

2011 Schedule of Benefits

See the January 1, 2011 Plan Document for an all-inclusive listing

S M A R T H E A L T H	SmartHealth Network www.mysmarthealth.org		Non-Network
Deductibles/Co-Pays/ Cost-Share Percentages and Plan Maximums	Tier 1 <i>Ascension Health MI Provider Network</i>	Tier 2 (See Notes below) <i>Blue Cross Blue Shield Providers</i>	Tier 3 (See Notes below) <i>Non-Network Providers</i>
Deductible • Individual • Family	<i>All services go toward deductible.</i> \$1,300* \$2,600* <i>*The full cost of prescription drugs goes toward deductible</i>		\$3,000 \$6,000
Co-Pays • Office/Primary • Mental Health/Substance Abuse Individual/Group Therapy • Office/Specialist • Urgent Care • ER • Inpatient Admission	\$0 after Deductible \$0 after Deductible \$0 after Deductible \$0 after Deductible \$100 after Deductible \$0 after Deductible	20% after Deductible 20% after Deductible 20% after Deductible 20% after Deductible \$100 after Deductible 20% after Deductible	50% after Deductible 50% after Deductible 50% after Deductible 50% after Deductible \$100 after Deductible 50% after Deductible
Cost-Share • Plan pays • You pay	100% after Deductible 0% after Deductible except for DME/P&O	80% after Deductible 20% after Deductible	50% after Deductible 50% after Deductible
Lifetime Maximum	Unlimited		
Annual Out-Of-Pocket Maximum • Individual • Family	N/A N/A	\$3,000 \$6,000	No Limit No Limit
Services			
Preventive Services • Annual Routine Physical • Well Baby/Child Care • Annual Gynecological Exam • Routine Immunizations • Colonoscopy • Annual Screening Mammogram	\$0 \$0 \$0 \$0 \$0 \$0	\$0 \$0 \$0 \$0 \$0 \$0	50% after Deductible 50% after Deductible 50% after Deductible 50% after Deductible 50% after Deductible 50% after Deductible
Wellness/Disease Management • Diabetic Education • Smoking Cessation Intervention (Counseling) • Health Coach/Wellness Assistance • Catastrophic Case Management • Nurse Case Manager	\$0 \$0 Prior Authorization Required \$0 \$0 - Prior Authorization Required	Not Covered \$0 Not Covered Not Covered Not Covered	Not Covered Not Covered Not Covered Not Covered Not Covered
Note: (1) Any claim incurred through a Non-Network provider could result in Balance Billing and/or additional charges to the member. (2) Prior Authorization Required - Failure to secure "Prior Authorization" for services noted in the Plan Document will result in no coverage/benefit paid under the Plan. (3) Deductibles, Co-Pays, and Balance Billing do not accrue toward Annual Out-Of-Pocket Maximum.			

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Outpatient/Diagnostic Services <ul style="list-style-type: none"> ▪ Lab, Pathology, Radiology, Anesthesia ▪ Outpatient Surgery ▪ Radiation & Chemotherapy ▪ Diagnostic Infertility Testing ▪ Physical/Occupational/Speech Therapy (60 visit maximum per condition) ▪ Dialysis 	0% after Deductible 0% after Deductible 0% after Deductible 0% after Deductible 0% after Deductible 0% after Deductible	20% after Deductible 20% after Deductible 20% after Deductible 20% after Deductible 20% after Deductible 20% after Deductible	50% after Deductible 50% after Deductible 50% after Deductible 50% after Deductible 50% after Deductible 50% after Deductible
Office Visit <ul style="list-style-type: none"> ▪ Primary Care (Family Practice/General Internal Medicine/Pediatrics) ▪ Specialist (Including OB/GYN) ▪ Pre/Postnatal Care 	0% after Deductible 0% after Deductible 0% after Deductible	20% after Deductible 20% after Deductible 20% after Deductible	50% after Deductible 50% after Deductible 50% after Deductible
Mental Health/Substance Abuse <ul style="list-style-type: none"> ▪ Inpatient Admission ▪ Partial Day Treatment ▪ Intensive Outpatient Therapy w/ Domicile ▪ Intensive Outpatient Therapy ▪ Individual Therapy ▪ Group Therapy 	0% after Deductible 0% after Deductible 0% after Deductible 0% after Deductible 0% after Deductible 0% after Deductible	20% after Deductible 20% after Deductible 20% after Deductible 20% after Deductible 20% after Deductible 20% after Deductible	50% after Deductible 50% after Deductible 50% after Deductible 50% after Deductible 50% after Deductible 50% after Deductible
Emergency Care <ul style="list-style-type: none"> ▪ ER ▪ Urgent Care ▪ Ambulance ▪ Medical Transfer/Transport (air/other) 	\$100 Co-Pay after Deductible 0% after Deductible \$0 after Deductible Prior Authorization Required	\$100 Co-Pay after Deductible 20% after Deductible \$0 after Deductible Prior Authorization Required	\$100 Co-Pay after Deductible 50% after Deductible \$0 after Deductible Prior Authorization Required
Note: (1) Any claim incurred through a Non-Network provider could result in Balance Billing and/or additional charges to the member. (2) Prior Authorization Required - Failure to secure "Prior Authorization" for services noted in the Plan Document will result in no coverage/benefit paid under the Plan. (3) Deductibles, Co-Pays, and Balance Billing do not accrue toward Annual Out-Of-Pocket Maximum.			

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Inpatient Services			
<ul style="list-style-type: none"> ▪ Per Admission <ul style="list-style-type: none"> Semi-private Room Special Care Units Direct or Scheduled Admission to Observation Ancillary Services Surgery Anesthesia Physician Charges Maternity and Newborn Nursery Care Radiation and Chemotherapy ▪ Emergency Room Admission ▪ Extended Care Facility (120 Day Annual Maximum) 	\$100 Co-Pay after Deductible	\$150 Co-Pay Plus 20% after Deductible	50% after Deductible
	\$100 Co-Pay after Deductible 0% after Deductible	\$150 Co-Pay Plus 20% after Deductible 20% after Deductible	50% after Deductible
	\$100 Co-Pay after Deductible 0% after Deductible	\$150 Co-Pay Plus 20% after Deductible 20% after Deductible	50% after Deductible
Other Services			
<ul style="list-style-type: none"> ▪ Chiropractor (\$1,000 Annual Maximum – All services) ▪ Durable Medical Equipment/Prosthetics & Orthotics (DME/P&O) ▪ Hearing Aid ▪ Home Health Care ▪ Hospice ▪ Allergy Testing & Treatment ▪ Physician supervised weight loss services or a comprehensive SmartHealth weight loss program (Cost-sharing may apply) ▪ Bariatric Surgery ▪ Organ/Bone Marrow/Other Transplants 	0% after Deductible	20% after Deductible	50% after Deductible
	\$0 after Deductible up to \$7,500 then 20% for remainder of year 0% after Deductible \$2,000 Maximum (3 yr)	20% after Deductible (excluded from OOP Max)	50% after Deductible
	0% after Deductible	Not Covered	Not Covered
	0% after Deductible	20% after Deductible	50% after Deductible
	0% after Deductible	20% after Deductible	50% after Deductible
	0% after Deductible	20% after Deductible	50% after Deductible
	Criteria May Apply	Not Covered	Not Covered
	0% after Deductible	Not Covered	Not Covered
	Prior Authorization Required	20% after Deductible	50% after Deductible
	0% after Deductible	Prior Authorization Required	Prior Authorization Required
	0% after Deductible	20% after Deductible	50% after Deductible
	Prior Authorization Required	Prior Authorization Required	Prior Authorization Required
Note: (1) Any claim incurred through a Non-Network provider could result in Balance Billing and/or additional charges to the member. (2) Prior Authorization Required - Failure to secure "Prior Authorization" for services noted in the Plan Document will result in no coverage/benefit paid under the Plan. (3) Deductibles, Co-Pays, and Balance Billing do not accrue toward Annual Out-Of-Pocket Maximum.			
Exclusions — See the January 1, 2011 Plan Document for complete information regarding Plan Exclusions			
Experimental/Investigational Procedures Custodial Care Cosmetic Surgery Hospital Confinement Charges in a facility other than an approved hospital Anesthesia for non-covered benefits Identified Dental procedures Identified DME/P&O equipment/supplies Organ/Bone Marrow transplant charges when donor is Covered Person and recipient is not (no duplicate payments) Cardiac Rehab - Phase 3 Any other services identified in the Plan Document as "exclusions" Any other service that is not listed as a covered benefit Any procedure which does not have FDA approvals for intended procedures			

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