PPO Plans 4, 5, 6: Summary of Benefits

EFFECTIVE 7/01/06

This is a **summary** of benefits: Please refer to your contract documents for exclusions, limitations and allowable charges. Lifetime maximum benefit is $2,000,000. (Certain services have additional limits.) All annual limits are for calendar year.

Alliance PPO Plan Benefits	Benefit Level: Choose from 1 of 3 plans					
	Preferred Provider (PPO)			Nonpreferred Provider		
	Plan 4	Plan 5	Plan 6	Plan 4	Plan 5	Plan 6
Annual Deductible Options (per individual): Family deductible is three times individual amount chosen.[1,2]	$1,000	$2,500	$10,000	$2,000	$5,000	$17,000
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. Family limit is two times the individual amount.[1]	50% $5,000 ($10,000 family)	50% $5,000 ($10,000 family)	Plan pays 100%	70% $7,000 ($14,000 family)	70% $7,000 ($14,000 family)	20% $3,000 ($6,000 family)
Stop-Loss Amount: The stop-loss amount is the shared coinsurance with the carrier and does not include the deductible. The carrier pays 100% after stop-loss. Family amounts are shown in aggregate.	$10,000 ($20,000 family)	$10,000 ($20,000 family)	N/A	$10,000 ($20,000 family)	$10,000 ($20,000 family)	$15,000 ($30,000 family)
Annual Out-of-Pocket Limit: Includes deductible and coinsurance only – does not include co-payments, penalty amounts or non-covered charges. Co-pays and special deductibles do not apply to calendar year deductible or out-of-pocket maximums.	$6,000 ($13,000 Family)	$7,500 ($17,500 Family)	$10,000 ($30,000 Family)	$9,000 ($20,000 Family)	$12,000 ($29,000 Family)	$20,000 ($57,000 Family)
PPO Primary Provider (PPP)* vs. PPO Specialist (including Urgent Care) Office Visit/Exam Co-payment	$30/$40	$40/$50	$50/$60	NA	NA	NA
Office Visit/Exams (nonroutine) and Urgent Care:	PPP or Specialist office visit/exam co-pay (deductible does not apply)			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, Norplant, cervical cap)						
All other services received during an office visit						
Preventative/Routine Services						
Office exam/physical	PPP or Specialist office visit/exam co-pay (deductible does not apply)			non-PPO deductible/coinsurance		
Routine lab and x-ray, mammograms, Pap tests, immunizations, routine vision or hearing screenings, immunizations	Plan pays in full			non-PPO deductible/coinsurance; vision screening not covered		
Acupuncture Treatment (max. **$500/calendar year**)	PPO deductible/coinsurance			Not covered		
Ambulance Services, Ground and Emergency Air Ambulance	PPO deductible/coinsurance					
Ambulance, Nonemergency Air Transport	PPO deductible/coinsurance			non-PPO deductible/coinsurance		
Cardiac Rehabilitation, Outpatient (max. benefit 36 visits/calendar year)	PPO deductible/coinsurance			Not covered		
Emergency Room Treatment	$100 co-payment plus PPO coinsurance (deductible waived on 50% coinsurance plans)					
Home Health Care/Home I.V. Services (max. **100 visits /calendar year**)	PPO deductible/coinsurance			non-PPO deductible/coinsurance		
Hospice Services (max. **six months of care**)	PPO deductible/coinsurance			non-PPO deductible/coinsurance		
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/coinsurance			non-PPO deductible/coinsurance		
Routine Nursery Care for Covered Newborns (deductible waived if mother is covered and the baby is discharged on same day)	PPO deductible/coinsurance			non-PPO deductible/coinsurance		
Lab X-Ray and Other Diagnostic Tests	PPO deductible/coinsurance			non-PPO deductible/coinsurance		
Maternity Services, Including Routine Pediatrician Care for Covered Newborns (Also see "Inpatient Hospital/Facility Services")	PPO deductible/coinsurance			non-PPO deductible/coinsurance		
Mental Health Services, Inpatient and Outpatient				Not covered		
Inpatient hospitalization	PPO deductible/coinsurance					
Outpatient therapy, medication checks, intake evaluations	Specialist co-pay					
Outpatient group therapy	$35	$45	$55			

Alliance PPO Plan Benefits (continued)	Preferred Provider (PPO)	Nonpreferred Provider
Prosthetics and Orthotics (limit of $2,500 per calendar year)	PPO deductible/coinsurance	non-PPO deductible/coinsurance
Pulmonary Rehabilitation (maximum 20 visits per calendar year)	PPO deductible/coinsurance	Not covered
Short-Term Rehabilitation, Inpatient and Outpatient (Includes services in a rehabilitation facility and outpatient physical, occupational and speech therapy services.) Inpatient hospitalization (max. **10 days**/calendar year) Outpatient Therapy (max. 20 visits per calendar year)	 PPO deductible/coinsurance PPO deductible/coinsurance	Not covered
Smoking/Tobacco Use Cessation Counseling: A maximum of two **90-day** courses of drug therapy (see "Prescription Drugs" below); up to **90 minutes** total provider contact time OR two multi-session group counseling programs per calendar year.	PPO deductible/coinsurance	Not covered
Spinal Manipulation (max. benefit of $500/calendar year)	PPO deductible/coinsurance	
Supplies and Durable Medical Equipment (max. benefit of $2,500 per calendar year)	PPO deductible/coinsurance	non-PPO deductible/coinsurance
Surgery, Inpatient or Outpatient (For transplants, see "Transplant Services" below.)	PPO deductible/coinsurance	non-PPO deductible/coinsurance
Therapy: Chemotherapy, Dialysis and Radiation	PPO deductible/coinsurance	non-PPO deductible/coinsurance
TMJ/CMJ Services, Dental Accidents, Oral Surgery (Only limited and specific procedures are covered.)	PPO deductible/coinsurance	non-PPO deductible/coinsurance
Transplant Services (Must be received at a facility that contracts with carrier or with the carrier's transplant network.) **Heart, Kidney, Liver, Lung, Bone Marrow Only** (Subject to a lifetime maximum benefit of **$250,000** for all transplant services combined, excluding outpatient prescription drugs.)	PPO deductible/coinsurance	Not covered
Chemical Dependency Rehabilitation (Alcoholism and Drug Abuse Services)		
Inpatient Services (max. **30 days/calendar year**) Outpatient/office services (max. **30 visits/calendar year**)	PPO deductible/coinsurance PPO deductible/coinsurance	Not covered Not covered

Prescription Drugs			
Co-payments are not applied to out-of-pocket or subject to deductible. Certain drugs or products may require prior approval or benefits will be denied. Benefits are limited to **$5,000/year**.	**Tier 1**	**Tier 2**	**Tier 3**
Retail Pharmacy Program (up to a 30-day supply or 120 units, whichever is less)	$20	$40	$60
Mail-Order Plan (up to 90-day supply or 120 units whichever is less; 2.5 x retail amount)	$50	$100	$150

- 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.
- Initial treatment of a medical emergency is paid at the Preferred Provider benefit level. Follow-up treatment and treatment that is not for an emergency is paid at the Nonpreferred Provider level.
- Prior notification is required for certain Covered Health Services. 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.
- Admission review is required for inpatient admissions. You pay a penalty for covered medical/surgical facility services if admission review approval is not obtained. Some services, such as transplants, require additional approval. See contract for details.
- Calendar year limits are for Preferred Provider and Nonpreferred Provider charges/visits combined.

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