Ascension

SmartHealth

2025 SmartHealth Medical Plan Options

	SmartHealth PPO Copay Plan Option			SmartHealth HDHP Option		
	Ascension Network	**BlueChoice Options Network (IL)**	**Out-of-Network**	**Ascension Network**	**BlueChoice Options Network (IL)**	**Out-of-Network**
Annual Deductible	*All eligible expenses apply toward all deductibles.*			*All eligible expenses apply toward all deductibles.*		
Single	$1,000	$4,000	$6,000	$2,500	$7,500	$10,000
Family	$2,000	$8,000	$12,000	$5,000	$15,000	$20,000
Total Annual OOP max including Deductible	*All eligible expenses apply toward all OOP maximums. Copays do not apply to the deductible.*			*All eligible expenses apply toward all OOP maximums.*		
Single	$4,500	$9,200	$12,500	$4,500	$9,200	$13,000
Family	$9,000	$18,400	$25,000	$9,000	$18,400	$26,000
Inpatient/Outpatient Services	**Copay/Coinsurance**			**Copay/Coinsurance**		
Inpatient Hospital Services	20% after deductible	40% after deductible	50% after deductible	15% after deductible	40% after deductible	50% after deductible
Outpatient Services (i.e. Lab, Radiology)	20% after deductible	40% after deductible	50% after deductible	15% after deductible	40% after deductible	50% after deductible
Urgent Care	$50 copay	$75 copay	$200 copay after deductible	15% after deductible	$200 copay after deductible	$200 copay after Blue Choice Options Network (IL) deductible
Emergency Room Visit	$500 copay	$500 copay	$500 copay	15% after deductible	15% after Ascension Network deductible	15% after Ascension Network deductible
Physician Office Services	**Copay/Coinsurance**			**Copay/Coinsurance**		
Primary Care Visits (Family Practice/General Internal Medicine/Pediatrics)	$30 copay	40% after deductible	50% after deductible	15% after deductible	40% after deductible	50% after deductible
Specialist Visits	$60 copay	40% after deductible	50% after deductible	15% after deductible	40% after deductible	50% after deductible
Mental Health Visits (Individual therapy/ group therapy/ e-visits)	$30 copay	$30 copay	50% after deductible	15% after deductible	15% after Ascension Network deductible	50% after deductible
Therapy (Physical/Speech/Occupational) Annual max: 60 visits	20% after deductible	40% after deductible	50% after deductible	15% after deductible	40% after deductible	50% after deductible
Chiropractic Office Visit Annual max: 35 visits	$35 copay	40% after deductible	50% after deductible	15% after deductible	40% after deductible	50% after deductible
Preventive Health Care Adult/Child & Immunizations	$0	$0	50% after deductible	$0	$0	50% after deductible
Prescription Drugs	*Prescription drugs do not count toward deductibles.*			*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.*		

	ARx 30-day	**ARx 90-day**	**Retail 30-day**	**ARx Home Delivery 90-day**	**ARx Specialty 30-day Generic & Preferred**	**ARx Specialty 30-day Non-Preferred**	**ARx 30-day**	**ARx 90-day**	**Retail 30-day**	**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 $30.00	Up to $40.00	N/A	N/A	Up to $25.00	Up to $75.00	Up to $30.00	Up to $40.00	N/A	N/A
Preferred Brand name	20% (min $0/ max $65)	20% (min $0/ max $200)	25% (min $0/ max $125)	20% (min $0/ max $100)	N/A	N/A	20% (min $0/ max $65)	20% (min $0/ max $200)	25% (min $0/ max $125)	20% (min $0/ max $100)	N/A	N/A
Non-preferred Brand Name	30% (min $0/ max $165)	30% (min $0/ max $500)	35% (min $0/ max $175)	30% (min $0/ max $250)	N/A	N/A	30% (min $0/ max $165)	30% (min $0/ max $500)	35% (min $0/ max $175)	30% (min $0/ max $250)	N/A	N/A
Specialty	N/A	N/A	N/A	N/A	40% (max $200) 40% (max $250)	40% (max $400)	N/A	N/A	N/A	N/A	40% (max $200) 40% (max $250)	40% (max $400)
Biweekly Premiums												
Annual Pay Band	$46,000.00 or less	$44,000.01 - $108,000.00	$108,000.01 - $223,000.00	$223,000.01 - $349,000.00	$349,000.01 or more	Part-time (all bands)	$46,000.00 or less	$44,000.01 - $108,000.00	$108,000.01 - $223,000.00	$223,000.01 - $349,000.00	$349,000.01 or more	Part-time (all bands)
Associate	$68.92	$76.61	$81.73	$99.00	$139.00	$131.70	$52.52	$60.09	$65.13	$80.00	$114.00	$114.33
Associate Plus Spouse or Associate Plus LDB	$138.59	$158.56	$171.88	$230.20	$260.20	$242.26	$102.41	$121.90	$134.90	$192.89	$222.89	$203.56
Associate Plus Child(ren)	$129.88	$148.32	$159.94	$176.00	$235.96	$216.11	$101.77	$120.12	$131.68	$145.00	$202.00	$187.56
Associate Plus Family or Associate Plus Children/LDB	$199.54	$230.28	$250.76	$316.25	$346.25	$356.01	$142.08	$171.20	$190.61	$255.03	$285.03	$290.33

Notes: Tobacco Surcharge: If you or a covered family member use tobacco products, a $50 surcharge will be deducted biweekly from your paycheck.