

Effective Date 6/1/2012 **Health Plan** Alliant Plus **Ref** RQ-52793

This is a brief summary of benefits. THIS IS NOT A CONTRACT OR CERTIFICATE OF COVERAGE. All benefit descriptions, including alternative care, are for medically necessary services. The Member will be charged the lesser of the cost share for the covered service or the actual charge for that service. For full coverage provisions, including limitations, please refer to your certificate of coverage.

In accordance with the Patient Protection and Affordable Care Act of 2010,

- The lifetime maximum on the dollar value of covered essential health benefits no longer applies. Members whose coverage ended by reason of reaching a lifetime limit under this plan are eligible to enroll in this plan, and
- Dependent children who are under the age of twenty-six (26) are eligible to enroll in this plan.

Benefits	Inside Network	Outside Network
Plan deductible	Individual deductible: \$350 per calendar year Family deductible: \$1,050 per calendar year	Shared with in-network
Individual deductible carryover	4th quarter carryover applies	4th quarter carryover applies
Plan coinsurance	Plan pays 90%, you pay 10%	Plan pays 70%, you pay 30% of the Usual, Customary and Reasonable (UCR) charges.
Out-of-pocket limit	Individual out-of-pocket limit: \$3,000 Family out-of-pocket limit: \$9,000 Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit: Plan coinsurance, emergency services at a Managed Health Care Network (MHCN) facility and ambulance services.	Out-of-pocket limit is shared with in-network Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit: Plan coinsurance, emergency services at a non-Managed Health Care Network (MHCN) facility and ambulance services.
Pre-existing condition (PEC) waiting period	No PEC	Same as in-network
Lifetime maximum	Unlimited	Same as in-network maximum
Outpatient services (Office visits)	\$20 copay, deductible and coinsurance apply	\$20 copay, deductible and coinsurance apply
Hospital services	Inpatient services: \$100 copay, per day for up to 3 days per admit Deductible and coinsurance apply Outpatient surgery: \$20 copay, deductible and coinsurance apply	Inpatient services: \$100 copay, per day for up to 3 days per admit Deductible and coinsurance apply Outpatient surgery: \$20 copay, deductible and coinsurance apply
Prescription drugs (some injectable drugs may be covered under Outpatient services)	Formulary generic/formulary brand \$15/\$30 copay per 30 day supply	Formulary generic/formulary brand \$20/\$35 copay per 30 day supply
Prescription mail order	\$5 discount per 30 day supply	Not covered
Acupuncture	Covered up to 8 visits per medical diagnosis per calendar year without prior authorization; additional visits when approved by the plan \$20 copay, deductible and coinsurance apply	\$20 copay, deductible and coinsurance apply
Ambulance services	Plan pays 80%, you pay 20%	Same as in-network
Chemical dependency	Inpatient: \$100 copay, per day for up to 3 days per admit Deductible and coinsurance apply Outpatient: \$20 copay, deductible and coinsurance apply	Inpatient: \$100 copay, per day for up to 3 days per admit Deductible and coinsurance apply Outpatient: \$20 copay, deductible and coinsurance apply

Devices, equipment and supplies <ul style="list-style-type: none"> Durable medical equipment Orthopedic appliances Post-mastectomy bras limited to two (2) every six (6) months <ul style="list-style-type: none"> Ostomy supplies Prosthetic devices 	<p>Covered at 50%</p> <p>Covered at 50%</p>	<p>Covered at 50%, deductible applies</p> <p>Covered at 50%, deductible applies</p>
Diabetic supplies	<p>Insulin, needles, syringes and lancets-see Prescription drugs. External insulin pumps, blood glucose monitors, testing reagents and supplies-see Devices, equipment and supplies. When Devices, equipment and supplies or Prescription drugs are covered and have benefit limits, diabetic supplies are not subject to these limits.</p>	<p>Insulin, needles, syringes and lancets-see Prescription drugs. External insulin pumps, blood glucose monitors, testing reagents and supplies-see Devices, equipment and supplies. When Devices, equipment and supplies or Prescription drugs are covered and have benefit limits, diabetic supplies are not subject to these limits.</p>
Diagnostic lab and X-ray services	<p>Inpatient: Covered under Hospital services Outpatient: Deductible and coinsurance apply</p> <p>High end radiology imaging services such as CT, MR and PET must be determined Medically Necessary and require prior authorization except when associated with Emergency care or inpatient services.</p>	<p>Inpatient: Covered under Hospital services Outpatient: Deductible and coinsurance apply</p> <p>High end radiology imaging services such as CT, MR and PET must be determined Medically Necessary and require prior authorization except when associated with Emergency care or inpatient services.</p>
Emergency services (copay waived if admitted)	<p>\$75 copay Deductible and coinsurance apply</p>	<p>\$75 copay In-network deductible and coinsurance apply</p>
Hearing exams (routine)	<p>\$20 copay, deductible and coinsurance apply</p>	<p>\$20 copay, deductible and coinsurance apply</p>
Hearing hardware	<p>Not covered</p>	<p>Not covered</p>
Home health services	<p>Covered in full. No visit limit.</p>	<p>No visit limit Deductible and coinsurance apply</p>
Hospice services	<p>Covered in full</p>	<p>Deductible and coinsurance apply</p>
Infertility services	<p>Not covered</p>	<p>Not covered</p>
Manipulative therapy	<p>Covered up to 10 visits per calendar year without prior authorization \$20 copay, deductible and coinsurance apply</p>	<p>Visit limits shared with in-network \$20 copay, deductible and coinsurance apply</p>
Massage services	<p>See Rehabilitation services</p>	<p>See Rehabilitation services</p>
Maternity services	<p>Inpatient: \$100 copay, per day for up to 3 days per admit Deductible and coinsurance apply Outpatient: \$20 copay, deductible and coinsurance apply. Routine care not subject to outpatient services copay.</p>	<p>Inpatient: \$100 copay, per day for up to 3 days per admit Deductible and coinsurance apply Outpatient: \$20 copay, deductible and coinsurance apply. Routine care not subject to outpatient services copay.</p>
Mental Health	<p>Inpatient: \$100 copay, per day for up to 3 days per admit Deductible and coinsurance apply Outpatient: \$20 copay, deductible and coinsurance apply</p>	<p>Inpatient: \$100 copay, per day for up to 3 days per admit Deductible and coinsurance apply Outpatient: \$20 copay, deductible and coinsurance apply</p>
Naturopathy	<p>Covered up to 3 visits per medical diagnosis per calendar year without prior authorization; additional visits when approved by plan \$20 copay, deductible and coinsurance apply</p>	<p>\$20 copay, deductible and coinsurance apply</p>
Newborn Services	<p>Initial hospital stay: See Hospital Services; Office visits: See Outpatient Services; Routine well care: See Preventive care. Any applicable cost share for newborn services is separate from that of the mother.</p>	<p>Initial hospital stay: See Hospital Services; Office visits: See Outpatient Services; Routine well care: See Preventive care. Any applicable cost share for newborn services is separate from that of the mother.</p>
Obesity-related surgery (bariatric)	<p>Not covered</p>	<p>Not covered</p>
Organ transplants Donor search & harvest applies to lifetime max	<p>Unlimited, no waiting period</p> <p>Inpatient: \$100 copay, per day for up to 3 days per admit Deductible and coinsurance apply Outpatient: \$20 copay, deductible and coinsurance apply</p>	<p>Shared with in-network</p> <p>Inpatient: \$100 copay, per day for up to 3 days per admit Deductible and coinsurance apply Outpatient: \$20 copay, deductible and coinsurance apply</p>
Preventive care Well-care physicals, immunizations, Pap smear exams, mammograms	<p>Covered in full</p>	<p>\$150 per person; \$300 per family per calendar year Coinsurance applies</p> <p>Routine mammograms: Deductible and coinsurance apply</p>

Rehabilitation services (Occupational, speech, physical including services for neurodevelopmentally disabled children age six and under) Rehabilitation visits are a total of combined therapy visits per calendar year	Inpatient: 60 days per calendar year \$100 copay, per day for up to 3 days per admit Deductible and coinsurance apply Outpatient: 60 visits per calendar year \$20 copay, deductible and coinsurance apply	Inpatient: Day limits shared with in-network \$100 copay, per day for up to 3 days per admit Deductible and coinsurance apply Outpatient: Visit limits shared with in-network \$20 copay, deductible and coinsurance apply
Skilled nursing facility	Up to 60 days per calendar year, deductible and coinsurance apply	Day limits shared with in-network benefit, deductible and coinsurance apply
Sterilization (vasectomy, tubal ligation)	Inpatient: \$100 copay, per day for up to 3 days per admit Deductible and coinsurance apply Outpatient: \$20 copay, deductible and coinsurance apply	Inpatient: \$100 copay, per day for up to 3 days per admit Deductible and coinsurance apply Outpatient: \$20 copay, deductible and coinsurance apply
Temporomandibular Joint (TMJ) services	\$1,000 per calendar year; \$5,000 lifetime max Inpatient: \$100 copay, per day for up to 3 days per admit Deductible and coinsurance apply Outpatient: \$20 copay, deductible and coinsurance apply	Shared with in-network Inpatient: \$100 copay, per day for up to 3 days per admit Deductible and coinsurance apply Outpatient: \$20 copay, deductible and coinsurance apply
Tobacco cessation counseling	Quit for Life Program - covered in full	Applicable cost shares apply
Routine vision care (1 visit every 12 months)	\$20 copay, deductible and coinsurance waived	\$20 copay, deductible and coinsurance apply
Optical hardware Lenses, including contact lenses and frames	\$100 per 12 months Not subject to deductible and coinsurance	Shared with in-network

Coverage provided by Group Health Options, Inc.

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