

## Schedule of Medical Benefits



### SmartHealth Network

Deductibles/Co-Pays/ Copayments and Plan Maximums	Tier 1 <i>Ascension Health Michigan Network</i>	Tier 2 (See Notes below) <i>Community Blue/Blue Preferred PPO Network</i>
<b>Deductible</b> <ul style="list-style-type: none"> <li>▪ Individual</li> <li>▪ Family</li> </ul>	\$0 \$0	\$ 750 \$1,500
<b>Co-Pays</b> <ul style="list-style-type: none"> <li>▪ Office/Primary</li> <li>▪ Mental Health/Substance Abuse Individual/Group Therapy</li> <li>▪ Office/Specialist</li> <li>▪ Urgent Care</li> <li>▪ ER</li> <li>▪ Inpatient Admission</li> </ul>	\$15 Co-Pay \$15 Co-Pay \$20 Co-Pay \$20 Co-Pay \$100 Co-Pay \$100 Co-Pay	\$20 Co-Pay \$20 Co-Pay \$30 Co-Pay \$40 Co-Pay \$125 Co-Pay \$150 Co-Pay
<b>Copayments</b> <ul style="list-style-type: none"> <li>▪ Plan pays</li> <li>▪ You pay</li> </ul>	100% 0% except for Chiropractic, DME/P&O	80% after Deductible 20% after Deductible
<b>Lifetime Maximum</b>	\$2 million	
<b>Annual Out-Of-Pocket Maximum</b> <ul style="list-style-type: none"> <li>▪ Individual</li> <li>▪ Family</li> <li>▪ Inpatient Admission Co-Pay per Family</li> </ul>	N/A N/A \$300	\$3,000 \$6,000 \$ 450
Services		
<b>Preventive Services</b> <ul style="list-style-type: none"> <li>▪ Annual Routine Physical</li> <li>▪ Well Baby/Child Care</li> <li>▪ Annual Gynecological Exam</li> <li>▪ Routine Immunizations</li> <li>▪ Colonoscopy</li> <li>▪ Annual Screening Mammogram</li> </ul>	\$0 \$0 \$0 \$0 \$0 \$0	\$20 Co-Pay \$20 Co-Pay \$20 Co-Pay 20% after Deductible 20% after Deductible 20% after Deductible
<b>Wellness/Disease Management</b> <ul style="list-style-type: none"> <li>▪ Diabetic Education &amp; Support</li> <li>▪ Health Coach, Special Needs/Wellness Assistance (cost-sharing may apply)</li> <li>▪ Dietetic Support/Healthy-eating Guides</li> <li>▪ Catastrophic Case Management                Asthma, Diabetes, Obesity, Multi-Skeletal,                Congestive Heart Failure, Mental Health</li> <li>▪ Smoking Cessation</li> <li>▪ Nurse Case Manager</li> </ul>	\$0 Prior Authorization Required \$0 \$0 \$0 \$0 - Prior Authorization Required	Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered
Note: (1) For very specific services specified in the Provider Directory (available at <a href="http://www.SmartHealth-mi.org">www.SmartHealth-mi.org</a> ), the associate pays Tier 1 Co-Pays even if services are provided by a Tier 2 provider (excluding Office Visit Co-Pays). (2) Any claim incurred in Tier 2 could result in Balance Billing and/or additional charges to the member. (3) 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. (4) Deductibles, Co-Pays, and Balance Billing do not accrue toward Annual Out-Of-Pocket Maximum.		

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### SmartHealth Network

	<b>SmartHealth Network</b>	
<b>Services, continued</b>	<b>Tier 1</b>	<b>Tier 2 (See Notes below)</b>
	<i>Ascension Health Michigan Ministry</i>	<i>Community Blue/Blue Preferred PPO Network</i>
<b>Outpatient/Diagnostic Services</b> <ul style="list-style-type: none"> <li>▪ Lab, Pathology, Radiology, Anesthesia</li> <li>▪ Outpatient Surgery</li> <li>▪ Radiation &amp; Chemotherapy</li> <li>▪ Diagnostic Infertility Testing</li> <li>▪ Physical/Occupational/Speech Therapy (60 maximum visits per condition)</li> <li>▪ Observation Stay (under 24 hrs)</li> <li>▪ Dialysis</li> </ul>	\$0 \$0 \$0 \$0 \$0 \$0 \$0	20% after Deductible 20% after Deductible 20% after Deductible 20% after Deductible 20% after Deductible 20% after Deductible 20% after Deductible
<b>Office Visit</b> <ul style="list-style-type: none"> <li>▪ Primary Care (Family Practice/General Internal Medicine/Pediatrics)</li> <li>▪ Specialist (Including OB/GYN)</li> <li>▪ Pre/Postnatal Care</li> </ul>	\$15 Co-Pay  \$20 Co-Pay \$20 Co-Pay (once per Pregnancy)	\$20 Co-Pay  \$30 Co-Pay \$30 Co-Pay (once per Pregnancy)
<b>Mental Health/Substance Abuse</b> <ul style="list-style-type: none"> <li>▪ Inpatient Per Admission Co-Pay</li> <li>▪ Partial Day Treatment</li> <li>▪ Intensive Outpatient Therapy w/ Domicile</li> <li>▪ Intensive Outpatient Therapy</li> <li>▪ Individual Therapy</li> <li>▪ Group Therapy</li> </ul>	\$100 Co-Pay \$0 \$0 \$0 \$15 Co-Pay \$15 Co-Pay	\$150 Co-Pay, plus 20% after Deductible 20% after Deductible 20% after Deductible 20% after Deductible \$20 Co-Pay \$20 Co-Pay
<b>Emergency Care</b> <ul style="list-style-type: none"> <li>▪ ER               <ul style="list-style-type: none"> <li>If Observation Occurs</li> <li>If Admission Occurs</li> </ul> </li> <li>▪ Urgent Care</li> <li>▪ Ambulance</li> <li>▪ Medical Transfer/Transport (air/other)</li> </ul>	\$100 Co-Pay \$0 \$0 \$20 Co-Pay \$0 Prior Authorization Required	\$125 Co-Pay \$0 \$0 \$40 Co-Pay \$0 Prior Authorization Required

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 (2) Any claim incurred in Tier 2 could result in Balance Billing and/or additional charges to the member.  
 (3) 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.  
 (4) Deductibles, Co-Pays, and Balance Billing do not accrue toward Annual Out-Of-Pocket Maximum.

