



Alliant Plus Health Plan Summary of Benefits

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| National Association for Socially Responsible Orgs Co-op | | |
| Effective Date 7/1/2006 | | Ref 0651661001 |
| This is a brief summary of benefits and limitations. THIS IS NOT A CONTRACT. For a more detailed description of your benefits and exclusions, refer to your certificate of coverage or contact your employer or benefits administrator. | | |
| Benefit | Inside Network | Outside Network |
| Network | When care is provided or referred by the Managed Health Care Network (MHCN). Benefit allowances utilized inside the Network cannot be duplicated outside the Network. | When care is not provided by or referred by the Managed Health Care Network. Benefit allowances utilized outside the Network cannot be duplicated inside the Network. |
| Hospital Admission Certification | Not required. | All scheduled inpatient hospital admissions must be authorized by GHO at least seventy-two (72) hours in advance. |
| "Welcome" Outpatient Service Waiver | No "Welcome" Outpatient Service Waiver. | Not applicable. |
| Annual Deductible | \$100 per Member or \$300 per family unit per calendar year. | \$200 per Member or \$600 per family unit per calendar year. |
| Plan Coinsurance | 80% after the annual deductible is satisfied. | 60% of the Usual, Customary and Reasonable (UCR) charges are covered after the annual deductible is satisfied. |
| Lifetime Maximum | \$2,000,000 per Member. | \$2,000,000 per Member. |
| Hospital Services Covered inpatient medical and surgical services, including acute chemical withdrawal (detoxification) | Covered at the plan coinsurance after the annual deductible is satisfied. | Covered at the plan coinsurance after the annual deductible is satisfied. |
| Covered outpatient hospital surgery (including ambulatory surgical centers) | Covered subject to the applicable outpatient services copayment and at the plan coinsurance after the annual deductible is satisfied. | Covered subject to the applicable outpatient services copayment and at the plan coinsurance after the annual deductible is satisfied. |
| Outpatient Services (Office Visits) Covered outpatient medical and surgical services | Covered subject to a \$15 copayment and at the plan coinsurance after the annual deductible is satisfied. | Covered subject to a \$20 copayment and at the plan coinsurance after the annual deductible is satisfied. |
| Allergy testing | Covered subject to the applicable outpatient services copayment and at the plan coinsurance after the annual deductible is satisfied. | Covered subject to the applicable outpatient services copayment and at the plan coinsurance after the annual deductible is satisfied. |
| Oncology (radiation therapy, chemotherapy) | Covered subject to the applicable outpatient services copayment and at the plan coinsurance after the annual deductible is satisfied. | Covered subject to the applicable outpatient services copayment and at the plan coinsurance after the annual deductible is satisfied. |

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| <p>Drugs – Outpatient (including mental health drugs, contraceptive drugs and devices and diabetic supplies) Prescription drugs, medicines, supplies and devices for a supply of thirty (30) days or less when listed in the GHO drug formulary</p> | <p>Covered subject to the lesser of the MHCN's charge or a \$15 copayment for generic drugs or \$30 copayment for brand name drugs.</p> | <p>Covered subject to a \$20 copayment for generic drugs or \$35 copayment for brand name drugs.</p> |
| <p>Over-the-counter drugs and medicines</p> | <p>Not covered.</p> | <p>Not covered.</p> |
| <p>Allergy serum</p> | <p>Covered subject to the applicable prescription drug cost share for each thirty (30) day supply.</p> | <p>Covered subject to the applicable prescription drug cost share for each thirty (30) day supply.</p> |
| <p>Injectables</p> | <p>Injections that can be self-administered are subject to the applicable prescription drug cost share.</p> | <p>Injections that can be self-administered are subject to the applicable prescription drug cost share.</p> |
| <p>Mail order drugs and medicines</p> | <p>Covered subject to two (2) times the applicable prescription drug cost share for each ninety (90) day supply or less.</p> | <p>Not covered.</p> |
| <p>Growth hormones</p> | <p>Covered at the plan coinsurance after the annual deductible is satisfied, subject to a twelve (12) month waiting period.</p> | <p>Covered at the plan coinsurance after the annual deductible is satisfied, subject to a twelve (12) month waiting period.</p> |
| <p>Out-of-Pocket Limit (Stop Loss)</p> | <p>Limited to an aggregate maximum of \$2,000 per Member or \$6,000 per family per calendar year. Except as otherwise noted, total out-of-pocket expenses for the following Covered Services are included in the out-of-pocket limit:</p> <ul style="list-style-type: none"> • Plan coinsurance • Emergency services at a MHCN Facility • Ambulance services | <p>Limited to an aggregate maximum of \$6,000 per Member or \$18,000 per family per calendar year. Except as otherwise noted, total out-of-pocket expenses for the following Covered Services are included in the out-of-pocket limit:</p> <ul style="list-style-type: none"> • Plan coinsurance • Emergency services at a non-MHCN Facility |
| <p>Acupuncture</p> | <p>Covered subject to the applicable outpatient services copayment and at the plan coinsurance for self-referrals to a MHCN Provider up to a maximum of eight (8) visits per Member per medical diagnosis per calendar year, after the annual deductible is satisfied. When approved by GHO, additional visits are covered subject to the applicable outpatient services copayment and at the plan coinsurance after the annual deductible is satisfied.</p> | <p>Covered subject to the applicable outpatient services copayment and at the plan coinsurance after the annual deductible is satisfied.</p> |

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| <p>Ambulance Services Emergency ground/air transport</p> <p>Non-emergent ground/air interfacility transfer</p> | <p>Covered at 80%.</p> <p>Covered at 80% for MHCN-initiated transfers, except hospital-to-hospital ground transfers covered in full.</p> | <p>Covered at 80%.</p> <p>Covered at 80% for transport from one medical facility to the nearest facility equipped to render further Medically Necessary treatment when prescribed by the attending physician. Services are not subject to the annual deductible. Coinsurance does not apply to the out-of-pocket limit.</p> |
| <p>Chemical Dependency Inpatient services</p> | <p>Covered subject to the applicable inpatient services copayment and at the plan coinsurance after the annual deductible is satisfied.</p> | <p>Covered at the plan coinsurance after the annual deductible is satisfied.</p> |
| <p>Outpatient services</p> | <p>Covered subject to the applicable outpatient services copayment and at the plan coinsurance after the annual deductible is satisfied.</p> | <p>Covered subject to the applicable outpatient services copayment and at the plan coinsurance after the annual deductible is satisfied.</p> |
| <p>Benefit period allowance</p> | <p>\$13,000 maximum per Member per any twenty-four (24) consecutive calendar month period.</p> <p>Acute detoxification covered as any other medical service. Charges incurred are not subject to the twenty-four (24) month maximum.</p> | <p>\$13,000 maximum per Member per any twenty-four (24) consecutive calendar month period.</p> <p>Acute detoxification covered as any other medical service. Charges incurred are not subject to the twenty-four (24) month maximum.</p> |
| <p>Devices, Equipment and Supplies (for home use) Covered items include:</p> <ul style="list-style-type: none"> • Durable medical equipment • Orthopedic appliances • Post-mastectomy bras [limited to two (2) every six (6) months] • Ostomy supplies • Prosthetic devices | <p>Covered at 50% up to \$5,000 (\$2,500 maximum benefit) per calendar year.</p> <p>Covered at 50% up to \$40,000 (\$20,000 maximum benefit) per calendar year.</p> | <p>Covered at 50% up to \$5,000 (\$2,500 maximum benefit) per calendar year after the annual deductible is satisfied.</p> <p>Covered at 50% up to \$40,000 (\$20,000 maximum benefit) per calendar year after the annual deductible is satisfied.</p> |
| <p>Diabetic Supplies</p> | <p>Insulin, needles, syringes and lancets - see Drugs-Outpatient. External insulin pumps, blood glucose monitors, testing reagents and supplies - see Devices, Equipment and Supplies. When Devices, Equipment and Supplies have a dollar maximum, diabetic supplies are not subject to this maximum benefit limit.</p> | <p>Insulin, needles, syringes and lancets - see Drugs-Outpatient. External insulin pumps, blood glucose monitors, testing reagents and supplies - see Devices, Equipment and Supplies. When Devices, Equipment and Supplies have a dollar maximum, diabetic supplies are not subject to this maximum benefit limit.</p> |
| <p>Diagnostic Laboratory and Radiology Services</p> | <p>Covered at the plan coinsurance after the annual deductible is satisfied.</p> | <p>Covered at the plan coinsurance after the annual deductible is satisfied.</p> |

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| <p>Emergency Services</p> | <p>Covered subject to a \$75 copayment per Member per emergency visit at a MHCN Facility, then covered at the plan coinsurance after the annual deductible is satisfied. Copayment is waived if the Member is admitted as an inpatient to the hospital directly from the emergency department. Emergency admissions are covered subject to the applicable inpatient services cost share.</p> | <p>Covered subject to a \$125 deductible per Member per emergency visit at a non-MHCN Facility (world-wide), then covered at the plan coinsurance after the annual deductible is satisfied. Deductible is waived if the Member is admitted as an inpatient to the hospital directly from the emergency department. Emergency admissions are covered subject to the applicable inpatient services cost share. The Member must notify GHO within twenty-four (24) hours following admission and agree to have care managed by the MHCN in order to have inpatient services covered under the MHCN benefit level. If the Member does not notify GHO within twenty-four (24) hours following admission, or declines to have care managed by the MHCN, all inpatient services are covered subject to the applicable inpatient services cost share.</p> |
| <p>Hearing Examinations and Hearing Aids</p> | <p>Hearing examinations to determine hearing loss are covered subject to the applicable outpatient services copayment and at the plan coinsurance after the annual deductible is satisfied.</p> <p>Hearing aids, including hearing aid examinations are not covered.</p> | <p>Hearing examinations to determine hearing loss are covered subject to the applicable outpatient services copayment and at the plan coinsurance after the annual deductible is satisfied.</p> <p>Hearing aids, including hearing aid examinations, are not covered.</p> |
| <p>Home Health Services</p> | <p>Covered in full. No visit limit.</p> | <p>Covered at the plan coinsurance after the annual deductible is satisfied.</p> |
| <p>Hospice Services</p> | <p>Covered in full.</p> | <p>Covered at the plan coinsurance after the annual deductible is satisfied.</p> |
| <p>Infertility Services (including sterility)</p> | <p>Not covered.</p> | <p>Not covered.</p> |
| <p>Manipulative Therapy</p> | <p>Covered subject to the applicable outpatient services copayment and at the plan coinsurance for self-referrals to a MHCN Provider for manipulative therapy of the spine up to a maximum of ten (10) visits per Member per calendar year, after the annual deductible is satisfied. When approved by GHO, additional manipulation visits are covered subject to the applicable outpatient services copayment and at the plan coinsurance after the annual deductible is satisfied.</p> | <p>Covered subject to the applicable outpatient services copayment and at the plan coinsurance for manipulative therapy of the spine or extremities up to a maximum of ten (10) visits per Member per calendar year, after the annual deductible is satisfied.</p> |
| <p>Maternity and Pregnancy Services Delivery and associated hospital care</p> | <p>Covered subject to the applicable inpatient services copayment and at the plan coinsurance after the annual deductible is satisfied.</p> | <p>Covered at the plan coinsurance after the annual deductible is satisfied.</p> |
| <p>Routine prenatal and postpartum care</p> | <p>Covered subject to the applicable outpatient services copayment and at the plan coinsurance after the annual deductible is satisfied.</p> | <p>Covered subject to the applicable outpatient services copayment and at the plan coinsurance after the annual deductible is satisfied.</p> |

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| <p>Mental Health Services Inpatient services</p> | <p>Covered subject to the applicable inpatient services cost share for up to twelve (12) days per Member per calendar year at a GHO-approved mental health care facility. Coinsurance applies to the out-of-pocket limit.</p> | <p>Covered subject to the applicable inpatient services cost share for up to twelve (12) days per Member per calendar year. Coinsurance applies to the out-of-pocket limit.</p> |
| <p>Outpatient services</p> | <p>Covered subject to the applicable outpatient services cost share for up to twenty (20) visits per Member per calendar year. Coinsurance applies to the out-of-pocket limit.</p> | <p>Covered subject to the applicable outpatient services cost share for up to twenty (20) visits per Member per calendar year. Coinsurance does not apply to the out-of-pocket limit.</p> |
| <p>Naturopathy</p> | <p>Covered subject to the applicable outpatient services copayment and at the plan coinsurance for self-referrals to a MHCN Provider up to a maximum of three (3) visits per Member per medical diagnosis per calendar year, after the annual deductible is satisfied. When approved by GHO, additional visits are covered subject to the applicable outpatient services copayment and at the plan coinsurance after the annual deductible is satisfied.</p> | <p>Covered subject to the applicable outpatient services copayment and at the plan coinsurance after the annual deductible is satisfied.</p> |
| <p>Optical Services Routine eye examinations</p> | <p>Covered subject to the applicable outpatient services copayment once every twelve (12) months, except as Medically Necessary.</p> | <p>Not covered. Eye examinations for eye pathology are covered when Medically Necessary.</p> |
| <p>Lenses, including contact lenses, and frames</p> | <p>Not covered. One contact lens per diseased eye, when in lieu of an intraocular lens, is covered at the plan coinsurance after the annual deductible is satisfied following cataract surgery, provided the Member has been continuously covered by GHO since such surgery.</p> | <p>Not covered. One contact lens per diseased eye, when in lieu of an intraocular lens, is covered at the plan coinsurance after the annual deductible is satisfied following cataract surgery, provided the Member has been continuously covered by GHO since such surgery.</p> |
| <p>Organ Transplants</p> | <p>Covered subject to the applicable Copayment and at the plan coinsurance up to a \$200,000 lifetime benefit maximum (including donor costs up to \$50,000) after the annual deductible is satisfied. Coverage for all transplants, including follow-up care, is excluded until the Member has been continuously enrolled under a GHO or Group Health Cooperative (GHC) plan for twelve (12) months.</p> | <p>Covered at the plan coinsurance up to a \$200,000 lifetime benefit maximum (including donor costs up to \$50,000) after the annual deductible is satisfied. Coverage for all transplants, including follow-up care, is excluded until the Member has been continuously enrolled under a GHO or Group Health Cooperative (GHC) plan for twelve (12) months. Transplant services must be received at a facility authorized in advance by GHO.</p> |

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| <p>Pre-Existing Condition</p> | <p>Covered (except as specified) subject to the applicable cost share, after the Member has been continuously covered under a GHO plan for three (3) consecutive months, except as described below. Coverage for PKU formula, maternity and breast reconstruction following a mastectomy is not subject to the pre-existing condition waiting period.</p> <p>Pre-existing condition wait will be credited for a Member whose date of application for coverage under this GHO plan is within ninety (90) days of termination of prior similar coverage, provided the Member has satisfied the pre-existing condition wait under such prior coverage.</p> | <p>Covered (except as specified) subject to the applicable cost share, after the Member has been continuously covered under a GHO plan for three (3) consecutive months, except as described below. Coverage for PKU formula, maternity and breast reconstruction following a mastectomy is not subject to the pre-existing condition waiting period.</p> <p>Pre-existing condition wait will be credited for a Member whose date of application for coverage under this GHO plan is within ninety (90) days of termination of prior similar coverage, provided the Member has satisfied the pre-existing condition wait under such prior coverage.</p> |
| <p>Preventive Services (well adult and well child physicals, immunizations, pap smears, mammograms)</p> | <p>Covered subject to the applicable outpatient services copayment and at the plan coinsurance when in accordance with the well-care schedule established by GHO. Not subject to the annual deductible. Excluded are physicals for travel, employment, insurance, license, etc. Services provided during a preventive care visit which are not in accordance with the well-care schedule are covered subject to the applicable outpatient services copayment and at the plan coinsurance after the annual deductible is satisfied.</p> | <p>Not covered, except for routine mammography services covered at the plan coinsurance after the annual deductible is satisfied. Excluded are physicals for travel, employment, insurance, license, etc.</p> |
| <p>Rehabilitation Services Inpatient physical, occupational and restorative speech therapy services combined, including services for neurodevelopmentally disabled children age six (6) and under</p> | <p>Covered subject to the applicable inpatient services copayment and at the plan coinsurance for up to sixty (60) days per calendar year, after the annual deductible is satisfied.</p> | <p>Covered at the plan coinsurance for up to sixty (60) days per calendar year, after the annual deductible is satisfied.</p> |
| <p>Outpatient physical, occupational and restorative speech therapy services combined, including services for neurodevelopmentally disabled children age six (6) and under</p> | <p>Covered subject to the applicable outpatient services copayment and at the plan coinsurance for up to sixty (60) visits per calendar year, after the annual deductible is satisfied.</p> | <p>Covered subject to the applicable outpatient services copayment and at the plan coinsurance for up to sixty (60) visits per calendar year, after the annual deductible is satisfied.</p> |
| <p>Skilled Nursing Facility (SNF)</p> | <p>Covered at the plan coinsurance up to sixty (60) days per Member per calendar year, after the annual deductible is satisfied.</p> | <p>Covered at the plan coinsurance up to sixty (60) days per Member per calendar year, after the annual deductible is satisfied.</p> |
| <p>Sterilization (vasectomy, tubal ligation)</p> | <p>Covered subject to the applicable outpatient services copayment and at the plan coinsurance after the annual deductible is satisfied. Procedures to reverse a sterilization are not covered.</p> | <p>Covered subject to the applicable outpatient services copayment and at the plan coinsurance after the annual deductible is satisfied. Procedures to reverse a sterilization are not covered.</p> |

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| <p>Temporomandibular Joint (TMJ) Services Inpatient and outpatient TMJ services</p> <p>Lifetime benefit maximum</p> | <p>Covered subject to the applicable copayment and at the plan coinsurance up to a \$1,000 maximum per Member per calendar year, after the annual deductible is satisfied.</p> <p>Covered up to \$5,000 per Member.</p> | <p>Covered subject to the applicable copayment and at the plan coinsurance up to a \$1,000 maximum per Member per calendar year, after the annual deductible is satisfied.</p> <p>Covered up to \$5,000 per Member.</p> |
| <p>Tobacco Cessation Individual/group sessions</p> <p>Approved pharmacy products</p> | <p>Covered in full.</p> <p>Covered subject to the lesser of the MHCN's charge or the applicable prescription drug cost share for a supply of thirty (30) days or less of a prescription or refill when prescribed by a MHCN Provider and obtained at a MHCN Facility.</p> | <p>Not covered.</p> <p>Not covered.</p> |
| <p>Limitations</p> | <p>Coverage for cosmetic services is limited to breast reconstruction following mastectomy, and reconstructive breast reduction on non-diseased breast.</p> | <p>Coverage for cosmetic services is limited to breast reconstruction following mastectomy, and reconstructive breast reduction on non-diseased breast.</p> |
| <p>Exclusions</p> | <p>Services or programs not provided or authorized by MHCN staff (except as specified); travel medications; investigational or experimental procedures, drugs and devices; dental care; arch supports including custom shoe modifications or inserts and their fittings except for therapeutic shoes, modifications and shoe inserts for severe diabetic foot disease; convalescent or custodial care; cardiac rehabilitation programs; services covered by first-party insurance; services covered by government and military programs; employment, license, immigration or insurance examinations or reports.</p> <p>Unless otherwise noted as covered, the following services are also excluded: diagnostic testing of sterility, infertility or sexual dysfunction; work-related conditions (including self-employment, L&I and worker's compensation).</p> | <p>Travel medications; investigational or experimental procedures, drugs and devices; dental care; arch supports including custom shoe modifications or inserts and their fittings except for therapeutic shoes, modifications and shoe inserts for severe diabetic foot disease; convalescent or custodial care; cardiac rehabilitation programs; services covered by first-party insurance; services covered by government and military programs; employment, license, immigration or insurance examinations or reports.</p> <p>Unless otherwise noted as covered, the following services are also excluded: diagnostic testing of sterility, infertility or sexual dysfunction; work-related conditions (including self-employment, L&I and worker's compensation); routine eye examinations; most preventive care services.</p> |