sup>
<b>Office Visits</b> (per visit unless otherwise noted) Primary Care (Family Practice/General Internal Medicine/Pediatrics)	\$30 Copay	40% after Deductible	50% after Deductible
<b>Specialist</b> (including OB/GYN)	\$60 Copay	40% after Deductible	50% after Deductible
<b>Amwell Online Care</b> <ul style="list-style-type: none"> <li>Behavioral Health Online Visit</li> <li>Urgent Care Online Visit</li> </ul>	\$30 Copay \$30 Copay	N/A N/A	N/A N/A
<b>All other E-Visits</b> <ul style="list-style-type: none"> <li>Primary Care</li> <li>Specialist</li> </ul>	\$30 Copay \$60 Copay	40% after Deductible 40% after Deductible	50% after Deductible 50% after Deductible
<b>Pre/Postnatal Care &amp; Delivery</b>	20% after Deductible	40% after Deductible	50% after Deductible
<ul style="list-style-type: none"> <li>Maternity Imaging (Ultrasound)</li> </ul>	20% after Deductible	40% after Deductible	50% after Deductible
<b>Mental Health</b> (per visit unless otherwise noted) <ul style="list-style-type: none"> <li>Individual Therapy/Group Therapy</li> <li>E-Visits</li> <li>Partial Day Treatment/Intensive Outpatient Therapy</li> <li>Inpatient Admission*</li> </ul>	\$30 Copay \$30 Copay 20% after Deductible 20% after Deductible <sup>(2)</sup>	\$30 Copay \$30 Copay 20% after Ascension Network Deductible 20% after Ascension Network Deductible <sup>(2)</sup>	50% after Deductible 50% after Deductible 50% after Deductible 50% after Deductible <sup>(2)</sup>
<b>Substance Use Disorder</b> (per visit unless otherwise noted) <ul style="list-style-type: none"> <li>Individual Therapy/Group Therapy</li> <li>E-Visits</li> <li>Partial Day Treatment/Intensive Outpatient Therapy</li> <li>Acute Inpatient Care*</li> </ul>	\$30 Copay \$30 Copay 20% after Deductible 20% after Deductible <sup>(2)</sup>	\$30 Copay \$30 Copay 20% after Ascension Network Deductible 20% after Ascension Network Deductible <sup>(2)</sup>	50% after Deductible 50% after Deductible 50% after Deductible 50% after Deductible <sup>(2)</sup>
<b>Emergency Care</b> (per visit unless otherwise noted) <ul style="list-style-type: none"> <li>ER Visit</li> </ul>	\$500 Copay (Waived if admitted)	\$500 Copay (Waived if admitted)	\$500 Copay (Waived if admitted)
<ul style="list-style-type: none"> <li>Urgent Care</li> </ul>	\$75 Copay	\$200 Copay after Deductible	\$200 Copay after National Network Deductible
<ul style="list-style-type: none"> <li>Ambulance</li> </ul>	20% after Deductible	20% after Ascension Network Deductible	20% after Ascension Network Deductible
<ul style="list-style-type: none"> <li>Medical Transfer/Transport (non-emergent)*</li> </ul>	20% after Deductible <sup>(2)</sup>	20% after Ascension Network Deductible <sup>(2)</sup>	20% after Ascension Network Deductible <sup>(2)</sup>
<b>Inpatient Services</b> (per admission)* Room and Board, Ancillary Services, Surgery, Anesthesia, Physician Charges	20% after Deductible <sup>(2)</sup>	40% after Deductible <sup>(2)</sup>	50% after Deductible <sup>(2)</sup>

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<b>Inpatient Admission through Emergency Room</b> (Note: Authorization required upon admission.)	20% after Deductible	40% after Deductible	40% after National Network Deductible
<b>Allergy Testing &amp; Treatment</b>	\$25 Copay (per visit)	40% after Deductible (per visit)	50% after Deductible (per visit)
<b>Extended Care Facility</b> (per admission)	20% after Deductible	40% after Deductible	50% after Deductible
<b>Home Health Care</b> (Annual maximum - 100 visits)	20% after Deductible	40% after Deductible	50% after Deductible
<b>Hospice</b>	20% after Deductible	40% after Deductible	50% after Deductible
<b>Other Services*</b> • Durable Medical Equipment (DME)*	20% after Deductible (Annual out of pocket maximum \$250) <sup>(2)</sup>	40% after Deductible <sup>(2)</sup>	50% after Deductible <sup>(2)</sup>
<b>Prosthetics &amp; Orthotics (P&amp;O)*</b>	20% after Deductible <sup>(2)</sup>	40% after Deductible <sup>(2)</sup>	50% after Deductible <sup>(2)</sup>
<b>Foot Orthotics</b> (2 pairs every 3 years)*	20% after Deductible (per pair) <sup>(2)</sup>	50% after Deductible (per pair) <sup>(2)</sup>	50% after Deductible (per pair) <sup>(2)</sup>
<b>Hearing Aid</b> (3-year maximum - \$2,000)	20% after Deductible	40% after Deductible	50% after Deductible
<b>Bariatric Surgery*</b>	See Inpatient Services <sup>(2)</sup>	See Inpatient Services <sup>(2)</sup>	See Inpatient Services <sup>(2)</sup>
<b>Organ/Bone Marrow/Other Transplants*</b>	See Inpatient Services <sup>(2)</sup>	See Inpatient Services <sup>(2)</sup>	See Inpatient Services <sup>(2)</sup>
<b>Wellness/Disease Management</b> (Diabetic Education per Medicare guidelines)	\$0	\$0	50% after Deductible
<b>Smoking Cessation Intervention</b> (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 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](http://www.mysmarthealth.org).

**Exclusions -** See the SmartHealth Medical Summary Plan Description at [www.mysmarthealth.org](http://www.mysmarthealth.org) for complete information regarding exclusions.

**Prescription Drugs -** Go to [www.mysmarthealth.org/plan-coverage/pharmacy](http://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](http://www.mysmarthealth.org).

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**Ascension**

2025 Schedule of Benefits: Rx

<b>Prior Authorization Required?</b>	Yes - when applicable. Refer to current formulary.
<b>Quantity Level Limits</b>	Yes
<b>Annual Out-of-Pocket Maximums</b>	Applies to PPO Plan Participants \$4,500 per individual/\$9,000 per family
<b>Mandatory Generic Provision</b>	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.
<b>Mandatory Specialty Provision</b>	For more information, please visit <a href="http://www.mysmarthealth.org/plan-coverage/pharmacy">www.mysmarthealth.org/plan-coverage/pharmacy</a>
<b>Ascension Rx</b> (30 day supply)	Generic: Up to \$25 copay Preferred Brand: 20% (no minimum/maximum \$65) Non-Preferred Brand: 30% (no minimum/maximum \$165) Ascension Preferred Diabetic Supplies (Strips/Lancets)/Insulin: \$10 copay
<b>Ascension Rx</b> (90 day supply)	Generic: Up to \$75 copay Preferred Brand: 20% (no minimum/maximum \$200) Non-Preferred Brand: 30% (no minimum/maximum \$500) Ascension Preferred Diabetic Supplies (Strips/Lancets)/Insulin: \$30 copay
<b>Retail Benefit</b> (30 day supply)	Generic: Up to \$30 copay Preferred Brand: 25% (no minimum/maximum \$125) Non-Preferred Brand: 35% (no minimum/maximum \$175)
<b>Ascension Rx Home Delivery</b> (90 day supply)	Generic: Up to \$40 copay Preferred Brand: 20% (no minimum/maximum \$100) Non-Preferred Brand: 30% (no minimum/maximum \$250) Ascension Preferred Diabetic Supplies (Strips/Lancets)/Insulin: \$25 copay
<b>Ascension Rx Specialty Pharmacy</b> (30 day supply)	Specialized Generic: 40% (maximum \$200) Preferred Specialty: 40% (maximum \$250) Non-Preferred Specialty: 40% (maximum \$400)
<b>Pharmacy Benefit Manager (PBM)</b>	MaxorPlus
<b>Mail Order Benefit Manager</b>	Ascension Rx Home Delivery
<b>Specialty Drug Benefit Manager</b>	Ascension Rx Specialty Pharmacy

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