

Benefit Summary  
Hospitality Industry (HIHIT) - Gold Plan



**Effective Date** 1/1/2011      **Health Plan** Alliant Plus      **Ref** RQ-38584

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
<b>Plan deductible</b>	Individual deductible: \$500 per calendar year Family deductible: \$1,500 per calendar year	Shared with in-network
<b>Individual deductible carryover</b>	4th quarter carryover does not apply	4th quarter carryover does not apply
<b>Plan coinsurance</b>	Plan pays 80%, you pay 20%	Plan pays 70%, you pay 30% of the Usual, Customary and Reasonable (UCR) charges.
<b>Deductible and/or coinsurance waiver riders</b>	1st 4 visits per calendar year are not subject to deductible and/or coinsurance. Lab and xray services covered in full up to \$500 combined per calendar year.	Visit limit shared with in-network
<b>Out-of-pocket limit</b>	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.
<b>Pre-existing condition (PEC) waiting period</b>	No PEC	Same as in-network
<b>Lifetime maximum</b>	Unlimited	Shared with in-network maximum
<b>Outpatient services (Office visits)</b>	\$25 copay primary/\$50 copay specialty, deductible and coinsurance apply	\$25 copay primary/\$50 copay specialty, deductible and coinsurance apply
<b>Hospital services</b>	<b>Inpatient services:</b> Deductible and coinsurance apply <b>Outpatient surgery:</b> \$25 copay primary/\$50 copay specialty, deductible and coinsurance apply	<b>Inpatient services:</b> Deductible and coinsurance apply <b>Outpatient surgery:</b> \$25 copay primary/\$50 copay specialty, deductible and coinsurance apply
<b>Prescription drugs (some injectable drugs may be covered under Outpatient services)</b>	Formulary generic/formulary brand \$20/\$40 copay per 30 day supply	Formulary generic/formulary brand \$25/\$45 copay per 30 day supply
<b>Prescription mail order</b>	\$5 discount per 30 day supply	Not covered
<b>Acupuncture</b>	Self-referred up to 8 visits per medical diagnosis per calendar year; additional visits when approved by the plan \$25 copay, deductible and coinsurance apply	\$25 copay, deductible and coinsurance apply
<b>Ambulance services</b>	Plan pays 80%, you pay 20%	Same as in-network
<b>Chemical dependency</b>	<b>Inpatient:</b> Deductible and coinsurance apply <b>Outpatient:</b> \$25 copay, deductible and coinsurance apply	<b>Inpatient:</b> Deductible and coinsurance apply <b>Outpatient:</b> \$25 copay, deductible and coinsurance apply

<b>Devices, equipment and supplies</b> <ul style="list-style-type: none"> <li>Durable medical equipment</li> <li>Orthopedic appliances</li> <li>Post-mastectomy bras limited to two (2) every six (6) months</li> </ul> <ul style="list-style-type: none"> <li>Ostomy supplies</li> <li>Prosthetic devices</li> </ul>	<p>Covered at 80%</p> <p>Covered at 80%</p>	<p>Covered at 80%, deductible applies</p> <p>Covered at 80%, deductible applies</p>
<b>Diabetic supplies</b>	<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>
<b>Diagnostic lab and X-ray services</b>	<p><b>Inpatient:</b> Covered under Hospital services  <b>Outpatient:</b> Covered in full up to \$500 per calendar year, then deductible and coinsurance apply</p> <p>High end radiology imaging services such as CT, MR and PET must be determined Medically Necessary and require preauthorization except when associated with Emergency care or inpatient services.</p>	<p><b>Inpatient:</b> Covered under Hospital services  <b>Outpatient:</b> Covered in full up to \$500 per calendar year, then deductible and coinsurance apply</p> <p>High end radiology imaging services such as CT, MR and PET must be determined Medically Necessary and require preauthorization except when associated with Emergency care or inpatient services.</p>
<b>Emergency services</b> (copay waived if admitted)	\$150 copay Deductible and coinsurance apply	\$150 copay Deductible and coinsurance apply
<b>Hearing exams (routine)</b>	\$25 copay, deductible and coinsurance apply	\$25 copay, deductible and coinsurance apply
<b>Hearing hardware</b>	Not covered	Not covered
<b>Home health services</b>	Covered in full. No visit limit.	No visit limit Deductible and coinsurance apply
<b>Hospice services</b>	Covered in full	Deductible and coinsurance apply
<b>Infertility services</b>	Not covered	Not covered
<b>Manipulative therapy</b>	Self-referred up to 10 visits per calendar year \$25 copay, deductible and coinsurance apply	Visit limits shared with in-network \$25 copay, deductible and coinsurance apply
<b>Massage services</b>	See Rehabilitation services	See Rehabilitation services
<b>Maternity services</b>	<b>Inpatient:</b> Deductible and coinsurance apply <b>Outpatient:</b> \$25 copay, deductible and coinsurance apply	<b>Inpatient:</b> Deductible and coinsurance apply <b>Outpatient:</b> \$25 copay, deductible and coinsurance apply
<b>Mental Health</b>	<b>Inpatient:</b> Deductible and coinsurance apply <b>Outpatient:</b> \$25 copay, deductible and coinsurance apply	<b>Inpatient:</b> Deductible and coinsurance apply <b>Outpatient:</b> \$25 copay, deductible and coinsurance apply
<b>Naturopathy</b>	Self-referred up to 3 visits per medical diagnosis per calendar year; additional visits when approved by plan \$25 copay, deductible and coinsurance apply	\$25 copay, deductible and coinsurance apply
<b>Obesity-related surgery (bariatric)</b>	Not covered	Not covered
<b>Organ transplants</b> Donor search & harvest applies to lifetime max	Unlimited, no waiting period <b>Inpatient:</b> Deductible and coinsurance apply <b>Outpatient:</b> \$25 copay, deductible and coinsurance apply	Shared with in-network <b>Inpatient:</b> Deductible and coinsurance apply <b>Outpatient:</b> \$25 copay, deductible and coinsurance apply
<b>Preventive care</b> Well-care physicals, immunizations, Pap smear exams, mammograms	Covered in full	\$25 copay (deductible and coinsurance waived) Routine mammograms: Deductible and coinsurance apply
<b>Rehabilitation services</b> (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	<b>Inpatient:</b> 60 days per calendar year Deductible and coinsurance apply <b>Outpatient:</b> 60 visits per calendar year \$25 copay, deductible and coinsurance apply	<b>Inpatient:</b> Day limits shared with in-network Deductible and coinsurance apply <b>Outpatient:</b> Visit limits shared with in-network \$25 copay, deductible and coinsurance apply

<b>Skilled nursing facility</b>	Up to 60 days per calendar year, deductible and coinsurance apply	Day limits shared with in-network benefit, deductible and coinsurance apply
<b>Sterilization</b> (vasectomy, tubal ligation)	<b>Inpatient:</b> Deductible and coinsurance apply <b>Outpatient:</b> \$25 copay, deductible and coinsurance apply	<b>Inpatient:</b> Deductible and coinsurance apply <b>Outpatient:</b> \$25 copay, deductible and coinsurance apply
<b>Temporomandibular Joint (TMJ) services</b>	\$1,000 per calendar year; \$5,000 lifetime max <b>Inpatient:</b> Deductible and coinsurance apply <b>Outpatient:</b> \$25 copay, deductible and coinsurance apply	Shared with in-network <b>Inpatient:</b> Deductible and coinsurance apply <b>Outpatient:</b> \$25 copay, deductible and coinsurance apply
<b>Tobacco cessation</b> See pharmacy benefit for associated drug coverage	Free & Clear Program - covered in full	Not Covered
<b>Routine vision care</b> (1 visit every 12 months)	\$25 copay, deductible and coinsurance waived	\$25 copay, deductible and coinsurance apply
<b>Optical hardware</b> Lenses, including contact lenses and frames	\$250 per 12 months Not subject to deductible and coinsurance	Shared with in-network

Coverage provided by Group Health Options, Inc.

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