



Summary of Benefits

HMO

Renewing Business 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. Your maximum out-of-pocket per calendar year for covered services is \$3,500 individual or \$7,000 family subject to provisions of the coverage certificate. 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.**

Physician's care including: <ul style="list-style-type: none"> Primary Care Preventative Care including lab and x-rays; screening mammograms and pap smears Specialist and Consultant Care Well-Child Care Routine Immunizations and Injections Urgent Care Facility Specialty Pharmaceuticals (injections administered in physician's office) 	\$35 copay for each visit to a Participating Primary Care Physician and \$50 copay 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 	\$35 copay
<ul style="list-style-type: none"> Chemotherapy, Radiation Therapy, Dialysis 	No copay
Physician's Routine/preventive care office visits, including for maternity care; therapeutic injections; medication checks; limited smoking cessation counseling services, consultations, etc.	\$35 copay for each visit to a Participating Primary Care Physician and \$50 for each visit to a Participating Specialist Physician.
Diagnostic Laboratory Tests & X-ray Examinations	You pay nothing other than the office visit copay if these services are performed during an office visit with a Participating Physician. Otherwise, a separate copay for the procedure may apply.
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). Physician's and Surgeon's Care Blood and blood derivatives	You pay \$500 per day up to a maximum of \$2,500 per member per calendar year, and then the plan pays 100%. Plan pays 100% Plan pays 100% of cost of administration.
Outpatient Hospital Services not including services received in the Emergency Room Chemotherapy, Radiation Therapy, Dialysis Specialty Pharmaceuticals (administered in outpatient hospital)	Plan pays 100% after a \$350 copay for each visit to a Participating Hospital Outpatient Dept. when authorized. No copay. Fees vary by HMO carrier in accordance with each carrier's commercial plan.
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	You pay \$35 each office visit. You pay nothing for physician's hospital care. Regular hospital benefits and copays apply for hospital stay.
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. Termination of pregnancy when medically necessary	Regular office copay. Plan covers 50% of all costs including hospital, after copay. Plan covers 100% after a \$350 copay for outpatient hospital services; regular hospital benefits and copays apply for hospital stay.
Short-Term Rehabilitation/Therapy Services Inpatient & Outpatient Physical and Occupational Therapy Inpatient Outpatient Cardiac and Pulmonary Rehabilitation Speech and Hearing Therapy	Same as Inpatient hospital Same as Specialist Physician \$50 per visit with 2 month maximum Fees vary by HMO carrier in accordance with carrier's commercial plan.

HMO GRANDFATHERED PLANS

Health Promotion Classes/information varies by company, can include but is not limited to nutrition, weight control, smoking cessation, CPR.	Fees vary by HMO carrier in accordance with each carrier's commercial plan.
Skilled Nursing Facility Care	Plan pays 100% of all charges after you pay \$500 per admission, up to 30 days per calendar year.
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	Hospital copay applies
In-Plan Emergency Care for non life-threatening emergencies, call your primary care doctor for instructions.	\$150 copay; then plan pays 100% of usual, customary and reasonable charges.
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.	\$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.
Local Ambulance Services when medically indicated.	Plan pays 100% after you pay \$50 copay for ground transportation or \$100 copay for air transportation.
Hospice 6 months life expectancy. To include respite care.	Inpatient same copay as hospitalization. Outpatient no charge. Other benefit specifics in accordance with each carrier's commercial plan.
Home Health Care Medically appropriate health services provided at the home of a Member as prescribed or directed by a Participating Physician.	Plan pays 100%, you pay nothing
Substance Use Disorder Services (Alcoholism and Drug Abuse Services)	Inpatient: You pay \$500 per day up to a maximum of \$2,500 per member per calendar year for these services. Outpatient: You pay \$35 each office visit.

Prescription Drugs, Insulin, Diabetic Supplies, Enteral Nutritional Products, Special Medical Foods¹				
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	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 Formulary¹	Tier 3 Non-formulary¹
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	50% copay. Pre-certification required.			
Acupuncture	\$50 per visit. 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	\$50 per visit. Limited to 10 visits per member per calendar year.			
Prosthetic Devices (varies by carrier)*	50% copay			

*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 General Exclusions

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| <ul style="list-style-type: none"> • 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 | <ul style="list-style-type: none"> • 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 |
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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 HMO.