

**Effective Date** 10/1/2009**Health Plan** Alliant Select**Ref** RQ-15927

This is a brief summary of benefits. THIS IS NOT A CONTRACT OR CERTIFICATE OF COVERAGE. All benefit descriptions, including alternative care, are for medically necessary services. The Member will be charged the lesser of the cost share for the covered service or the actual charge for that service. For full coverage provisions, including limitations, please contact our Sales or Customer Service Departments or refer to the plan contract.

Benefits	Inside Network
<b>Plan deductible (PCY) - per calendar year</b>	No Annual Deductible
<b>Plan coinsurance</b>	No Plan Coinsurance
<b>Pre-existing condition (PEC) waiting period</b>	No PEC
<b>Out-of-pocket limit</b>	Individual out-of-pocket limit: \$2000 Family out-of-pocket limit: \$4000
<b>Lifetime Maximum</b>	\$2 million
<b>Outpatient Services (Office visits - OV)</b>	\$20 copay
<b>Hospital services</b>	<b>Inpatient services:</b> Covered in full <b>Outpatient surgery:</b> \$20 copay
<b>Prescription drugs</b>	Formulary generic and/or brand \$20 copay
<b>Prescription mail order</b>	\$5 discount per 30 day supply
<b>Acupuncture</b>	Self-referred up to 8 visits per medical diagnosis PCY; additional visits when approved by plan \$20 copay
<b>Ambulance Services</b>	80/20% coinsurance
<b>Chemical Dependency</b>	\$14,500 per 24 months <b>Outpatient:</b> \$20 copay <b>Inpatient:</b> Covered in full
<b>Devices, equipment and supplies (DME prosthetics)</b>	Covered in full
<b>Diagnostic lab and X-ray Services (outpatient)</b>	Covered in full
<b>Emergency Services (copay waived if admitted)</b>	\$75 copay at a designated facility \$125 copay at a non designated facility
<b>Growth hormone</b>	Covered at pharmacy cost share; no wait
<b>Hearing exams (Routine)</b>	\$20 copay
<b>Hearing hardware</b>	Not covered
<b>Home health</b>	Covered in full. No visit limit.
<b>Infertility services</b>	Not covered
<b>Manipulative therapy</b>	Self-referred up to 10 visits PCY \$20 copay
<b>Maternity services</b>	<b>Outpatient:</b> \$20 copay <b>Inpatient:</b> Covered in full
<b>Mental Health</b>	<b>Outpatient:</b> 20 visits PCY \$20 copay <b>Inpatient:</b> 12 days PCY Covered in full
<b>Naturopathy</b>	Self-referred up to 3 visits per medical diagnosis PCY; additional visits when approved by plan \$20 copay
<b>Obesity-related surgery (bariatric)</b> When medically necessary and authorized lifetime max	Not covered

<b>Organ transplants</b> Donor search & harvest rolls to lifetime max	Credit wait period <b>Outpatient:</b> \$20 copay <b>Inpatient:</b> Covered in full
<b>Preventive care</b> Well-care physicals, immunizations, Pap smear exams, mammograms	\$20 copay
<b>Rehabilitation services</b> (Occupational, speech, physical-including massage) Rehab visits are a total of combined therapy visits PCY	<b>Outpatient:</b> 60 visits PCY \$20 copay <b>Inpatient:</b> 60 days PCY Covered in full
<b>Skilled nursing facility (PCY)</b>	Covered in full up to 60 days
<b>Sterilization</b> (vasectomy, tubal ligation)	\$20 copay
<b>Temporomandibular Joint (TMJ) Services</b>	\$1,000 PCY; \$5,000 lifetime max <b>Outpatient:</b> \$20 copay <b>Inpatient:</b> Covered in full
<b>Tobacco Cessation</b> See pharmacy benefit for associated drug coverage	Free & Clear Program - covered in full
<b>Vision care</b> Routine vision exam (1 visit every 12 months) No limit for medically necessary eye visits	\$20 copay
<b>Optical Hardware</b> Lenses, including contact lenses, and frames	Not covered

