Summary of Plan Benefits – 90/70 Plan and 80/60 Plan

Benefit Description	Percent after selected deductible In-Network *Plan Pays*	 Out-of-Network *Plan Pays*
Covered Expenses		
® Hospital Services		
Inpatient	90/80%*	70/60%*
Emergency Room (Waived if Admitted)	90/80% After $50 Co-Pay	70/60% After $50 Co-Pay
® Physician Services		
Hospital Visits	90/80%*	70/60%*
Office Visits: Primary Care	100% after $10 Co-Pay	70/60%*
Specialist	100% after $20 Co-Pay	70/60%*
Inpatient / Outpatient Surgery	90/80%*	70/60%*
Second Surgical Opinion	90/80%*	70/60%*
Pre-admission Testing	90/80% after $20 Co-Pay	70/60%*
X-Ray and Laboratory (except done in Hospital	90/80% After $20 Co-Pay	70/60%*
Routine Well Child Care ($250 max)	90/80%	70/60%*
Routine Physical Exam, including Pap Smears (250 max)	90/80%	70/60%*
Mammography	90/80% After $20 Co-Pay	70/60%*
Spinal Manipulation **($1,000 max, 16 visits max, $35 Co-Pay, Must be pre-certified)**	As described	N/A
® Physical Therapy & Outpatient Rehabilitation ($2,500 max)	90/80%*	70/60%*
® Skilled Nursing Care ($12,500 max)	90/80%*	70/60%*
® Home Health Care ($5,000 max)	90/80%*	N/A
® Hospice Care ($5,000 maximum)	90/80%*	N/A
® Ambulance Service ($1,000 max) ($75 Co-Pay)	90/80%	70/60%
® Durable Medical equipment ($1,000 max)	90/80%*	N/A
® Other Covered Expenses	90/80%*	70/60%*
® Maternity Care (For Member & Covered Spouse Only)	90/80%*	70/60%*
® Emergency Accident Care Co-Payment $50 (Waived if admitted to Hospital)	90/80%	70/60%*

***Deductible and co-insurance percentages apply to all in-network (except as noted) and out-of-network expenses. Any specified Co-Pay amounts will not be included in deductible or out-of-pocket accumulations. In-network and the out-of-network covered expenses, excluding Co-Pay amounts, will apply jointly combined with the in-network and the out-of-network deductibles and out-of-pocket maximums.**

Summary of Plan Benefits – 90/70 Plan and 80/60

Benefit Description	In-Network *Plan Pays*	Out-Out-of-Network *Plan Pays*
® Outpatient Prescription Drugs		
Retail: (Max. 30 day supply per prescription)		
Generic	100% after $10 Co-Pay	Not Covered
Brand No Generic Avail	100% after $20 Co-Pay	Not Covered
Brand Generic Avail	100% after $30 Co-Pay	
Mail Order: (Max. 90 day supply per prescription)		
Generic	100% after $20 Co-Pay	Not Covered
Brand No Generic Avail	100% after $40 Co-Pay	Not Covered
Brand Generic Avail	Not Covered	Not Covered
Maximum $2,000 per Plan year Individual Program Maximum $4,000 per Plan year Family Program		
® Hospital per Confinement Deductible ($100 In-Network, $200 Out-of-Network)	90/80%*	70/60%*
® Urgent Care Facility ($35 Co-Pay)	90/80%	70/60%*

Maximums	In-Network			Out-of-Network		
® Calendar Year Deductible*						
Per Individual Program	$250	$500	$1000	$500	$1,000	$2000
Per Family Program	$750	$1,500	$3000	$1500	$3,000	$6000
	90% Plan			90% Plan		
® Calendar Year Out-of-Pocket Maximum*	Per Individual		$1,000	Per Individual		$3,000
	Per Family		$3,000	Per Family		$9,000
® **(Excludes deductible and co-payment accumulations)**	80% Plan			80% Plan		
	Per Individual		$2,000	Per Individual		$4,000
	Per Family		$6,000	Per Family		$12,000
® Maximum Lifetime Benefits per Individual						
Hospice Care	$5,000			$5,000		
Organ Transplants **(Must be pre-Authorized, Refer to Plan Booklet)**	Covered			Covered		
Policy Maximum for All Combined In-Network and Out-of-Network Benefits	$2,000,000			$2,000,000		

*Deductible and co-insurance percentages apply to all in-network (except as noted) and out-of-network expenses. Any specified Co-Pay amounts will not be included in deductible or out-of-pocket accumulations. In-network and the out-of-network covered expenses, excluding Co-Pay amounts, will apply jointly combined with the in-network and the out-of-network deductibles and out-of-pocket maximums. Unless indicated otherwise, the listed maximum amounts are per calendar year.

Summary of Plan Benefits – 90/70 Plan and 80/60

Benefit Description	In-Network	Out-of-Network
¤ Substance Abuse Services Both inpatient and outpatient services are covered **in-network only.** Outpatient Substance Abuse Services- **in-network only,** up to 25 visits per covered person per Plan year. However, the following co-payments apply on a Per Plan year basis: First five (5) visits, in-network, International Health Alliance will cover 60% of the allowable charges; Visits 6-15, in network, International Health Alliance will cover 40% of the allowable charges; Visits 16-25, in-network, International Health Alliance will cover 20% of the allowable charges. The maximum allowable benefit for each covered person per Plan year is $1,000. The lifetime maximum allowable benefit for each covered person is $25,000. Detoxification is covered if provided in a network hospital or related institution.	As described	**N/A**
® Mental Health Services Both inpatient and outpatient services are covered **in-network only**. Up to 25 days per Plan year in participating hospital or related institution. Two (2) partial hospitalization days may be submitted for one inpatient day. Outpatient mental health – **in-network only**, up to 25 visits per covered person per Plan year. However, for outpatient mental health services, the following co-payments apply on a per Plan year basis: First five (5) visits-International Health Alliance will cover 60% of allowable charges, in-network; Visits 6-15, International Health Alliance will cover 50% of allowable charges, in-network; Visits 16-25, International Health Alliance will cover 30% of allowable charges, in-network; **Maximum allowable benefit for each outpatient treatment is $150.**	As described	**N/A**

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Refer to your pre-certification/pre-authorization listing for all services that require it.
ALL CLAIMS ARE PAID IN ACCORDANCE WITH INTERNATIONAL HEALTH ALLIANCE' NETWORK FEE SCHEDULES.

Please refer directly to International Health Alliance for information on any benefits in this International Health Alliance Handbook Benefits information which are not listed on these pages:

Except for Hospital admissions for Emergency Care, Pre-certification is required in advance of all Hospital Confinements. Emergency confinements must be certified within 48 hours of admission. If Hospital Confinement is not pre-certified as required, all benefits will be denied for that confinement.