Allegian Health Plan Summary

Medical Plan Year Deductible	**$500 Individual**	**$1,000 Family**
Out-of-Pocket Maximum (includes deductible and copays)	**$4,500 Individual**	**$9,000 Family**
Annual Maximum		**Unlimited**
Primary Care Provider (PCP) Office Visit • Includes lab/X-ray services, injectables, and supplies • Other services provided in a physician's office are subject to additional deductible and copayments/coinsurance		$25 copayment
Specialist Office Visit • Includes lab/X-ray services • Other services provided in a physician's office are subject to additional deductible and copayments/coinsurance		$60 copayment
Preventive Care Well-woman exam, immunizations, physicals, mammograms, colorectal cancer screening		no copayment
Surgical Procedures Performed in the Physician's Office		20% copayment*
Minor Emergency/Urgency Care Visit		$75 copayment
Emergency Room		20% copayment*
Ambulance Air/Ground		20% copayment*
Inpatient Services Facility charges, physician services, surgical procedures, pre-admission testing, operating/recovery room, newborn delivery and nursery, ICU/coronary care units, laboratory tests/X-rays, rehabilitation facility		20% copayment*
Outpatient Services Facility charges, physician services, surgical procedures, observation unit		20% copayment*
Diagnostic Tests MRI, CT scan, sleep study, stress test, PET scan, ultrasound, cardiac imaging, genetic testing, colonoscopy (non-preventive)		20% copayment*
Behavioral Health Mental Health/Chemical Dependency		20% copayment*
Home Health Care *Limited to 30 visits per plan year*		20% copayment*
Hospice Care		20% copayment*
Skilled Nursing Facility *Limited to 60 days per plan year*		20% copayment*
Accidental Dental Care *Limited to $3,000 per plan year*		20% copayment*
Prosthetics *Lifetime Maximum $10,000 per device*		20% copayment*
Orthotics *Lifetime Maximum $10,000*		20% copayment*
Spinal Manipulation *Limited to 10 visits per plan year*		20% copayment*
Durable Medical Equipment *Limited to $3,000 per plan year*		20% copayment*
All Other Covered Services		20% copayment*
Pharmacy Plan Year Deductible	**$100 per Member**	
Annual Maximum	**Unlimited**	
Participating Retail Pharmacy Standard Drugs/30-day supply		
Tier 1: Generic	$10 per prescription	
Tier 2: Preferred Brand Name	$40 per prescription	
Tier 3: Non-Preferred Brand Name	$65 per prescription	
Tier 4: Specialty/High Cost Drugs	20% per prescription out-of-pocket maximum of $4,000	
Participating Mail Order Pharmacy Maintenance Drugs/90-day supply		
Tier 1: Generic	$30 per prescription	
Tier 2: Preferred Brand Name	$120 per prescription	
Tier 3: Non-Preferred Brand Name	$195 per prescription	
Tier 4: Specialty/High Cost Drugs	Not Covered	
Participating Mail Order Pharmacy and Local Participating Pharmacies		

* Subject to deductible