



Summary of Benefits

Hybrid HMO New/Renewing Business NON-Grandfathered Plans Effective March 1, 2012

HMO Service Area Requirements: In order to be eligible for one of the HMO plans offered through the Alliance, an employee or subscriber obtaining individual coverage must live or work within the HMO's service area. The HMO plans offered through the Alliance provide the following benefits when medically necessary. Copays are due at the time of service. This is only a summary of benefits; each carrier can give you their actual contract language and definitions of covered benefits, limitations, exclusions and allowable charges. Details of coverage may differ among carriers. All Alliance HMO carriers offer at least these benefits. Mental Health and Substance Use Disorder Services are covered the same as any other benefit. **Unlimited lifetime maximum benefit.**

Annual Calendar Year Deductible <ul style="list-style-type: none"> • Individual • Family Annual Out-of-Pocket Maximum* <ul style="list-style-type: none"> • Individual • Family (Family limits are shown in aggregate) Coinsurance (Paid by member- individual and Family) <p>*Member's deductible and copays (excluding prescription drug copays) and percent coinsurance apply towards the Out-of-Pocket Maximum for this HMO Hybrid plan. Once member reaches OOP maximum, plan pays 100% covered services for the remainder of the calendar year, except for prescription drug copays.</p>	\$1,000 \$3,000 \$5,000 (\$4,000 coinsurance + \$1,000 deductible) \$12,000 (\$9,000 coinsurance + \$3,000 deductible) 20%
Physician's Non-routine care including: <ul style="list-style-type: none"> • Primary Care • Specialist and Consultant Care • Urgent Care Facility • Specialty Pharmaceuticals (injections administered in physician's office) 	\$35 copay for each visit to a Participating Primary Care Physician and \$50 for each visit to a Participating Specialist Physician. No limit to the number of visits per calendar year. A referral is no longer needed from your Primary Care physician to see a Participating Specialist Physician. \$50 copay Fees vary by HMO carrier in accordance with each carrier's commercial plan.
<ul style="list-style-type: none"> • Outpatient Mental Health Services (provided by a designated specialist) 	\$35 copay per visit
<ul style="list-style-type: none"> • Chemotherapy, Radiation Therapy, Dialysis 	Subject to deductible and 20% coinsurance.
Physician's Routine/preventive care including: <ul style="list-style-type: none"> • Routine lab and x-ray, mammograms, Pap tests, colonoscopy, routine vision or hearing screenings, immunizations, health education and counseling, including for smoking cessation • Well-Child Care 	No copay
Diagnostic Laboratory Tests & X-ray Examinations	Subject to deductible and 20% coinsurance. Included in Office Visit copay
Care in a Participating Hospital including room and board (private room only when ordered by a Participating Physician), intensive care, coronary care, cardiac surgery, dialysis, radiation therapy, cathode ray scanning and other inpatient hospital charges such as operating room, drugs, x-ray, lab, supplies and short-term rehabilitation. Inpatient Mental Health services (provided in a designated Participating Hospital).	Subject to deductible and 20% coinsurance.
Physician's and Surgeon's Care Blood and blood derivatives	Subject to deductible and 20% coinsurance. Subject to deductible and 20% coinsurance.
Outpatient Hospital Services not including services received in the Emergency Room Chemotherapy, Radiation Therapy, Dialysis Specialty Pharmaceuticals (administered in outpatient hospital)	Subject to deductible and 20% coinsurance. Fees vary by HMO carrier in accordance with each carrier's commercial plan.

Hybrid HMO (Continued)

<p>Maternity Care Physician's care of mother before, during and six weeks after delivery; physician's hospital care of mother. No waiting period. Newborns are covered from birth, provided proper notification is submitted on a timely basis. Includes emergency air transportation when the life of the mother or infant is in danger.</p>	<p>You pay \$35 each office visit. You pay nothing for physician's hospital care. Regular hospital benefits and copays apply for hospital stay.</p>
<p>Family Planning Services Contraceptive counseling; IUDs provided when indicated. Sterilization procedures and initial studies, diagnostic procedures and services for infertility as determined necessary by a Participating Physician.</p>	<p>\$35 office copay. \$50 Specialist Copay Plan covers 50% of all costs including hospital, after copay.</p>
<p>Short-Term Rehabilitation & Therapy Services, Inpatient & Outpatient Physical and Occupational Therapy Outpatient Inpatient Cardiac and Pulmonary Rehabilitation Speech and Hearing Therapy</p>	<p>Same as Inpatient hospital Same as Specialist Physician \$50 per visit with 2 month maximum Subject to deductible and 20% coinsurance with 2 month maximum</p>
<p>Health Promotion Classes/information varies by company, can include but is not limited to nutrition, weight control, smoking cessation, CPR</p>	<p>Fees vary by HMO carrier In accordance with each carrier's commercial plan</p>
<p>Skilled Nursing Facility Care</p>	<p>Subject to deductible and 20% coinsurance - up to 30 days per calendar year</p>
<p>Transplant Services (Must be received at a facility that contracts with carrier or with the carrier's transplant network.) Transplant benefits vary by carrier Heart, Kidney, Liver, Lung, Bone Marrow & Cornea Only</p>	<p>Hospital copay applies</p>
<p>In-Plan Emergency Care for non life-threatening emergencies, call your primary care doctor for instructions</p>	<p>\$150 copay; then plan pays 100% of usual, customary and reasonable charges</p>
<p>Out-of-Plan Emergency Care by non-plan physicians or providers. Worldwide emergency health coverage. Necessary medical services to Members requiring immediate treatment while temporarily outside the Service Area.</p>	<p>\$150 copay; then plan pays 100% of usual, customary and reasonable charges for emergency services only. Notify Plan within 48 hours to determine validity and extent of coverage.</p>
<p>Local Ambulance Services when medically indicated.</p>	<p>Plan pays 100% after you pay \$50 copay for ground transportation or \$100 copay for air transportation.</p>
<p>Hospice 6 months life expectancy. To include respite care.</p>	<p>Inpatient: Subject to deductible and 20% coinsurance. Outpatient: no charge. Other benefit specifics in accordance with each carrier's commercial plan</p>
<p>Home Health Care Medically appropriate health services provided at the home of a Member as prescribed or directed by a Participating Physician.</p>	<p>Subject to deductible and 20% coinsurance.</p>
<p>Substance Use Disorder Services (Alcoholism and Drug Abuse Services)</p>	<p>Inpatient: Subject to deductible and 20% coinsurance. Outpatient: You pay \$35 each office visit.</p>

Hybrid HMO (Continued)

Prescription Drugs, Insulin, Diabetic Supplies, Enteral Nutritional Products, Special Medical Foods ¹				
		Brand-Name Drug		
		If a generic equivalent is available and you buy the brand-name, you pay:	If there is no generic equivalent available:	
			Tier 2 Formulary ¹	Tier 3 Non-formulary ¹
Copays are not applied to out-of-pocket limit. Certain drugs, special medical foods and enteral nutritional products require prior approval or benefits will be denied.	Tier 1 Generic Drug¹			
Retail Pharmacy Program (up to a 30-day supply or 120 units, whichever is less)	\$20	\$20 plus difference in covered charge between brand-name and generic equivalent	\$45	\$75
Mail Order Plan (up to 90-day supply or 360 units, whichever is less)	\$50		\$112.50	\$187.50
Specialty Pharmaceuticals – Tier 4 <i>(injectables or oral/inhalation forms)</i>	20% of medication cost, with minimum \$75 copay and maximum \$400 copay per script			
Nonprescription enteral nutritional products and special medical foods (up to 30-day supply per 30 day period; requires prior approval)	Fees vary by HMO carrier in accordance with each carrier's commercial plan.			
Other Services				
Durable Medical Equipment	Subject to deductible and 50% coinsurance Pre-certification required.			
Acupuncture	Subject to deductible and 20% coinsurance. Limited to 20 visits per member per calendar year.			
Autism Spectrum Disorders (max. \$36,000 each calendar year for applied behavioral analysis when part of a preauthorized treatment plan; covered services include preauthorized physical, speech, and occupational therapy)	Usual copays or coinsurance based on place of treatment and type of service			
Chiropractic	Subject to deductible and 20% coinsurance. Limited to 10 visits per member per calendar year.			
Prosthetics (varies by carrier)*	Subject to deductible and 50% coinsurance			

**Provision is subject to further investigation under PPACA

¹ Prescription drugs must be purchased at a pharmacy that participates in the Retail Pharmacy or Mail Order Service programs.

HMO Hybrid General Exclusions

- Visual training, eyeglasses, contact lenses
- Dental services except TMJ and craniomandibular disorders covered same as any illness
- Corrective appliances, artificial aids, and durable medical equipment except as provided
- Cosmetic surgery other than breast reconstruction following a mastectomy
- Custodial care, domiciliary care, rest cures
- Organ transplants, except heart, kidney, liver, lung, bone marrow and cornea only
- Care for conditions which state or local law require be treated in a public facility
- Care for military service-connected disabilities that a Member is legally entitled to receive from or at the expense of the government
- Services and items not reasonable and necessary for the diagnosis or treatment of an illness or injury, except approved preventive health services
- Experimental medical, surgical or other health care procedures
- Long-term physical or other rehabilitation therapy
- Reversal of voluntarily induced sterility
- Personal comfort items
- Hospital take-home drugs
- Elective abortions
- Services and items to improve the functioning of a malformed body member or system, unless medically necessary

The above is only a general description. Details of coverage differ among HMO's. The specific terms of coverage, exclusions and limitations are contained in the Evidence of Coverage, Member Handbook or Certificate issued by the individual carrier.