

Benefit Summary
Hospitality Industry (HIHIT) - Platinum Plan



Effective Date 1/1/2011 **Health Plan** Alliant Plus **Ref** RQ-38585

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: \$200 per calendar year Family deductible: \$600 per calendar year	Shared with in-network
Individual deductible carryover	4th quarter carryover does not apply	4th quarter carryover does not apply
Plan coinsurance	Plan pays 90%, you pay 10%	Plan pays 80%, you pay 20% of the Usual, Customary and Reasonable (UCR) charges.
Deductible and/or coinsurance waiver riders	Deductible does not apply to outpatient services	Deductible does not apply to outpatient services
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	Shared with in-network maximum
Outpatient services (Office visits)	\$20 copay primary/\$40 copay specialty, deductible does not apply Coinsurance applies	\$20 copay primary/\$40 copay specialty, deductible does not apply Coinsurance applies
Hospital services	Inpatient services: \$200 copay, per admit Deductible and coinsurance apply Outpatient surgery: \$20 copay primary/\$40 copay specialty, deductible does not apply Coinsurance applies	Inpatient services: \$200 copay, per admit Deductible and coinsurance apply Outpatient surgery: \$20 copay primary/\$40 copay specialty, deductible does not apply Coinsurance applies
Prescription drugs (some injectable drugs may be covered under Outpatient services)	Formulary generic/formulary brand \$20/\$40 copay per 30 day supply	Formulary generic/formulary brand \$25/\$45 copay per 30 day supply
Prescription mail order	\$5 discount per 30 day supply	Not covered
Acupuncture	Self-referred up to 8 visits per medical diagnosis per calendar year; additional visits when approved by the plan \$20 copay, deductible does not apply Coinsurance applies	\$20 copay, deductible does not apply Coinsurance applies
Ambulance services	Plan pays 80%, you pay 20%	Same as in-network
Chemical dependency	Inpatient: \$200 copay, per admit Deductible and coinsurance apply Outpatient: \$20 copay, deductible does not apply Coinsurance applies	Inpatient: \$200 copay, per admit Deductible and coinsurance apply Outpatient: \$20 copay, deductible does not apply Coinsurance applies

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 80%</p> <p>Covered at 80%</p>	<p>Covered at 80%, deductible applies</p> <p>Covered at 80%, 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 does not apply to outpatient services Coinsurance applies</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>Inpatient: Covered under Hospital services Outpatient: Deductible does not apply to outpatient services Coinsurance applies</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>
Emergency services (copay waived if admitted)	\$150 copay Deductible and coinsurance apply	\$150 copay Deductible and coinsurance apply
Hearing exams (routine)	\$20 copay, deductible does not apply Coinsurance applies	\$20 copay, deductible does not apply Coinsurance applies
Hearing hardware	Not covered	Not covered
Home health services	Covered in full. No visit limit.	No visit limit Deductible and coinsurance apply
Hospice services	Covered in full	Deductible and coinsurance apply
Infertility services	Not covered	Not covered
Manipulative therapy	Self-referred up to 10 visits per calendar year \$20 copay, deductible does not apply Coinsurance applies	Visit limits shared with in-network \$20 copay, deductible does not apply Coinsurance applies
Massage services	See Rehabilitation services	See Rehabilitation services
Maternity services	Inpatient: \$200 copay, per admit Deductible and coinsurance apply Outpatient: \$20 copay, deductible does not apply Coinsurance applies	Inpatient: \$200 copay, per admit Deductible and coinsurance apply Outpatient: \$20 copay, deductible does not apply Coinsurance applies
Mental Health	Inpatient: \$200 copay, per admit Deductible and coinsurance apply Outpatient: \$20 copay, deductible does not apply Coinsurance applies	Inpatient: \$200 copay, per admit Deductible and coinsurance apply Outpatient: \$20 copay, deductible does not apply Coinsurance applies
Naturopathy	Self-referred up to 3 visits per medical diagnosis per calendar year; additional visits when approved by plan \$20 copay, deductible does not apply Coinsurance applies	\$20 copay, deductible does not apply Coinsurance applies
Obesity-related surgery (bariatric)	Not covered	Not covered
Organ transplants Donor search & harvest applies to lifetime max	Unlimited, no waiting period Inpatient: \$200 copay, per admit Deductible and coinsurance apply Outpatient: \$20 copay, deductible does not apply Coinsurance applies	Shared with in-network Inpatient: \$200 copay, per admit Deductible and coinsurance apply Outpatient: \$20 copay, deductible does not apply Coinsurance applies
Preventive care Well-care physicals, immunizations, Pap smear exams, mammograms	Covered in full	\$20 copay (deductible and coinsurance waived) Routine mammograms: Coinsurance applies

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 \$200 copay, per admit Deductible and coinsurance apply Outpatient: 60 visits per calendar year \$20 copay, deductible does not apply Coinsurance applies	Inpatient: Day limits shared with in-network \$200 copay, per admit Deductible and coinsurance apply Outpatient: Visit limits shared with in-network \$20 copay, deductible does not apply Coinsurance applies
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: \$200 copay, per admit Deductible and coinsurance apply Outpatient: \$20 copay, deductible does not apply Coinsurance applies	Inpatient: \$200 copay, per admit Deductible and coinsurance apply Outpatient: \$20 copay, deductible does not apply Coinsurance applies
Temporomandibular Joint (TMJ) services	\$1,000 per calendar year; \$5,000 lifetime max Inpatient: \$200 copay, per admit Deductible and coinsurance apply Outpatient: \$20 copay, deductible does not apply Coinsurance applies	Shared with in-network Inpatient: \$200 copay, per admit Deductible and coinsurance apply Outpatient: \$20 copay, deductible does not apply Coinsurance applies
Tobacco cessation See pharmacy benefit for associated drug coverage	Free & Clear Program - covered in full	Not Covered
Routine vision care (1 visit every 12 months)	\$20 copay, deductible and coinsurance waived	\$20 copay, deductible does not apply Coinsurance applies
Optical hardware 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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