



October 2008 - September 2009 Medical Plan Comparison

PLAN BENEFIT	ALLIANT PLUS BALANCE PLAN		ALLIANT PLUS MID PLAN		ALLIANT PLUS 50/50 PLAN	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
<b>Provider Network Access</b>	Group Health, Virginia Mason, The Everett Clinic	First Choice Network or **Any Licensed Provider	Group Health, Virginia Mason, The Everett Clinic	First Choice Network or **Any Licensed Provider	Group Health, Virginia Mason, The Everett Clinic	First Choice Network or **Any Licensed Provider
<b>Annual Deductible</b>	\$100 individual 3x Family (shared in & out of network) <b>waived for all outpatient services</b>		\$500 individual 3x Family (shared in & out of network) <b>waived for all outpatient services</b>		\$3,000 individual 3x Family (shared in & out of network) <b>waived for all outpatient services</b>	
<b>Out of Pocket Limit</b> excludes deductible	\$2,000 individual 3X Family (shared in & out of network)		\$2,000 individual 3X Family (shared in & out of network)		\$5,000 individual 3X Family (shared in & out of network)	
<b>ER Copay</b>	\$100, waived if admitted	\$150 waived if admitted	\$100, waived if admitted	\$150 waived if admitted	\$100, waived if admitted	\$150 waived if admitted
<b>Physician Office Visits</b>	\$20 copay, 100%* deductible waived	\$20 copay, 100%* deductible waived	\$20 copay, 80% deductible waived	\$20 copay, 60% deductible waived	50%, deductible waived	50%, deductible waived
<b>Preventive Care</b> in accordance w/ well care schedule	\$20 copay, 100%* deductible waived	\$20 copay, 100%* deductible waived	\$20 copay, 80% deductible waived	\$20 copay, 60% deductible waived	50%, deductible waived	50%, deductible waived
<b>Diagnostic Lab and Radiology</b>						
Inpatient	90% after deductible	70% after deductible	80% after deductible	60% after deductible	50% after deductible	50% after deductible
Outpatient	100%* deductible waived	100%* deductible waived	80%, deductible waived	60%, deductible waived	50%, deductible waived	50%, deductible waived
<b>Alternative Care</b>						
Spinal Manipulations 10 visits per calendar year	\$20 copay, 100%* deductible waived	\$20 copay, 100%* deductible waived	\$20 copay, 80% deductible waived	\$20 copay, 60% deductible waived	50%, deductible waived	50%, deductible waived
Acupuncture 8 visits per calendar year	\$20 copay, 100%* deductible waived	\$20 copay, 100%* deductible waived	\$20 copay, 80% deductible waived	\$20 copay, 60% deductible waived	50%, deductible waived	50%, deductible waived
<b>Rehabilitation Services</b>						
Inpatient 60 days per calendar year	90% after deductible	70% after deductible	80% after deductible	60% after deductible	50% after deductible	50% after deductible
Outpatient 60 visits per calendar year	\$20 copay, 100%* deductible waived	\$20 copay, 100%* deductible waived	\$20 copay, 80% deductible waived	\$20 copay, 60% deductible waived	50%, deductible waived	50% deductible waived
<b>Chemical Dependency</b> \$14,500 per any 24 consecutive months						
Inpatient	90% after deductible	70% after deductible	80% after deductible	60% after deductible	50% after deductible	50% after deductible
Outpatient	\$20 copay, 100%* deductible waived	\$20 copay, 100%* deductible waived	\$20 copay, 80% deductible waived	\$20 copay, 60% deductible waived	50%, deductible waived	50%, deductible waived
<b>Mental Health</b>						
Inpatient (facility) 12 days per calendar year	90 % after deductible	70% after deductible	80% after deductible	60% after deductible	50% after deductible	50% after deductible
Outpatient 20 visits per calendar year	\$20 copay, 100%* deductible waived	\$20 copay, 100%* deductible waived	\$20 copay, 80% deductible waived	\$20 copay, 60% deductible waived	50%, deductible waived	50%, deductible waived
<b>Lifetime Maximum</b> Up to \$5,000 annual restoration	\$2,000,000	\$2,000,000	\$2,000,000	\$2,000,000	\$2,000,000	\$2,000,000
<b>Prescription Drugs</b>						
Retail (30 day supply)	\$20/\$40	\$25/\$45	\$20/\$40	\$25/\$45	\$20/\$40	\$25/\$45
Mail Order (90 day supply)	2x retail cost share	Not covered	2x retail cost share	Not covered	2x retail cost share	Not covered

\* Deductible and Coinsurance do not apply to outpatient services

\*\* Subject to Usual, Customary and Reasonable (UCR) charges. Balance billing may apply.

This is a brief summary of benefits. For complete details of benefits and exclusions, please refer to the actual plan certificate of coverage or contract. Should there be any discrepancy the contract will be the determining document on how benefits are paid.