

Smith County

Health Benefit Plan

Effective July 1, 2010 - December 31, 2010

Benefit Feature	Preferred In Network	Non Preferred In Network	Out of Network
Lifetime Maximum Benefit	\$2,000,000		
Annual Deductible accumulative			
<input type="checkbox"/> Individual	\$500	\$500	\$5,000
<input type="checkbox"/> Family Max	\$1,500	\$1,500	\$7,000
Annual Out-of-Pocket Max.	Plus penalties	Plus penalties	Plus penalties
<input type="checkbox"/> Individual	\$3,000	\$4,000	No Limit
<input type="checkbox"/> Family Max	\$9,000	\$12,000	No Limit
Coinsurance			
<input type="checkbox"/> Plan Pays	90%	70%	50%
Precertification for Inpatient procedures MM Solutions 1-800-625-6834	\$250 penalty if precertification rules are not followed	\$250 penalty if precertification rules are not followed	\$250 penalty if precertification rules are not followed
Physician's Fees			
<input type="checkbox"/> Office Visit	\$35 Copay then 100%	\$50 Copay then 100%	50% after deductible
<input type="checkbox"/> Office surgery; in-patient MRI;PET;CAT scans & other out-patient services	\$50 Copay then 90%	70% after deductible	50% after deductible
Maximum for Physician Other Services ONLY	No Limit	No Limit	No Limit
Hospital Care			
<input type="checkbox"/> Inpatient	\$200 Copay then 90%	\$600 Copay then 70%	\$1000 Copay then 50%
<input type="checkbox"/> Outpatient	\$100 Copay then 90%	\$400 Copay then 70%	\$600 Copay then 50%
<input type="checkbox"/> Emergency Room	\$150 Copay then 90%	\$200 Copay then 70%	\$400 Copay then 60%
Maximum	No Limit	No Limit	No Limit
Pre-Admission Testing	Applicable Copay	Applicable Copay	50% after deductible
Lab Services			
<input type="checkbox"/> DRL	\$70 Copay then 90%	70% after deductible	50% after deductible
<input type="checkbox"/> Other	\$70 Copay then 90%	70% after deductible	50% after deductible
Preventive Care	\$35 Copay then 100%	\$50 Copay then 100%	50% after deductible
	\$600 Calendar Year Maximum (Childhood Immunizations, Mammograms and PSA do not apply to the Calendar Year Maximum)		
Maternity Care			
<input type="checkbox"/> Physician Office Visit	\$35 Copay then 100%	\$50 Copay then 100%	50% after deductible
<input type="checkbox"/> Other Services	Applicable Copay	Applicable Copay	50% after deductible
Home Health Care (\$10,000 Calendar Year Maximum In Network, \$7,000 CYM Out of Network)	100%	100%	50% after deductible
Skilled Nursing Facility (\$10,000 Calendar Year Maximum In Network, \$7,000 CYM Out of Network)	100%	100%	50% after deductible
Hospice Care (\$20,000 LTM In Network, \$14,000 LTM Out of Network)	100%	100%	50% after deductible
Prescription Drugs			
30 day max supply			
<input type="checkbox"/> Generic	\$10 Copay	\$10 Copay	Not Covered Not Covered Not Covered
<input type="checkbox"/> Brand/No Generic Available	\$45 Copay	\$45 Copay	
<input type="checkbox"/> Brand with Generic Available	\$75 Copay	\$75 Copay	
90 day max supply			
<input type="checkbox"/> Mail Order	2 Copays	2 Copays	Not Covered
Mental Health			
<input type="checkbox"/> Inpatient (30 days CYM In Network, 15 days CYM Out of Network)	Applicable Copay	Applicable Copay	50% after deductible
<input type="checkbox"/> Outpatient(30 days CYM In Network, 15 Days CYM Out of Network)	Applicable Copay	Applicable Copay	50% after deductible
Substance Abuse			
<input type="checkbox"/> Inpatient	Applicable Copay	Applicable Copay	50% after deductible
<input type="checkbox"/> Outpatient	Applicable Copay	Applicable Copay	50% after deductible
	\$25,000 Calendar Year Maximum and limited to three separate treatments per Lifetime		
Durable Medical Equipment	\$70 Copay then 90%	70% after deductible	50% after deductible
Physical Therapy	Applicable Copay	70% after deductible	50% after deductible