

2011 Schedule of Benefits

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

SMART HEALTH	SmartHealth Network www.mysmarthealth.org		Non-Network
Deductibles/Co-Pays/ Cost-Share Percentages and Plan Maximums	Tier 1* <i>Ascension Health Michigan Network</i>	Tier 2* <i>Blue Cross Blue Shield</i>	Tier 3* <i>Non-Network Providers</i>
Deductible ▪ Individual ▪ Family	\$0 \$0	\$400 \$800	\$3,000 \$6,000
Co-Pays ▪ Office/Primary ▪ Mental Health/Substance Abuse Individual/Group Therapy ▪ Office/Specialist ▪ Urgent Care ▪ ER ▪ Inpatient Admission ▪ Chiropractor	\$15 Co-Pay \$15 Co-Pay \$25 Co-Pay \$30 Co-Pay \$100 Co-Pay \$100 Co-Pay \$25 Co-Pay	\$25 Co-Pay \$25 Co-Pay \$35 Co-Pay \$50 Co-Pay \$100 Co-Pay \$150 Co-Pay, plus 20% after Deductible \$35 Co-Pay	50% after Deductible 50% after Deductible 50% after Deductible 20% no Deductible \$100 Co-Pay 50% after Deductible 50% after Deductible
Cost-Share ▪ Plan pays ▪ You pay	100% 0% 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	\$2,500 \$5,000	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
<p>*Notes: (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.</p>			

Benefits are subject to change based on ongoing clarification of Federal Rules.

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S M A R T H E A L T H	SmartHealth Network www.mysmarthealth.org		Non-Network
<i>Services, continued</i>	Tier 1* <i>Ascension Health Michigan Network</i>	Tier 2* <i>Blue Cross Blue Shield</i>	Tier 3* <i>Non-Network Providers</i>
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 \$0 \$0 \$0 \$0 \$0	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 	\$15 Co-Pay \$25 Co-Pay \$25 Co-Pay (once per Pregnancy)	\$25 Co-Pay \$35 Co-Pay \$35 Co-Pay (once per Pregnancy)	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 	\$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 \$25 Co-Pay \$25 Co-Pay	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 \$30 Co-Pay \$0 Prior Authorization Required	\$100 Co-Pay \$50 Co-Pay \$0 Prior Authorization Required	\$100 Co-Pay 20%, no Deductible \$0 Prior Authorization Required
*Notes: (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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