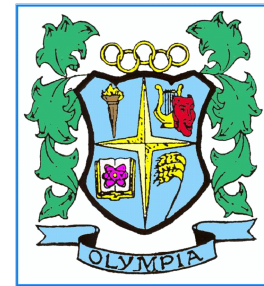




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**SCHEDULE OF BENEFITS  
MEDICAL BENEFITS**

<b>DEDUCTIBLE, PER CALENDAR YEAR</b>		
Employee	\$500	
Employee + 1	\$1,000	
Per Family Unit	\$1,500	
<b>MAXIMUM OUT-OF-POCKET AMOUNT PER CALENDAR YEAR</b>	<b>PPO Provider</b>	<b>Non-PPO Provider</b>
Employee (including deductible)	\$1,000	\$2,000
Employee + 1 (including deductible)	\$2,000	\$6,000
Per Family Unit (including deductible)	\$3,000	\$6,000
<ul style="list-style-type: none"> <li>• <b>The Preferred Provider and Non-Preferred Provider Out-of-Pocket Maximums are calculated on a separate basis.</b></li> <li>• Unless otherwise noted, the Plan will pay the designated percentage of covered charges after the calendar year deductible is met until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of covered charges for the rest of the calendar year.</li> <li>• The following do not apply to your out-of-pocket limit:               <ul style="list-style-type: none"> <li>○ Co-payments</li> <li>○ Outpatient Mental Illness/Substance Abuse services</li> <li>○ Plan Exclusions</li> </ul> </li> </ul>		
<b>ANNUAL MAXIMUM</b>	\$2,000,000	
Covered charges for routine mammograms (including diagnostic ultrasounds) do not apply to the lifetime maximum when received from a Preferred Provider.		
<b>COVERED SERVICES</b>	<b>PPO Provider</b>	<b>Non-PPO Provider</b>
<b>Well-Adult Care</b> (age 16+) (Immunizations excluded with the exception of HPV (for females only at recommended age) and Shingles over age 60)	100% up to \$400 maximum per calendar year then deductible/90%	
<b>Well-Child Care</b> (birth to age 16) (Immunizations excluded with the exception of HPV (for females only at recommended age) and Shingles over age 60)	100% up to \$200 per calendar year then deductible/90%	
<b>Hospital Services</b>		
Room and Board (semi-private)	90%	70%
ICU or CCU	90%	70%
Other Inpatient	90%	70%
Outpatient Surgery & Diagnostic	90%	70%
Outpatient Pre-Admission Testing	90%	70%
Outpatient Emergency Room	\$100 Copayment, then 90% (Deductible waived)	\$100 Copayment, then 70% (Deductible waived)
Hospital Satellite Urgent Care Clinic	\$20 Copayment, then 100% (Deductible waived)	70%
Inpatient Rehabilitation Facility	90%	70%
<b>Skilled Nursing Facility</b> <sup>1</sup>	90%	70%
<b>Physician Services</b>		

<sup>1</sup> Skilled Nursing has 120 days per Sickness or Injury maximum.

Inpatient visits	90%	70%
Office visits (exams only)	\$20 Copayment, then 100% (Deductible waived)	70%
Labs, X-rays	90%	70%
Office Surgery	90%	70%
Other Surgery	90%	70%
Second Surgical Opinions	90%	70%
<b>Colonoscopy</b> (preventive as recommended by the AMA and ACS guidelines)	100% (Deductible waived)	70%
<b>Routine Hearing Exam</b> (age 19+)	\$20 Copayment, then 100% (Deductible waived)	Not covered
<b>Routine Mammograms (does not apply to Wellness Maximum)</b>	100% (Deductible waived)	70%
<b>Home Health Care</b> <sup>2</sup>	90%	70%
<b>Hospice Care</b>	90%	70%
<b>Oral Surgery</b>	90%	70%
<b>Private Duty Nursing</b>	90%	70%
<b>TMJ</b>	\$1,000 maximum per calendar year	
<b>Ambulance Service</b>	80%	80%
<b>Occupational Therapy</b>	90%	70%
<b>Speech Therapy</b>	90%	70%
<b>Physical Therapy</b>	90%	70%
<b>Respiratory Therapy</b>	90%	70%
<b>Spinal Manipulations</b>	80% \$250 maximum per calendar year	
<b>Chiropractic Care</b>	80%	
<b>Durable Medical Equipment</b>	90%	70%
<b>Prosthetics</b>	90%	70%
	<b>PPO Provider</b>	<b>Non-PPO Provider</b>
<b>Medical Supplies</b>	90%	70%
<b>Maternity</b>	Same as any Sickness	
<b>Birth Center</b>	90%	70%
<b>Mental Illness</b> <sup>3</sup>		
Office visits and outpatient treatment	50% Maximum 30 days/visits per calendar year	
Inpatient treatment	90% Maximum 30 days/visits per calendar year	70% Maximum 30 days/visits per calendar year
<b>Substance Abuse</b> <sup>3</sup>		
Office visits and outpatient treatment	50% Maximum 30 days/visits per calendar year	
Inpatient treatment	90% Maximum 30 days/visits per calendar year	70% Maximum 30 days/visits per calendar year

<sup>2</sup> Home Health Care has 100 days/visits maximum per calendar year.

<sup>3</sup> Mental Illness/Substance Abuse has 30 days/visits combined maximum per calendar year. Includes inpatient and outpatient services.

Substance Abuse Lifetime Maximum	\$25,000	
<b>Organ Transplants</b>	90%	70%
<b>Gastric Bypass Surgery</b>	\$5,000 Copayment, then 90% (Deductible waived)	\$5,000 Copayment, then 70% (Deductible waived)
<b>Lap Band Surgery</b>	\$2,500 Copayment, then 90% (Deductible waived)	\$2,500 Copayment, then 70% (Deductible waived)
<b>Autism Spectrum Disorder</b> Plan yr: 9-1-10 to 8-31-11 - \$37,260 Plan yr: 9-1-11 to 8-31-12 - \$38,527	90%	70%
Maximum benefit is the annual limit required by law. To determine the maximum benefit available, call the Customer Service department at the number listed on the back of your Identification Card.		
<b>All Other Covered Services<sup>4</sup></b>	90%	70%
<b>Prescription Drug Program Benefits</b>		
Pharmacy (30-day supply)		
Generic Drug	\$10 Copayment	
Formulary Drug	\$20 Copayment	
Non-Formulary Drug	\$40 Copayment	
Mail-Order (90-day supply)		
Generic Drug	\$15 Copayment	
Brand-Name Drug	\$30 Copayment	
Non-Formulary Drug	\$60 Copayment	
<b>Utilization Review Penalty</b>	\$1,000	

<sup>4</sup> Except with respect to dental and vision benefits described in the Dental and Vision Benefits section.



## **Dental and Vision Benefits**

### (A) Dental Expenses Covered

Dental services covered by the Plan are broken into the following four separate classes and are paid at the designated percentages of Reasonable and Customary Expenses Incurred up to maximum of \$1,500 per individual per calendar year:

Preventive/Basic Dental Services	80%
Major Dental Services	50%
Orthodontics Services	50%

- (1) Preventative/Basic Dental Services – paid at 80% with no deductible
- (a) routine oral examinations, limited to two (2) annually;
  - (b) routine prophylaxis (cleaning, scaling and polishing) by a dentist or dental hygienist, limited to two (2) per year;
  - (c) fluoride treatment (limited to age 19), limited to two (2) annually;
  - (d) fillings (deciduous and permanent);
  - (e) space maintainers;
  - (f) emergency treatment to relieve pain;
  - (g) endodontics including pulpotomy;
  - (h) oral surgery not otherwise covered under the Medical Benefits Section;
  - (i) extractions;
  - (j) periodontics;
  - (k) bitewing dental x-rays, limited to two (2) annually;
  - (l) full mouth or panoramic x-rays, limited to one (1) every twenty-four (24) months;

- (m) sealants, limited to one (1) per tooth annually up to age nineteen (19);
  - (n) local anesthetics except for three (3) or less simple extractions;
  - (o) denture repair, relining, recementing inlays, onlays and crowns;
  - (p) pulp capping and root canal therapy.
- (2) Major Services – with benefits paid at 50%
- (a) gold foil restorations
  - (b) inlays and onlays
  - (c) crowns or crown build-ups
  - (d) dentures, full and partial
  - (e) bridges, fixed and removable
- (3) Orthodontic Services– with benefits paid at 50% to a lifetime maximum of \$2500 per individual to age 19.
- (a) orthodontia care, treatment and supplies;
  - (b) space retainers and other tooth-straightening supplies;
  - (c) other tooth/jaw appliances for purposes of tooth straightening, limited to one (1) annually;

Dental Benefits are available under this Section only if, at the start of a course of orthodontic treatment, the patient is at least six (6) years old.

Dental expenses will not be reimbursed for:

- (1) Dental work of a cosmetic nature, including altering or extracting and replacing sound teeth to change appearance;
- (2) Travel to and from the dentist;

- (3) Implants or bridges involving implants;
- (4) Lost or misplaced Dentures and other prosthetic devices;
- (5) The placement of crowns, inlays, bridges or dentures, or the relining of dentures more than once in a consecutive five year period for the same teeth or missing teeth;
- (6) Expenses not specifically listed in this Section;
- (7) Charges for failure to keep a scheduled visit with a dentist;
- (8) Maintenance items such as, but not limited to, toothpaste, toothbrushes, floss, polishing paste, soaking solutions, etc.;
- (9) Athletic mouth guards, Oral hygiene, dietary purposes, plaque control, or other educational programs.

Vision care benefits are \$225 combined for exams, frames, lenses and contact lenses per individual, for Expenses Incurred once in a calendar year. The date of possession of frames, lenses, or contact lenses will be the date the expense is incurred.



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## UTILIZATION REVIEW

All inpatient surgeries /procedures and admissions, acute hospital, acute rehab, hospice and all potential organ transplants require notification to the Utilization Review Administrator prior to any elective admission or within forty-eight (48) hours of Emergency Admission.

### Pre-determination

Predetermination for Medical Necessity for the following outpatient procedures is recommended before services are rendered:

#### \*Surgical List

- Blepharoplasty
- Mammoplasty
- Mandibular Reconstruction, Osteotomy/jaw surgery
- Maxillary Osteomy, Orthognathic surgery
- Rhinoplasty
- Septoplasty
- Uvulopalatopharyngoplasty/Uvulectomy (UPPP)
- Uvulopalatogoplasty, laser assisted / LAUP
- Varicose veins
- Excision of Benign skin legion greater than \$500
- Tonsillectomy for adults 18 and over

#### \*Diagnostic List

- Hospice
- PET Scans
- Home Health Care and services, Infusion, IV/Intravenous Therapy
- Pulmonary Rehab
- All ongoing injectable medication treatment plans > than \$100.00 ie: Growth Hormones, Epogen, Neupogen, BetaSeron, Lupron,
- DME greater than \$1,000, ie. O2 equipment, CPAP Concentrators

\* All services sent to MCM – extension \*201

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