

Effective Date 1/1/2011**Health Plan** Alliant Plus**Ref** RQ-38583

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.

Benefits	Inside Network	Outside Network
Pre-deductible coverage	Deductible does not begin until \$1,000 individual/\$3,000 family of covered services are used. Coinsurance applies during the pre-deductible period	Shared with in-network
Plan deductible	Individual deductible: \$1,500 per calendar year Family deductible: \$4,500 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 70%, you pay 30% Applies during the pre-deductible coverage period and after the annual deductible is satisfied	Plan pays 50%, you pay 50% of the Usual, Customary and Reasonable (UCR) charges. Applies during the pre-deductible coverage period and after the annual deductible is satisfied
Out-of-pocket limit	Individual out-of-pocket limit: \$5,000 Family out-of-pocket limit: \$15,000 Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit: Annual deductible and plan coinsurance	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: Annual deductible and plan coinsurance
Pre-existing condition (PEC) waiting period	No PEC	Same as in-network
Lifetime maximum	Unlimited	Shared with in-network maximum
Outpatient services (Office visits)	Deductible and coinsurance apply	Deductible and coinsurance apply
Hospital services	Inpatient services: Deductible and coinsurance apply Outpatient surgery: Deductible and coinsurance apply	Inpatient services: Deductible and coinsurance apply Outpatient surgery: Deductible and coinsurance apply
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	2 x prescription cost share per 90 day supply	Not covered
Acupuncture	Self-referred up to 8 visits per medical diagnosis per calendar year; additional visits when approved by plan Deductible and coinsurance apply	Deductible and coinsurance apply
Ambulance services	Deductible and coinsurance apply	Deductible and coinsurance apply
Chemical Dependency	Inpatient: Deductible and coinsurance apply Outpatient: Deductible and coinsurance apply	Inpatient: Deductible and coinsurance apply Outpatient: 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 	Covered at the plan coinsurance and annual deductible	Covered at the plan coinsurance and annual deductible
<ul style="list-style-type: none"> Ostomy supplies Prosthetic devices 	Combined with above benefit	Combined with above benefit

Diabetic supplies	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.	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.
Diagnostic lab and X-ray services	Inpatient: Covered under Hospital services Outpatient: Deductible and coinsurance apply 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.	Inpatient: Covered under Hospital services Outpatient: Deductible and coinsurance apply 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.
Emergency services	Deductible and coinsurance apply	Deductible and coinsurance apply
Hearing exams (routine)	Deductible and coinsurance apply	Deductible and coinsurance apply
Hearing hardware	Not covered	Not covered
Home health services	Deductible and coinsurance apply	Deductible and coinsurance apply
Hospice services	Covered in full. Not subject to pre-deductible coverage limit.	Deductible and coinsurance apply
Infertility services	Not covered	Not covered
Manipulative therapy	Self-referred up to 10 visits per calendar year Deductible and coinsurance apply	Visit limits shared with in-network Deductible and coinsurance apply
Massage services	See Rehabilitation services	See Rehabilitation services
Maternity services	Inpatient: Deductible and coinsurance apply Outpatient: Deductible and coinsurance apply	Inpatient: Deductible and coinsurance apply Outpatient: Deductible and coinsurance apply
Mental Health	Inpatient: Deductible and coinsurance apply Outpatient: Deductible and coinsurance apply	Inpatient: Deductible and coinsurance apply Outpatient: Deductible and coinsurance apply
Naturopathy	Self-referred up to 3 visits per medical diagnosis per calendar year Deductible and coinsurance apply	Deductible and coinsurance apply
Obesity-related surgery (bariatric)	Not covered	Not covered
Organ transplants Donor search & harvest applies to lifetime max	Unlimited, no waiting period Inpatient: Deductible and coinsurance apply Outpatient: Deductible and coinsurance apply	Shared with in-network Inpatient: Deductible and coinsurance apply Outpatient: Deductible and coinsurance apply
Preventive care Well-care physicals, immunizations, Pap smear exams, mammograms	Covered in full	\$300 per person; \$600 per family per calendar year Routine mammograms: Deductible and coinsurance apply
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 Deductible and coinsurance apply Outpatient: 60 visits per calendar year Deductible and coinsurance apply	Inpatient: Day limits shared with in-network Deductible and coinsurance apply Outpatient: Visit limits shared with in-network Deductible and coinsurance apply
Skilled nursing facility	Up to 60 days per calendar year, deductible and coinsurance apply	Day limits shared with in-network, deductible and coinsurance apply
Sterilization (vasectomy, tubal ligation)	Inpatient: Deductible and coinsurance apply Outpatient: Deductible and coinsurance apply	Inpatient: Deductible and coinsurance apply Outpatient: Deductible and coinsurance apply
Temporomandibular Joint (TMJ) services	\$1,000 per calendar year; \$5,000 lifetime max Inpatient: Deductible and coinsurance apply Outpatient: Deductible and coinsurance apply	Shared with in-network Inpatient: Deductible and coinsurance apply Outpatient: Deductible and coinsurance apply
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)	Deductible and coinsurance apply	Deductible and coinsurance apply
Optical hardware Lenses, including contact lenses and frames	\$200 per 12 months	Shared with in-network