Ascension

SmartHealth

2024 SmartHealth Medical Plan Options

	SmartHealth PPO OLP Bronze Plan Option			SmartHealth PPO OLP Silver Plan Option			SmartHealth PPO OLP Gold Plan Option		
	Ascension Network	**National Network**	**Out-of-Network**	**Ascension Network**	**National Network**	**Out-of-Network**	**Ascension Network**	**National Network**	**Out-of-Network**
Annual Deductible	*All eligible expenses apply toward all deductibles.*			*All eligible expenses apply towards all deductibles.*			*All eligible expenses apply toward all deductibles.*		
Single	N/A	N/A	$1,000	N/A	N/A	$1,000	N/A	N/A	$500
Family	N/A	N/A	$2,000	N/A	N/A	$2,000	N/A	N/A	$1,000
Total Annual OOP max including Deductible	*All eligible expenses apply toward all OOP maximums. Note: copays do not apply to the deductible, but are counted toward OOP maximums.*			*All eligible expenses apply toward all OOP maximums. Note: copays do not apply to the deductible, but are counted towards OOP maximums.*			*All eligible expenses apply toward all OOP maximums. Note: copays do not apply to the deductible, but are counted towards the OOP maximums.*		
Single	$6,350	$6,350	$10,000	$6,350	$6,350	$10,000	$3,000	$3,000	$3,000
Family	$12,700	$12,700	$20,000	$12,700	$12,700	$20,000	$6,000	$6,000	$6,000
Inpatient/Outpatient Services	**Copay/Coinsurance**			**Copay/Coinsurance**			**Copay/Coinsurance**		
Inpatient Hospital Services	$750 copay - Adult $0 Copay - Child	$750 copay - Adult $0 copay - Child	20% after deductible	$750 copay	$750 copay	20% after deductible	$0 copay	$250 copay	30% after deductible
Outpatient Services (i.e. Pathology. Radiology, X-Rays)	$25 copay	$25 copay	20% after deductible	$25 copay	$25 copay	20% after deductible	$0 copay	$0 copay $10 copay - X-Ray	30% after deductible
Urgent Care	$35 copay	$35 copay	20% after deductible	$35 copay	$35 copay	20% after deductible	$0 copay	$35 copay	30% after deductible
Emergency Room Visit (waived if admitted)	$150 copay	$150 copay	$150 copay	$150 copay	$150 copay	$150 copay	$150 copay	$150 copay	$150 copay
Physician Office Services	**Copay/Coinsurance**			**Copay/Coinsurance**			**Copay/Coinsurance**		
Primary Care Visits (Family Practice/General Internal Medicine/Pediatrics)	$15 copay - Adult $0 copay - Child	$15 copay - Adult $0 copay - Child	20% after deductible	$10 copay - Adult $25 copay - Child	$10 copay - Adult $25 copay - Child	20% after deductible	$10 copay	$10 copay	30% after deductible
Specialist Visits	$25 copay	$25 copay	20% after deductible	$25 Copay	$25 copay	20% after deductible	$10 copay	$10 copay	30% after deductible
Mental Health Visits (Individual therapy/ group therapy/ e-visits)	$15 copay - Adult $0 copay - Child	$15 copay - Adult $0 copay - Child	20% after deductible	$10 copay - Adult $25 copay - Child	$10 copay - Adult $25 copay - Child	20% after deductible	$10 copay	$10 copay	30% after deductible
Therapy (Physical/Speech/Occupational) Annual max: 60 visits	$25 copay	$25 copay	20% after deductible	$25 copay	$25 copay	20% after deductible	$10 copay	$10 copay	$10 copay
Chiropractic Office Visit Annual max: 35 visits	$25 copay	$25 copay	$25 copay	$25 copay	$25 copay	$25 copay	$10 copay	$10 copay	$10 copay
Preventive Health Care Adult/Child & Immunizations	$0 copay	$0 copay	Not covered	$0 copay	$0 copay	Not covered	$0 copay	$0 copay	Not covered
Prescription Drugs	*Prescription drugs do not count toward deductibles.*			*Prescription drugs do not count toward deductibles.*			*Prescription drugs have separate OOP max - $6,450 Single/ $12,900 Family*		
	ARx 30-day supply	**ARx 90-day supply**	**Retail 30-day supply**	**ARx Home Delivery 90-day**	**ARx Specialty 30-day**		**ARx 30-day supply**	**ARx 90-day supply**	**Retail 30-day supply**	**ARx Home Delivery 90-day**	**ARx Specialty 30-day**	
Generic	$10	$25	$10	$25	N/A		$10	$25	$10	$25	N/A		$0	$0	$4	$10	N/A	
Preferred Brand name	$20	$50	$20	$50	N/A		$20	$50	$20	$50	N/A		$0	$0	$15	$37.50	N/A	
Non-preferred Brand Name	$35	$87.50	$35	$87.50	N/A		$35	$87.50	$35	$87.50	N/A		$0	$0	$30	$87.50	N/A	
Specialty	N/A	N/A	N/A	N/A	$35		N/A	N/A	N/A	N/A	$35		N/A	N/A	N/A	N/A	$0	
Biweekly Premiums																		
Annual Pay Band	$44,000.00 or less	$44,000.01-$104,000.00	$104,000.01-$215,000.00	$215,000.01-$337,000.00	$337,000.01 or more	Part-time (all bands)	$44,000.00 or less	$44,000.01-$104,000.00	$104,000.01 $215,000.00	$215,000.01-$337,000.00	$337,000.01 or more	Part-time (all bands)	$44,000.00 or less	$44,000.01-$104,000.00	$104,000.01-$215,000.00	$215,000.01 $337,000.00	$337,000.01 or more	Part-time (all bands)
Associate	$11.95	$14.94	$17.93	$20.91	$20.91	$104.60	$12.01	$15.01	$18.01	$21.01	$21.01	$105.04	$46.55	$49.88	$53.20	$56.54	$56.54	$116.39
Associate Plus Spouse or Associate Plus LDB	$57.98	$63.98	$70.39	$76.79	$76.79	$223.94	$57.84	$64.25	$70.68	$77.10	$77.10	$224.89	$128.20	$137.12	$142.45	$149.58	$149.58	$249.29
Associate Plus Child(ren)	$46.38	$51.54	$56.70	$61.85	$61.85	$180.39	$46.58	$51.76	$56.94	$62.10	$62.10	$181.13	$103.27	$110.44	$114.73	$120.46	$120.46	$200.78
Associate Plus Family or Associate Plus Children/LDB	$83.21	$92.46	$101.71	$110.96	$110.96	$323.60	$83.56	$92.84	$102.12	$111.41	$111.41	$324.94	$185.27	$198.14	$205.86	$216.15	$216.15	$360.26

Note: Tobacco Surcharge: If you or a covered family member use tobacco products, a $30 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.