



Summary of Benefits

HDHP Plans 7 & 8

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

This is a **summary** of benefits: Please refer to your contract documents for exclusions, limitations and allowable charges. Six month pre-existing period may apply to group plans, except for members up to age 19. Mental Health and Substance Use Disorder Services are covered the same as any other condition. The annual deductible must be satisfied before copays apply. **Unlimited lifetime maximum benefits.**

Alliance High Deductible Health Plan Benefits	Benefit Levels			
	Preferred Provider (PPO)		Nonpreferred Provider	
	Plan 7	Plan 8	Plan 7	Plan 8
Annual Deductible Options (per individual) ^{1,2} If a person takes Family Coverage, the whole Family Deductible (\$6,000) must be met through a combination of family members' expenses before anyone in the family has ANY expenses covered (except Preventive)	\$3,000 (\$6,000 Family)	\$5,000 (\$10,000 Family)	\$6,000 (\$12,000 Family)	\$10,000 (\$20,000 Family)
Coinsurance: Percentage of covered charges that the member pays after the deductible is met. The covered charge may be less than the billed charge. You pay difference between covered charge and billed charge if you visit a nonpreferred provider. ²	Plan pays 100% After Deductible	Plan pays 100% After Deductible	50% Up to \$4,000 (Up to \$8,000 Family)	50% Up to \$5,000 (Up to \$10,000 Family)
Annual Out-of-Pocket Limit: Includes deductible and coinsurance only – does not include copays, penalty amounts or non-covered charges.	\$3,000 (\$6,000 Family)	\$5,000 (\$10,000 Family)	\$10,000 (\$20,000 Family)	\$15,000 (\$30,000 Family)
PPO Primary Provider (PPP)* vs. PPO Specialist (including Urgent Care) Office Visit/Exam	PPO deductible		non-PPO deductible/coinsurance	
Office Visit/Exams (non-routine) and Urgent Care:	PPO deductible		non-PPO deductible/coinsurance	
Office Surgery (including casts, splints and dressings)				
Diagnostic (nonroutine) Lab Tests, X-Rays, EKGs, Other Diagnostic Tests				
Therapeutic Injections: Allergy injections, tests, serum				
Family Planning Services (IUD insertion, diaphragm, cervical cap) Infertility Counseling services limited to \$5,000 lifetime				
All other services received during an office visit (unless specifically mentioned below as being subject to deductible and coinsurance; e.g., therapy)				
Preventive/Routine Services, Adult/Child				
Office exam/physical	Plan pays in full		non-PPO deductible/coinsurance	
Routine lab and x-ray, mammograms, Pap tests, colonoscopy, routine vision or hearing screenings, immunizations, health education and counseling, including for smoking cessation	Plan pays in full		non-PPO deductible/coinsurance	
Acupuncture Treatment (max. \$500/calendar year)	PPO deductible		Not covered	
Ambulance Services, Ground and Emergency Air Ambulance	PPO deductible/coinsurance ⁷			
Ambulance, Nonemergency Air Transport	PPO deductible ³		non-PPO deductible/coinsurance ³	
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)	PPO deductible ³		non-PPO deductible/coinsurance ³	
Cardiac Rehabilitation, Outpatient (max. 36 visits/calendar year)	PPO deductible ³		Not covered	
Emergency Room Treatment	PPO deductible ^{3,7}		PPO deductible ^{3,7}	
Home Health Care/Home I.V. Services (max. 100 visits /calendar year)	PPO deductible ³		non-PPO deductible/coinsurance ³	
Hospice Services	PPO deductible ^{3,4}		non-PPO deductible/coinsurance ^{3,4}	
Inpatient Hospital/Facility Services: Acute Care Medical Surgical Facility (Also see "Transplant Services," if applicable)				
Medical/Surgical and Maternity-Related Room and Board, Covered Ancillaries	PPO deductible ⁴		non-PPO deductible/coinsurance ⁴	

Note: The specific terms of coverage, exclusions and limitations are contained in the carrier policy booklet.

HDHP 7 & 8 Non-Grandfathered HDHP Plans

Routine Nursery Care for Covered Newborns (deductible waived if mother is covered and the baby is discharged on same day)	PPO deductible ⁴	non-PPO Deductible/coinsurance ⁴	
Lab X-Ray and Other Diagnostic Tests (Outpatient Facility)	PPO deductible ³	non-PPO deductible/coinsurance ³	
Maternity Services , Including Routine Pediatric Care for Covered Newborns (Also see "Inpatient Hospital/Facility Services")	PPO deductible	non-PPO deductible/coinsurance	
Mental Health Services, Inpatient and Outpatient Inpatient Hospitalization Outpatient/Office Therapy, Medication Checks, Intake Evaluations	PPO deductible ⁴ PPO deductible ³	non-PPO deductible/coinsurance ^{3,4}	
Prosthetics and Orthotics (varies by carrier)*	PPO deductible ³	non-PPO deductible/coinsurance ³	
Pulmonary Rehabilitation (max. 20 visits per calendar year)	PPO deductible ³	Not covered	
Short-Term Rehabilitation, Inpatient and Outpatient (Includes services in a rehabilitation facility and outpatient/office physical, occupational and speech therapy services.) Inpatient Hospitalization (max. 10 days per calendar year) Outpatient/Office Therapy (max. 20 visits per calendar year)	PPO deductible ⁴ PPO deductible ³	non-PPO deductible/coinsurance ⁴ non-PPO deductible/coinsurance ³	
Spinal Manipulation (max. \$500/calendar year)	PPO deductible	Not covered	
Supplies and Durable Medical Equipment	PPO deductible ^{3,6}	non-PPO deductible/coinsurance ^{3,6}	
Surgery, Inpatient or Outpatient (For transplants, see "Transplant Services" below.)	PPO deductible ^{3,4}	non-PPO deductible/coinsurance ^{3,4}	
Therapy: Chemotherapy, Dialysis and Radiation	PPO deductible ^{3,4}	non-PPO deductible/coinsurance ^{3,4}	
TMJ/CMJ Services, Dental Accidents, Oral Surgery (Only limited and specific procedures are covered.)	PPO deductible ^{3,4}	non-PPO deductible/coinsurance ^{3,4}	
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	PPO deductible ⁴	Not covered	
Substance Use Disorder Services (Alcoholism and Drug Abuse Services) Inpatient Services Outpatient/Office Services	PPO deductible ⁴ PPO deductible ³	non-PPO deductible/coinsurance ⁴ deductible/coinsurance ³	
Prescription Drugs⁵			
The annual deductible must be satisfied before drug copays apply. Certain drugs or products may require preauthorization or benefits will be denied.	Tier 1 Generic Drug⁵	Tier 2 Formulary⁵	Tier 3 Non-Formulary⁵
Retail Pharmacy Program (up to a 30-day supply or 120 units, whichever is less)	\$20	\$45	\$75
Mail-Order Plan (up to 90-day supply or 360 units whichever is less; 2.5 x retail amount)	\$50	\$112.50	\$187.50
Specialty Pharmacy – Tier 4 (<i>injectables or oral/inhalation forms</i>)	20% of medication cost, with minimum \$75 copay and maximum \$400 copay per script ^{3,5}		

*Provision is subject to further investigation under PPACA

FOOTNOTES:

¹ The deductible must be met before benefit payments are made, excluding in-network preventive/routine care

² Deductibles and coinsurance for Preferred Provider and Nonpreferred Provider charges are separate and do not apply to one another. After you reach the applicable out-of-pocket limit, the carrier pays 100 percent of most of your covered preferred or nonpreferred provider charges, whichever is applicable.

³ Carriers may require prior notification or preauthorization for certain health services. In most cases, you are responsible for notifying the carrier before you receive these services. Please refer to the carrier policy booklet for specific information or services requiring prior notification or preauthorization. If you fail to provide prior notification or obtain preauthorization, benefits for covered services may be reduced or denied.

⁴ Carriers may require prior notification or preauthorization for inpatient admissions. You pay a penalty for covered facility services if prior notification is not given or preauthorization is not obtained. See carrier's policy booklet for details.

⁵ Prescription drugs must be purchased at a pharmacy that participates in the Retail Pharmacy, Specialty Pharmacy, or Mail Order Service programs.

⁶ Benefits for supplies are limited to a 30-day supply purchased during a 30-day period. Rental benefits for medical equipment and other items will not exceed purchase price of a new unit.

⁷ Initial treatment of a medical emergency is paid at the Preferred Provider benefit level. When received from an out-of-network provider, covered follow-up treatment and treatment that is not for an emergency is payable at the Non-Preferred Provider level.

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