Benefit Summary

# for Fred Hutchinson Cancer Research Center

GroupHealth

| **Effective Date** 7/1/2008 | **Health Plan** Alliant Plus | **Ref** RQ-4159 |
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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** | **Outside Network** |
|---|---|---|
| **Plan deductible** (PCY) - per calendar year | No Annual Deductible | Individual deductible: $200<br>Family deductible: $400 |
| **Plan coinsurance** | No Plan Coinsurance | Plan pays 80%, you pay 20% |
| **Pre-existing condition** (PEC) **waiting period** | 3 Months | Same as in-network |
| **Out-of-pocket limit** | Individual out-of-pocket limit: $750<br>Family out-of-pocket limit: $1500 | Individual out-of-pocket limit: $1500<br>Family out-of-pocket limit: $3000 |
| **Lifetime Maximum** | Unlimited | Shared with in-network maximum |
| **Outpatient Services** (Office visits - OV) | $20 copay | None, deductible and coinsurance apply |
| **Hospital services** | **Inpatient services:** Covered in full<br><br>**Outpatient surgery:** $20 copay | **Inpatient services:** Deductible and coinsurance apply<br><br>**Outpatient surgery:** None, deductible and coinsurance apply |
| **Prescription drugs** | Formulary generic/formulary brand/non-formulary<br>$15 copay | Formulary generic/formulary brand/non-formulary<br>Greater of $20 or 20% |
| **Prescription mail order** | 3 x prescription cost share per 90 day supply | Not covered |
| **Acupuncture** | Self-referred up to 8 visits per medical diagnosis PCY; additional visits when approved by plan<br>$20 copay | None, deductible and coinsurance apply |
| **Ambulance Services** | 80/20% coinsurance | Same as in-network |
| **Chemical Dependency** | $14,000 per 24 months<br><br>**Outpatient:** $20 copay<br>**Inpatient:** Covered in full | Benefit limits shared with in-network<br><br>**Outpatient:** None, deductible and coinsurance apply<br>**Inpatient:** Deductible and coinsurance apply |
| **Devices, equipment and supplies** (DME prosthetics) | Covered in full | Benefits and limits shared with in-network |
| **Diagnostic lab and X-ray Services** (outpatient) | Covered in full | Deductible and coinsurance apply |
| **Emergency Services** (copay waived if admitted) | $75 ER copay | $125 ER deductible<br>Plan deductible and coinsurance apply |
| **Growth hormone** | 12 month wait | Same as in-network<br>Deductible and coinsurance apply |
| **Hearing exams (Routine)** | $20 copay | None, deductible and coinsurance apply |
| **Hearing hardware** | Not covered | Not covered |
| **Home health** | Covered in full. No visit limit. | No visit limit<br>Deductible and coinsurance apply |
| **Infertility services** | Not covered | Not covered |
| **Manipulative therapy** | Self-referred up to 10 visits PCY; additional visits when approved by plan<br>$20 copay | 10 visit limit<br><br>None, deductible and coinsurance apply |
| **Maternity services** | **Outpatient:** $20 copay<br>**Inpatient:** Covered in full | **Outpatient:** None, deductible and coinsurance apply<br>**Inpatient:** Deductible and coinsurance apply |
| **Mental Health** | **Outpatient:** 20 visits PCY<br>$20 copay<br>**Inpatient:** 12 days PCY<br>Covered in full | **Outpatient:** Visit limits shared with in-network<br>None, deductible and coinsurance apply<br>**Inpatient:** Visit limits shared with in-network<br>Deductible and coinsurance apply |
| **Naturopathy** | Self-referred up to 3 visits per medical diagnosis PCY; additional visits when approved by plan<br>$20 copay | None, deductible and coinsurance apply |

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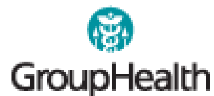
| **Obesity-related surgery (bariatric)**<br>When medically necessary and authorized lifetime max | Not covered | Not covered |
| **Organ transplants**<br>Donor search & harvest rolls to lifetime max | Waive 12 month wait<br><br>**Outpatient:** $20 copay<br>**Inpatient:** Covered in full | Benefit limit shared with in-network<br><br>**Outpatient:** None, deductible and coinsurance apply<br>**Inpatient:** Deductible and coinsurance apply |
| **Preventive care**<br>Well-care physicals, immunizations, Pap smear exams, mammograms | $20 copay | $300 per person; $600 per family PCY |
| **Rehabilitation services**<br>(Occupational, speech, physical-including massage) Rehab visits are a total of combined therapy visits PCY | **Outpatient:**60 visits PCY<br>$20 copay<br>**Inpatient:** 60 days PCY<br>Covered in full | **Outpatient:** Visit limits shared with in-network<br>None, deductible and coinsurance apply<br>**Inpatient:** Day limits shared with in-network<br>Deductible and coinsurance apply |
| **Skilled nursing facility** (PCY) | Covered in full up to 180 days | Days shared with in-network, deductible and coinsurance apply |
| **Sterilization** (vasectomy, tubal ligation) | $20 copay | None, deductible and coinsurance apply |
| **Temporomandibular Joint** (TMJ) **Services** | $1,000 PCY; $5,000 lifetime max<br><br>**Outpatient:** $20 copay<br>**Inpatient:** Covered in full | Shared with in-network<br><br>**Outpatient:** None, deductible and coinsurance apply<br>**Inpatient:** Deductible and coinsurance apply |
| **Tobacco Cessation**<br>See pharmacy benefit for associated drug coverage | Free & Clear Program - covered in full | Not Covered |
| **Vision care**<br>Routine vision exam (1 visit PCY)<br>No limit for medically necessary eye visits | $20 copay | None, deductible and coinsurance apply |
| **Optical Hardware**<br>Lenses, including contact lenses, and frames | $150 per 24 months | Shared with in-network |

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