Kibble & Prentice
A USI Company

WASHINGTON STATE BAR ASSOCIATION

Effective Date 6/1/09 to 5/31/10

MEDICAL PLANS THROUGH GROUP HEALTH OPTIONS INC.

THIS IS A BRIEF SUMMARY OF BENEFITS AND DOES NOT INCLUDE ALL PLAN PROVISIONS, LIMITATIONS OR EXCLUSIONS. IT IS NOT A CONTRACT. PLEASE REFER TO YOUR CERTIFICATE OF COVERAGE FOR A COMPLETE LIST OF PLAN PROVISIONS.

	Options Low - POS **Western Washington #61802** **Eastern Washington #69476**		**Options Select** **Western Washington #61073** **Eastern Washington #69282**	**Options High - POS** **Western Washington #61072** **Eastern Washington #69281**		**Alliant Plus- POS** **Western Washington #50929 or #52172** **Eastern Washington #58139 or #58199**	
	Inside Network	**Outside Network**	**Group Health Network**	**Inside Network**	**Outside Network**	**Inside Network**	**Outside Network**
	When care is provided or referred by the Managed Health Care Network (MHCN). **Benefit allowances utilized inside the Network cannot be duplicated outside the Network.**	When care is not provided by or referred by the Managed Health Care Network. **Benefit allowances utilized outside the Network cannot be duplicated inside the Network.**	**Managed Care Plan**	When care is provided or referred by the Managed Health Care Network (MHCN). **Benefit allowances utilized inside the Network cannot be duplicated outside the Network.**	When care is not provided by or referred by the Managed Health Care Network. **Benefit allowances utilized outside the Network cannot be duplicated inside the Network.**	When care is provided or referred by the Managed Health Care Network (MHCN). **Benefit allowances utilized inside the Network cannot be duplicated outside the Network.**	When care is not provided by or referred by the Managed Health Care Network. **Benefit allowances utilized outside the Network cannot be duplicated inside the Network.**
Annual Calendar Year Deductible	$750/member - $2,250/family		$350/member - $1,050/family	$350/member - $700/family		$350/member - $700/family	
Plan Coinsurance	80% after the annual deductible is satisfied	60% of the Usual, Customary and Reasonable (UCR) charges are covered after the annual deductible is satisfied	90% after the annual deductible is satisfied	90% after the annual deductible is satisfied	70% of the Usual, Customary and Reasonable (UCR) charges are covered after the annual deductible is satisfied	90% after the annual deductible is satisfied	70% of the Usual, Customary and Reasonable (UCR) charges are covered after the annual deductible is satisfied
Lifetime Maximum	$2,000,000 per Member	Shared with in-network	$2,000,000 per Member	$2,000,000 per Member	Shared with in-network	$2,000,000 per Member	Shared with in-network
Hospital Services Covered inpatient medical and surgical services, including acute chemical withdrawal (detoxification)	Covered at the plan coinsurance after the annual deductible is satisfied	Covered at the plan coinsurance after the annual deductible is satisfied	Covered at the plan coinsurance after the annual deductible is satisfied	$100 copay per day up to a maximum of 3 days per Member per admit; and at plan coinsurance after the annual deductible is satisfied	$100 copay per day up to a maximum of 3 days per Member per admit; and at plan coinsurance after the annual deductible is satisfied	$100 copay per day up to a maximum of 3 days per Member per admit, and at the plan coinsurance after the annual deductible is satisfied	$100 copay per day up to a maximum of 3 days per Member per admit, and at the plan coinsurance after the annual deductible is satisfied
Covered outpatient hospital surgery (including ambulatory surgical centers)	Covered subject to $25 copay and at the plan coinsurance after the annual deductible is satisfied.	Covered subject to a $25 copay and at the plan coinsurance after the annual deductible is satisfied.	Covered subject to a $20 copay and at the plan coinsurance after the annual deductible is satisfied	Covered subject to a $20 copay and at the plan coinsurance after the annual deductible is satisfied	Covered subject to a $20 copay and at the plan coinsurance after the annual deductible has been satisfied	Covered subject to a $20 copay, and at the plan coinsurance after the annual deductible is satisfied	Covered subject to a $20 copay, and at the plan coinsurance after the annual deductible is satisfied
Outpatient Services (Office Visits) Covered outpatient medical and surgical services	Covered subject to a $25 copay and at the plan coinsurance after the annual deductible is satisfied	Covered subject to a $25 copay and at the plan coinsurance after the annual deductible is satisfied	Covered subject to a $20 copay and at the plan coinsurance after the annual deductible is satisfied	Covered subject to a $20 copay and at the plan coinsurance after the annual deductible is satisfied	Covered subject to a $20 copay and at the plan coinsurance after the annual deductible is satisfied	Covered subject to a $20 copay and at the plan coinsurance after the annual deductible is satisfied	Covered subject to a $20 copay and at the plan coinsurance after the annual deductible is satisfied.
Allergy testing	Covered subject to a $25 copay and at the plan coinsurance after the annual deductible is satisfied.	Covered subject to a $25 copay and at the plan coinsurance after the annual deductible is satisfied	Covered subject to a $20 copay and at the plan coinsurance after the annual deductible is satisfied	Covered subject to a $20 copay and at the plan coinsurance after the annual deductible is satisfied	Covered subject to a $20 copay and at the plan coinsurance after the annual deductible is satisfied	Covered subject to a $20 copay and at the plan coinsurance after the annual deductible is satisfied	Covered subject to a $20 copay and at the plan coinsurance after the annual deductible is satisfied

	Options Low - POS		Options Select	Options High - POS		Alliant Plus-POS	
Oncology (radiation therapy, chemotherapy)	Covered subject to a $25 copay and at the plan coinsurance after the annual deductible is satisfied	Covered subject to a $25 copay and at the plan coinsurance after the annual deductible is satisfied	Covered subject to a $20 copay and at the plan coinsurance after the annual deductible is satisfied	Covered subject to a $20 copay and at the plan coinsurance after the annual deductible is satisfied.	Covered subject to a $20 copay and at the plan coinsurance after the annual deductible is satisfied.	Covered subject to a $20 copay and at the plan coinsurance after the annual deductible is satisfied.	Covered subject to a $20 copay and at the plan coinsurance after the annual deductible is satisfied.
Drugs - Outpatient (including mental health drugs, contraceptive drugs and devices and diabetic supplies) Prescription drugs, medicines, supplies and devices for a supply of thirty (30) days or less when listed in the GHO drug formulary	Covered subject to the lesser of the MHCN's charge or a $15 copayment for generic drugs or $30 copayment for brand name drugs. Over the counter drugs and medicines are not covered.	Covered subject to a $20 copay for generic drugs or $35 copay for brand name drugs. Over the counter drugs and medicines are not covered.	Covered subject to the lesser of the MHCN's charge or a $15 copay for generic drugs or $30 copay for brand name drugs. Over the counter drugs and medicines are not covered.	Covered subject to the lesser of the MHCN's charge or a $15 copay for generic drugs or $30 copay for brand name drugs. Over the counter drugs and medicines are not covered.	Covered subject to a $20 copay for generic drugs or $35 copay for brand name drugs. Over the counter drugs and medicines are not covered.	Covered subject to the lesser of the MHCN's charge or a $15 copay for generic drugs or $30 copay for brand name drugs. Over the counter drugs and medicines are not covered.	Covered subject to a $20 copay for generic drugs or $35 copay for brand name drugs. Over the counter drugs and medicines are not covered.
Allergy serum	Covered subject to the applicable prescription drug cost share for each thirty (30) day supply	Covered subject to the applicable prescription drug cost share for each thirty (30) day supply	Covered subject to the applicable prescription drug cost share for each thirty (30) day supply	Covered subject to the applicable prescription drug cost share for each thirty (30) day supply	Covered subject to the applicable prescription drug cost share for each thirty (30) day supply	Covered subject to the applicable prescription drug cost share for each thirty (30) day supply	Covered subject to the applicable prescription drug cost share for each thirty (30) day supply
Injectables	Injections that can be self-administered are subject to the applicable prescription drug cost share	Injections that can be self-administered are subject to the applicable prescription drug cost share	Injections that can be self-administered are subject to the applicable prescription drug cost share.	Injections that can be self-administered are subject to the applicable prescription drug cost share	Injections that can be self-administered are subject to the applicable prescription drug cost share	Injections that can be self-administered are subject to the applicable prescription drug cost share	Injections that can be self-administered are subject to the applicable prescription drug cost share
Mail order drugs and medicines	Covered subject to a $30 copayment for generic drugs or a $60 copayment for brand name drugs for each ninety (90) day supply	Not Covered	Covered subject to a $30 copayment for generic drugs or a $60 copayment for brand name drugs for each ninety (90) day supply	Covered subject to $5 discount from prescription drug cost share for each thirty (30) day supply or less.	Not Covered	Covered subject to $5 discount from the prescription drug cost share for each thirty (30) day supply or less.	Not Covered
Growth hormones	Covered as a pharmacy cost share item	Covered as a pharmacy cost share item	Covered as a pharmacy cost share item	Covered as a pharmacy cost share item	Covered as a pharmacy cost share item	Covered as a pharmacy cost share item	Covered as a pharmacy cost share item
Out of Pocket Limit (Stop Loss)	Except as otherwise noted, the following out-of-pocket expenses apply to the out-of-pocket limit:	Except as otherwise noted, the following out-of-pocket expenses apply to the out-of-pocket limit:	Except as otherwise noted, total out-of-pocket expenses for the following Covered Services are included in the out-of-pocket limit:	Except as otherwise noted, the following out-of-pocket expenses apply to the out-of-pocket limit:	Except as otherwise noted, the following out-of-pocket expenses apply to the out-of-pocket limit:	Except as otherwise noted, the following out-of-pocket expenses apply to the out-of-pocket limit:	Except as otherwise noted, the following out-of-pocket expenses apply to the out-of-pocket limit:
	Plan Coinsurance	Plan Coinsurance	Plan Coinsurance	Plan Coinsurance	Plan Coinsurance	Plan Coinsurance	Plan Coinsurance
	Emergency care copay at a MHCN Facility	Emergency care deductible at a non-MHCN Facility	Emergency services at a MHCN or non-MHCN Facility	Emergency care copay at a MHCN Facility	Emergency care deductible at a non-MHCN Facility	Emergency care copay at a MHCN Facility	Emergency care deductible at a non-MHCN Facility
	Ambulance coinsurance/copay	Ambulance coinsurance	Ambulance services	Ambulance coinsurance/copay	Ambulance coinsurance	Ambulance coinsurance / copay	Ambulance coinsurance
	Limited to an aggregate maximum of $2,000 per Member and $6,000 per family per calendar year	Out-of-pocket limit is shared with in-network.	Limited to an aggregate maximum of $2,000 per Member and $6,000 per family per calendar year	Limited to an aggregate maximum of $2,000 per Member and $4,000 per family per calendar year	Out-of-pocket limit is shared with in-network	Limited to an aggregate maximum of $2,000 per Member and $4,000 per family per calendar year	Out -of-pocket limit is shared with in-network

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Acupuncture	Self-referrals to a MHCN Provider covered up to a maximum of eight (8) visits per member per medical diagnosis per calendar year, covered subject to a $25 copay and at the plan coinsurance after the annual deductible is satisfied. When approved by GHO, additional visits are covered subject to a $25 copay and at the plan coinsurance after the annual deductible is satisfied.	Covered subject to a $25 copay and at the plan coinsurance after the annual deductible is satisfied.	Self-referrals to a MHCN Provider covered up to a maximum of eight (8) visits per Member per medical diagnosis per calendar year, subject to a $20 copay and at the plan coinsurance after the annual deductible is satisfied. When approved by GHO, additional visits are covered subject to a $20 copay and at the plan coinsurance after the annual deductible is satisfied.	Self-referrals to a MHCN Provider covered up to a maximum of eight (8) visits per member per medical diagnosis per calendar year, subject to a $20 copay, and at the plan coinsurance after the annual deductible is met. When approved by GHO, additional visits are covered subject to a $20 copay and at the plan coinsurance after the annual deductible is met.	Covered subject to a $20 copay and at the plan coinsurance after the annual deductible	Self-referrals to a MHCN Provider covered up to a maximum of eight (8) visits per member per medical diagnosis per calendar year, subject to a $20 copay and at the plan coinsurance after the annual deductible is satisfied. . When approved by GHO, additional visits are covered subject to a $20 copay and at the plan coinsurance after the deductible is satisfied..	Covered subject to $20 copay and at the plan coinsurance after the annual deductible is satisfied
Ambulance Services Emergency ground/air transport	Covered at 80%	Covered at 80%	Covered at 80%	Covered at 80%	Covered at 80%	Covered at 80%	Covered at 80%
Chemical Dependency Inpatient Services	Covered at the plan coinsurance after the annual deductible is satisfied	Covered at the plan coinsurance after the annual deductible is satisfied	Covered at the plan coinsurance after the annual deductible is satisfied	Covered subject to $!00 copay per day up to a maximum of 3 days per Member per admit, and at plan coinsurance after annual deductible is met	Covered subject to $100 per day up to a maximum of 3 days per Member per admit and at the plan coinsurance after the annual deductible is satisfied	Covered subject to $100 per day up to a maximum of 3 days per Member per admit and at the plan coinsurance after the annual deductible. Covered subject to the applicable inpatient services copayment.	Covered subject to $100 copay per day up to a maximum of 3 days per Member per admit and at the plan coinsurance after the annual deductible is satisfied.
Outpatient Services	Covered subject to a $25 copay and at the plan coinsurance after the annual deductible is satisfied	Covered subject to s $25 copay and at the plan coinsurance after the annual deductible is satisfied	Covered subject to a $20 copay and at the plan coinsurance after the annual deductible is satisfied.	Covered subject to a $20 copay and at the plan coinsurance after the annual deductible is met	Covered subject to a $20 copay, and at the plan coinsurance after the annual deductible is satisfied	Covered subject to a $20 copay and at the plan coinsurance after the annual deductible is satisfied	Covered subject to a $20 copay and at the plan coinsurance after the annual deductible is satisfied
Benefit Period Allowance	$14,500 maximum per Member per any twenty-four (24) consecutive calendar month period. Acute detoxification covered as any other medical service. Charges incurred are not subject to the twenty-four (24) month maximum.	$14,500 maximum per Member per any twenty-four (24) consecutive calendar month period. Benefit limits shared with in-network. Acute detoxification covered as any other medical service. Charges incurred are not subject to the twenty-four (24) month maximum.	$14,500 maximum per Member per any twenty-four (24) consecutive calendar month period. Acute detoxification covered as any other medical service. Charges incurred are not subject to the twenty-four (24) month maximum.	$14,500 maximum per Member per any twenty-four (24) consecutive calendar month period. Acute detoxification covered as any other medical service. Charges incurred are not subject to the twenty-four (24) month maximum.	$14,500 maximum per Member per any twenty-four (24) consecutive calendar month period. Benefit limits shared with in-network. Acute detoxification covered as any other medical service. Charges incurred are not subject to the twenty-four (24) month maximum.	$14,500 maximum per Member per any twenty-four (24) consecutive calendar month period. Acute detoxification covered as any other medical service. Charges incurred are not subject to the twenty-four (24) month maximum.	$14,500 maximum per Member per any twenty-four (24) consecutive calendar month period. Benefits Limits shared with in-network Acute detoxification covered as any other medical service. Charges incurred are not subject to the twenty-four (24) month maximum.

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Devices, Equipment and Supplies (for home use) Covered items include: •Orthopedic appliances •Durable medical equipment •Post-mastectomy bras [limited to two (2) every six (6) months]	Covered at 50% up to $5,000 ($2,500 benefit maximum) per calendar year.	Benefits and limits shared with in-network. Covered at 50% up to $5,000 ($2,500 benefit maximum) after the annual deductible is satisfied per calendar year.	Covered at 50% up to $5,000 ($2,500 benefit maximum) per calendar year.	Covered at 50% up to $5,000 ($2,500 benefit maximum) per calendar year.	Benefits and limits shared with in-network. Covered at 50% up to $5,000 ($2,500 benefit limit) after the annual deductible is satisfied per calendar year.	Covered at 50% up to $5,000 ($2,500 benefit maximum) per calendar year.	Benefits and limits shared with in-network. Covered at 50% up to $5,000 ($2,500 benefit maximum) per calendar year after the annual deductible is satisfied .
•Prosthetic devices •Ostomy supplies	Covered at 50% up to $40,000 ($20,000 benefit maximum) per calendar year	Benefits and limits shared with in-network. Covered at 50% up to $40,000 ($20,000 benefit maximum) after the annual deductible is satisfied per calendar year	Covered at 50% up to $40,000 ($20,000 benefit maximum) per calendar year	Covered at 50% up to $40,000 ($20,000 benefit maximum) per calendar year	Benefits and limits shares with in-network. Covered at 50% up to $40,000 ($20,000 benefit maximum) after the annual deductible is satisfied per calendar year.	Covered at 50% up to $40,000 ($20,000 benefit maximum) per calendar year	Benefits and limits shared with in-network. Covered at 50% up to $40,000 ($20,000 benefit maximum) per calendar year after the annual deductible is satisfied.
Diabetic Supplies	Insulin, needles, syringes and lancets - see Drugs-Outpatient. External insulin pumps, blood glucose monitors, testing reagents and supplies - see Devices, Equipment and Supplies. When Devices, Equipment and Supplies have a dollar maximum, diabetic supplies are not subject to this maximum benefit limit.	Insulin, needles, syringes and lancets - see Drugs-Outpatient. External insulin pumps, blood glucose monitors, testing reagents and supplies - see Devices, Equipment and Supplies. When Devices, Equipment and Supplies have a dollar maximum, diabetic supplies are not subject to this maximum benefit limit.	Insulin, needles, syringes and lancets - see Drugs-Outpatient. External insulin pumps, blood glucose monitors, testing reagents and supplies - see Devices, Equipment and Supplies. When Devices, Equipment and Supplies have a dollar maximum, diabetic supplies are not subject to this maximum benefit limit.	Insulin, needles, syringes and lancets - see Drugs-Outpatient. External insulin pumps, blood glucose monitors, testing reagents and supplies - see Devices, Equipment and Supplies. When Devices, Equipment and Supplies have a dollar maximum, diabetic supplies are not subject to this maximum benefit limit.	Insulin, needles, syringes and lancets - see Drugs-Outpatient. External insulin pumps, blood glucose monitors, testing reagents and supplies - see Devices, Equipment and Supplies. When Devices, Equipment and Supplies have a dollar maximum, diabetic supplies are not subject to this maximum benefit limit.	Insulin, needles, syringes and lancets - see Drugs-Outpatient. External insulin pumps, blood glucose monitors, testing reagents and supplies - see Devices, Equipment and Supplies. When Devices, Equipment and Supplies have a dollar maximum, diabetic supplies are not subject to this maximum benefit limit.	Insulin, needles, syringes and lancets - see Drugs-Outpatient. External insulin pumps, blood glucose monitors, testing reagents and supplies - see Devices, Equipment and Supplies. When Devices, Equipment and Supplies have a dollar maximum, diabetic supplies are not subject to this maximum benefit limit.
Diagnostic Laboratory and Radiology Services	Covered at the plan coinsurance after the annual deductible is satisfied	Covered at the plan coinsurance after the annual deductible is satisfied	Covered at the plan coinsurance after the annual deductible is satisfied	Covered at the plan coinsurance after the annual deductible is satisfied	Covered at the plan coinsurance after the annual deductible is satisfied	Covered at the plan coinsurance after the annual deductible is satisfied	Covered at the plan coinsurance after the annual deductible is satisfied

	Options Low - POS		Options Select	Options High - POS		Alliant Plus-POS	
Emergency Services							
At a MHCN Facility	Covered subject to the lesser of the MHCN's charge or a $75 copay per member per emergency visit at a MHCN Facility. Copay is waived if the Member is admitted as an inpatient to the hospital directly from the emergency department. Emergency admissions are covered subject to the applicable inpatient services cost share.		Covered subject to the lesser of the MHCN's charge or a $75 copay per member per emergency visit at a MHCN Facility. Copay is waived if the Member is admitted as an inpatient to the hospital directly from the emergency department. Emergency admissions are covered subject to the applicable inpatient services cost share.	Covered subject to the lesser of the MHCN's charge or a $75 copay per member per emergency visit at a MHCN Facility. Copay is waived if the Member is admitted as an inpatient to the hospital directly from the emergency department. Emergency admissions are covered subject to the applicable inpatient services cost share.		Covered subject to the lesser of the MHCN's charge or a $75 copay per member per emergency visit at a MHCN Facility. Copay is waived if the Member is admitted as an inpatient to the hospital directly from the emergency department. Emergency admissions are covered subject to the applicable inpatient services cost share.	
At a Non-MHCN Facility		Covered subject to a $125 copay or total charges of service, whichever is less, at a non-MHCN Facility. Emergency admissions are covered subject to the applicable inpatient services cost share. Copay is waived if the member is admitted as an inpatient to a non-MHCN hospital directly from the emergency department. The Member must notify GHO within twenty-four (24) hours following admission and agree to have care managed by the MHCN in order to have inpatient services covered at the MHCN benefit level. If the member does not notify GHO within twenty-four (24) hours following admission, or declines to have care managed by the MHCN, all inpatient services the member receives are covered subject to the applicable inpatient services cost share.	Covered subject to a $125 copay or total charges of service, whichever is less, at a non-MHCN Facility. Emergency admissions are covered subject to the applicable inpatient services cost share. Copay is waived if the member is admitted as an inpatient to a non-MHCN hospital directly from the emergency department. The Member must notify GHO within twenty-four (24) hours following admission and agree to have care managed by the MHCN in order to have inpatient services covered at the MHCN benefit level. If the member does not notify GHO within twenty-four (24) hours following admission, or declines to have care managed by the MHCN, all inpatient services the member receives are covered subject to the applicable inpatient services cost share.		Covered subject to a $125 copay or total charges of service, whichever is less, at a non-MHCN Facility. Emergency admissions are covered subject to the applicable inpatient services cost share. Copay is waived if the member is admitted as an inpatient to a non-MHCN hospital directly from the emergency department. The Member must notify GHO within twenty-four (24) hours following admission and agree to have care managed by the MHCN in order to have inpatient services covered at the MHCN benefit level. If the member does not notify GHO within twenty-four (24) hours following admission, or declines to have care managed by the MHCN, all inpatient services the member receives are covered subject to the applicable inpatient services cost share.		Covered subject to a $125 copay or total charges of service, whichever is less, at a non-MHCN Facility. Emergency admissions are covered subject to the applicable inpatient services cost share. Copay is waived if the member is admitted as an inpatient to a non-MHCN hospital directly from the emergency department. The Member must notify GHO within twenty-four (24) hours following admission and agree to have care managed by the MHCN in order to have inpatient services covered at the MHCN benefit level. If the member does not notify GHO within twenty-four (24) hours following admission, or declines to have care managed by the MHCN, all inpatient services the member receives are covered subject to the applicable inpatient services cost share.

	Options Low - POS		Options Select	Options High - POS		Alliant Plus-POS	
Hearing Examinations and Hearing Aids	Hearing examinations to determine hearing loss are covered subject to a $25 copay and at the plan coinsurance after the annual deductible is satisfied. Hearing aids, including hearing aid examinations are NOT covered.	Hearing examinations to determine hearing loss are covered subject to a $25 copay and at the plan coinsurance after the annual deductible is satisfied. Hearing aids, including hearing aid examinations are NOT covered.	Hearing examinations to determine hearing loss are covered subject to a $20 copay and at the plan coinsurance after the annual deductible is satisfied. Hearing aids, including hearing aid examinations are NOT covered.	Hearing examinations to determine hearing loss are covered subject to a $20 copay and at the plan coinsurance after the annual deductible is satisfied. Hearing aids, including hearing aid examinations are NOT covered.	Hearing examinations to determine hearing loss are covered subject to a $20 copay and at the plan coinsurance after the deductible is satisfied. Hearing aids, including hearing aid examinations are NOT covered.	Hearing examinations to determine hearing loss are covered subject to a $20 copay and at the plan coinsurance after the annual deductible is satisfied. Hearing aids, including hearing aid examinations are NOT covered.	Hearing examinations to determine hearing loss are covered subject to a $20 copay and at the plan coinsurance after the annual deductible is satisfied. Hearing aids, including hearing aid examinations are NOT covered.
Home Health Services	Covered in full. No visit limit.	No visit limit. Covered at the plan coinsurance after the annual deductible is satisfied.	Covered in full. No visit limit.	Covered in full. No visit limit.	No visit limit. Covered at the plan coinsurance after the annual deductible is satisfied.	Covered in full. No visit limit.	No visit limit. Covered at the plan coinsurance after the annual deductible is satisfied.
Hospice Services	Covered in full.	Covered at the plan coinsurance after the annual deductible is satisfied.	Covered in full.	Covered in full.	Covered at the plan coinsurance after the annual deductible is satisfied.	Covered in full.	Covered at the plan coinsurance after the annual deductible is satisfied.
Infertility Services (Including Sterility)	Not covered.	Not covered.	Not covered.	Not covered.	Not covered.	Not covered.	Not covered.
Manipulative Therapy	Self-referrals to a MHCN Provider for manipulative therapy of the spine covered up to a maximum of ten (10) visits per Member per calendar year, covered subject to a $25 copay, and at the plan coinsurance after the annual deductible is satisfied.	Manipulative therapy of the spine or extremities is covered up to a maximum of ten (10) visits per Member per calendar year, subject to a $25 copay and at the plan coinsurance after the annual deductible is satisfied.	Self-referrals to a MHCN Provider for manipulative therapy of the spine covered up to a maximum of ten (10) visits per Member per calendar year, subject to a $20 copay and at the plan coinsurance after the annual deductible is satisfied.	Self-referrals to a MHCN Provider for manipulative therapy of the spine covered up to a maximum of ten (10) visits per Member per calendar year, subject to a $20 copay and at the plan coinsurance after the annual deductible is satisfied.	Manipulative therapy of the spine or extremities is covered up to a maximum of ten (10) visits per Member per calendar year, subject to a $20 copay and at the plan coinsurance after the annual deductible is satisfied.	Self-referrals to a MHCN Provider for manipulative therapy of the spine covered up to a maximum of ten (10) visits per Member per calendar year, subject to a $20 copay and at the plan coinsurance after the annual deductible is satisfied.	Manipulative therapy of the spine or extremities is covered up to a maximum of ten (10) visits per Member per calendar year, subject to a $20 copay and at the plan coinsurance after the annual deductible is satisfied
Maternity and Pregnancy Services							
Delivery and associated hospital care	Covered at the plan coinsurance after the annual deductible is satisfied	Covered at the plan coinsurance after the annual deductible is satisfied	Covered at the plan coinsurance after the annual deductible is satisfied	Covered subject to a $100 copay per day up to a maximum of 3 days per Member per admit, and at the plan coinsurance after the deductible is satisfied.	Covered subject to a $100 copay per day up to a maximum of 3 days per Member per admit, and at the plan coinsurance after the deductible is satisfied..	Covered subject to a $100 copay per day up to a maximum of 3 days per Member per admit, and at the plan coinsurance after the deductible is satisfied.	Covered subject to a $100 copay per day up to a maximum of 3 days per Member per admit, and at the plan coinsurance after the deductible is satisfied.
Routine prenatal and postpartum care	Covered subject to a $25 copay and at the plan coinsurance after the annual deductible is satisfied	Covered subject to a $25 copay and at the plan coinsurance after the annual deductible is satisfied	Covered subject to a $20 copay then at the plan coinsurance after the annual deductible is satisfied.	Covered subject to a $20 copay and at the plan coinsurance after the annual deductible is satisfied	Covered subject to a $20 copay and at the plan coinsurance after the annual deductible is satisfied	Covered subject to a $20 copay and at the plan coinsurance after the annual deductible is satisfied	Covered subject to a $20 copay and at the plan coinsurance after the annual deductible is satisfied

	Options Low - POS		Options Select	Options High - POS		Alliant Plus-POS	
Mental Health Services							
Inpatient Services	Covered subject to deductible and plan coinsurance up to twelve (12) days per Member per calendar year at a GHO approved mental health care facility. All cost shares apply to the out of pocket maximum	Visit limit shared with in-network. Covered subject to deductible and plan coinsurance up to twelve (12) days per Member per calendar year. All cost shares apply to the out of pocket maximum	Covered subject to annual deductible and plan coinsurance up to twelve (12) days per Member per calendar year at a GHO-approved mental health care facility when authorized in advance by the MHCN. All cost shares apply to the out of pocket maximum	Covered subject to a $100 copay per day up to a maximum of 3 days per Member per admit, and plan coinsurance after the annual deductible is satisfied. Covered up to twelve (12) days per Member per calendar year at a GHO approved mental health care facility, when authorized in advance by the MHCN. All cost shares apply to the out of pocket maximum.	Visit limit shared with in-network Covered subject to a $100 copay per day up to 3 days per Member per admit and at the plan coinsurance after the annual deductible is satisfied up to twelve (12) days per Member per calendar year. All cost shares apply to the out of pocket maximum.	Covered subject to a $100 copay per day up to a maximum of 3 days per Member per admit, and the coinsurance after the annual deductible is satisfied. Covered up to twelve (12) days per Member per calendar year at a GHO approved mental health care facility, when authorized in advance by the MHCN. All cost shares apply to the out of pocket maximum.	Visit limit shared with in-network Covered subject to a $100 copay per day up to 3 days per Member per admit and at the plan coinsurance after the annual deductible is satisfied up to twelve (12) days per Member per calendar year. All cost shares apply to the out of pocket maximum.
Outpatient Services	Up to 20 visits, subject to a $25 copay and at the plan coinsurance after the annual deductible has been satisfied. All cost shares apply to the out of pocket maximum.	Visit limit shared with in-network. Up to 20 visits, subject to a $25 copay and at the plan coinsurance after the annual deductible has been satisfied. All cost shares apply to the out of pocket maximum.	Up to 20 visits, subject to a $20 copay, and at the plan coinsurance after the annual deductible is satisfied. All cost shares apply to the out of pocket maximum.	Up to 20 visits, subject to a $20 copay and at the plan coinsurance after the annual deductible is satisfied. All cost shares apply to the out of pocket maximum.	Visit limit shared with in-network. Up to 20 visits, subject to a $20 copay and at the plan coinsurance after the annul deductible is satisfied. All cost shares apply to the out of pocket maximum.	Up to 20 visits, subject to a $20 copay and at the plan coinsurance after the annual deductible is satisfied. All cost shares apply to the out of pocket maximum.	Visit limit shared with in-network. Up to 20 visits, subject to a $20 copay and at the plan coinsurance after the annual deductible is satisfied. All cost shares apply to the out of pocket maximum.
Naturopathy	Self-referrals to a MHCN Provider covered up to a maximum of three (3) visits per Member per medical diagnosis per calendar year, covered subject to a $25 copay and at the plan coinsurance after the annual deductible is satisfied. When approved by GHO, additional visits are covered subject to a $25 copay and at the plan coinsurance after the annual deductible is satisfied.	Covered subject to a $25 copay and at the plan coinsurance after the annual deductible is satisfied	Self-referrals to a MHCN Provider covered up to a maximum of three (3) visits per Member per medical diagnosis per calendar year, subject to a $20 copay and at the plan coinsurance after the annual deductible is satisfied. When approved by GHO, additional visits are covered subject to a $20 copay and at the plan coinsurance after the annual deductible is satisfied.	Self-referrals to a MHCN Provider covered up to a maximum of three (3) visits per Member per medical diagnosis per calendar year, subject to a $20 copay and at the plan coinsurance after the annual deductible is satisfied. When approved by GHO, additional visits are covered subject to a $20 copay and at the plan coinsurance after the annual deductible is satisfied.	Covered subject to a $20 copay and at the plan coinsurance after the deductible has been satisfied.	Self-referrals to a MHCN Provider covered up to a maximum of three (3) visits per Member per medical diagnosis per calendar year, subject to a $20 copay and at the plan coinsurance after the annual deductible is satisfied.. When approved by GHO, additional visits are covered subject to a $20 copay and at the plan coinsurance after the annual deductible is satisfied	Covered subject to a $20 copay and at the plan coinsurance after the deductible has been satisfied.

	Options Low - POS		Options Select	Options High - POS		Alliant Plus-POS	
Optical Services Routine Eye Examinations	Covered subject to a $25 copay once every twelve (12) months. No limit for medically necessary eye visits. Not subject to the annual deductible or plan coinsurance.	Not covered. Eye examinations for eye pathology are covered when Medically Necessary.	Covered subject to a $20 copay once every twelve (12) months. No limit for medically necessary eye visits. Not subject to the annual deductible or plan coinsurance..	Covered subject to a $20 copay once every twelve (12) months. No limit for medically necessary eye visits. Not subject to the annual deductible or plan coinsurance	Covered subject to a $20 copay and at the plan coinsurance after the deductible has been satisfied once every 12 months. No limit for medically necessary eye visits.	Covered subject to a $20 copay once every twelve (12) months. No limit for medically necessary eye visits. Not subject to the annual deductible or plan coinsurance	Covered subject to a $20 copay and at the plan coinsurance after the deductible has been satisfied once every 12 months. No limit for medically necessary eye visits.
Lenses, including contact lenses, and frames	Not Covered. One contact lens per diseased eye when in lieu of an intraocular lens, is covered at the plan coinsurance after the annual deductible is satisfied following cataract surgery, provided the Member has been continuously covered by GHO since such surgery.	Not Covered. One contact lens per diseased eye when in lieu of an intraocular lens, is covered at the plan coinsurance after the annual deductible is satisfied following cataract surgery, provided the Member has been continuously covered by GHO since such surgery.	Eyeglasses lenses and frames; or contact lenses, including exams associated with their fitting covered up to $100 per Member per any consecutive twelve (12) month period. Not subject to the annual deductible or plan coinsurance.. Contact lenses following cataract surgery, when in lieu of an intraocular lens, are covered at the plan coinsurance after the annual deductible is satisfied provided the Member has been continuously covered by GHO since such surgery. Contact lenses for eye pathology are covered in full. Replacement of these lenses are covered once within a twelve (12) month period and only when needed due to a change in the Member's medical condition.	Eyeglass lenses and frames; or contact lenses, including exams associated with their fitting covered up to $100 per Member per any consecutive twelve (12) month period. Not subject to deductible and coinsurance Contact lenses following cataract surgery, when in lieu of an intraocular lens, are covered subject to the plan coinsurance after the annual deductible has been satisfied provided the Member has been continuously covered by GHO since such surgery. Contact lenses for eye pathology are covered in full. Replacement of these lenses are covered once within a twelve (12) month period and only when needed due to a change in the Member's medical condition.	Shared with in-network. Eyeglass lenses and frames; or contact lenses, including exams associated with their fitting, covered up to $100 per member in any consecutive twelve (12) month period. Contact lenses following cataract surgery, when in lieu of an intraocular lens, are covered subject to the plan coinsurance after the annual deductible is satisfied provided the Member has been continuously covered by GHO since such surgery. Contact lenses for eye pathology are also covered in full. Replacement of these lenses are covered once within a twelve (12) month period and only when needed due to a change in the Member's medical condition.	Eyeglass lenses and frames; or contact lenses, including exams associated with their fitting covered up to $100 per Member per any consecutive twelve (12) month period. Not subject to deductible and coinsurance Contact lenses following cataract surgery, when in lieu of an intraocular lens, are covered in full provided the Member has been continuously covered by GHO since such surgery. Contact lenses for eye pathology are covered in full. Replacement of these lenses are covered once within a twelve (12) month period and only when needed due to a change in the Member's medical condition.	Shared with in-network Eyeglass lenses and frames; or contact lenses, including exams associated with their fitting, covered up to $100 per member in any consecutive twelve (12) month period. Contact lenses following cataract surgery, when in lieu of an intraocular lens, are covered in full provided the Member has been continuously covered by GHO since such surgery. Contact lenses for eye pathology are also covered in full. Replacement of these lenses are covered once within a twelve (12) month period and only when needed due to a change in the Member's medical condition.

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Organ Transplants	Covered up to a lifetime maximum of $250,000 (including donor costs up to $50,000), at the plan coinsurance after the annual deductible is satisfied. Coverage for all transplants, including follow-up care, is excluded until the Member has been continuously covered under a GHO or Group Health Cooperative (GHC) plan for six (6) months.	Covered up to a lifetime maximum of $250,000 (including donor costs up to $50,000), at the plan coinsurance after the annual deductible is satisfied. Coverage for all transplants, including follow-up care, is excluded until the Member has been continuously covered under a GHO or Group Health Cooperative (GHC) plan for six (6) months. Transplant services must be received at a facility authorized in advance by GHO.	Covered up to a lifetime maximum of $250,000 (including donor costs up to $50,000), at the plan coinsurance after the annual deductible is satisfied. Coverage for all transplants, including follow-up care, is excluded until the Member has been continuously covered under a GHO or Group health Cooperative (GHC) plan for six (6) months.	Covered up to a lifetime maximum of $250,000 (including donor costs up to $50,000). Inpatient-subject to $100 copay per day up to a maximum of 3 days per Member per admit, and at the plan coinsurance after the annual deductible is satisfied. Coverage for all transplants, including follow-up care, is excluded until the Member has been continuously covered under a GHO or Group Health Cooperative (GHC) plan for six (6) months.	Benefit limit shared with in-network Covered up to a lifetime maximum of $250,000 (including donor costs up to $50,000) Inpatient--subject to $100 copay per day up to a maximum of 3 days per Member per admit and at the plan coinsurance after the annual deductible is satisfied. Coverage for all transplants, including follow-up care, is excluded until the Member has been continuously covered under a GHO or Group Health Cooperative (GHC) plan for six (6) months. Transplant services must be received at a facility authorized in advance by GHO.	Covered up to a lifetime maximum of $250,000 (including donor costs up to $50,000). Inpatient-subject to $100 copay per day up to a maximum of 3 days per Member per admit, and at the plan coinsurance after the annual deductible is satisfied. Coverage for all transplants, including follow-up care, is excluded until the Member has been continuously covered under a GHO or Group Health Cooperative (GHC) plan for six (6) months.	Benefit limit shared with in-network Covered up to a lifetime maximum of $250,000 (including donor costs up to $50,000) Inpatient--subject to $100 copay per day up to a maximum of 3 days per Member per admit and at the plan coinsurance after the annual deductible is satisfied. Coverage for all transplants, including follow-up care, is excluded until the Member has been continuously covered under a GHO or Group Health Cooperative (GHC) plan for six (6) months. Transplant services must be received at a facility authorized in advance by GHO.
Pre-Existing Condition	Covered (except as specified) subject to the applicable cost share after the Member has been continuously covered under a GHO plan for three (3) consecutive months, except as described below. Coverage for PKU formula, maternity and breast reconstruction following a mastectomy is not subject to the pre-existing condition waiting period. Pre-existing condition wait will be credited for a Member whose date of application for coverage under this GHO plan is within ninety (90) days of termination of prior similar coverage, provided the Member has satisfied the pre-existing condition wait under such prior coverage.		Covered (except as specified) subject to the applicable cost share after the Member has been continuously covered under a GHO plan for three (3) consecutive months, except as described below. Coverage for PKU formula, maternity and breast reconstruction following a mastectomy is not subject to the pre-existing condition waiting period. Pre-existing condition wait will be credited for a Member whose date of application for coverage under this GHO plan is within ninety (90) days of termination of prior similar coverage, provided the Member has satisfied the pre-existing condition wait under such prior coverage.	Covered (except as specified) subject to the applicable cost share after the Member has been continuously covered under a GHO plan for three (3) consecutive months, except as described below. Coverage for PKU formula, maternity and breast reconstruction following a mastectomy is not subject to the pre-existing condition waiting period. Pre-existing condition wait will be credited for a Member whose date of application for coverage under this GHO plan is within ninety (90) days of termination of prior similar coverage, provided the Member has satisfied the pre-existing condition wait under such prior coverage.		Covered (except as specified) subject to the applicable cost share after the Member has been continuously covered under a GHO plan for three (3) consecutive months, except as described below. Coverage for PKU formula, maternity and breast reconstruction following a mastectomy is not subject to the pre-existing condition waiting period. Pre-existing condition wait will be credited for a Member whose date of application for coverage under this GHO plan is within ninety (90) days of termination of prior similar coverage, provided the Member has satisfied the pre-existing condition wait under such prior coverage.	

	Options Low - POS		Options Select	Options High - POS		Alliant Plus-POS	
Preventive Services (Well-Adult and Well-Child Physicals, Immunizations, pap Smears, Mammograms)	Covered subject to a $25 copay and at the plan coinsurance when in accordance with the well-care schedule established by GHO. Not subject to the annual deductible. Excluded are physicals for travel, employment, insurance, license, etc. Services provided during a preventive care visit which are not in accordance with the well-care schedule are subject to a $25 copay and at the plan coinsurance after the annual deductible is satisfied.	Not covered, except for routine mammography services covered at the plan coinsurance after the annual deductible is satisfied. Excluded are physicals for travel, employment, insurance, license, etc.	Covered subject to a $20 copay and at the plan coinsurance when in accordance with the well-care schedule established by GHO. Not subject to the annual deductible. Excluded are physicals for travel, employment, insurance, license, etc. Services provided during a preventive care visit which are not in accordance with the well-care schedule are covered subject to a $20 copay and at the plan coinsurance after the annual deductible is satisfied. .	Covered subject to a $20 copay and at the plan coinsurance when in accordance with the well-care schedule established by GHO. Not subject to the annual deductible. Excluded are physicals for travel, employment, insurance, license, etc. Services provided during a preventive care visit which are not in accordance with the well-care schedule are subject to a $20 copay and at the plan coinsurance after the annual deductible is satisfied.	Covered at the plan coinsurance up to $150 per Member and $300 per family per calendar year. Routine mammography services are covered at the plan coinsurance after the annual deductible is satisfied. Excluded are physicals for travel, employment, insurance, license, etc.	Covered subject to a $20 copay and at the plan coinsurance when in accordance with the well-care schedule established by GHO. Not subject to the annual deductible. Excluded are physicals for travel, employment, insurance, license, etc. Services provided during a preventive care visit which are not in accordance with the well-care schedule are subject to a $20 copay and at the plan coinsurance after the annual deductible is satisfied.	Covered at the plan coinsurance up to $150 per Member and $300 per family per calendar year. Routine mammography services are covered at the plan coinsurance after the annual deductible is satisfied. Excluded are physicals for travel, employment, insurance, license, etc.
Rehabilitation Services Inpatient physical, occupational and restorative speech therapy services combined, including services for neurodevelopmentally disabled children age six (6) and under	Covered up to sixty (60) days per calendar year, at the plan coinsurance after the annual deductible is satisfied.	Day limits shared with in-network. Covered up to sixty (60) days per calendar year, at the plan coinsurance after the annual deductible is satisfied.	Covered for up to sixty (60) days per calendar year at the plan coinsurance after the annual deductible is satisfied.	Covered up to sixty (60) days per calendar year, subject to a$100 copay per day up to a maximum of 3 days per Member per admit and at the plan coinsurance after the annual deductible is satisfied.	Day limits shared with in-network Covered up to sixty (60) days per calendar year, subject to a $100 copay per day up to a maximum of 3 days per Member per admit and at the plan coinsurance after the annual deductible is satisfied.	Covered up to sixty (60) days per calendar year, subject to a $100 copay up to a maximum of 3 days per Member per admit and at the plan coinsurance after the annual deductible is satisfied.	Day limits shared with in-network Covered up to sixty (60) days per calendar year, subject to a $100 copay per day up to a maximum of 3 days per Member per admit and at the plan coinsurance after the annual deductible is satisfied.
Outpatient physical, occupational and restorative speech therapy services combined, including services for neurodevelopmentally disabled children age six (6) and under	Covered up to sixty (60) visits per calendar year, subject to a $25 copay and at the plan coinsurance after the annual deductible is satisfied.	Visit limit shared with in-network. Covered up to sixty (60) visits per calendar year, subject to a $25 copay and at the plan coinsurance after the annual deductible is satisfied.	Covered up to sixty (60) visits per calendar year, subject to a $20 copay then at the plan coinsurance after the annual deductible is satisfied.	Covered up to sixty (60) visits per calendar year, subject to a $20 copay and at the plan coinsurance after the annual deductible is satisfied.	Visit limits shared with in-network Covered up to sixty (60) visits per calendar year, subject to a $20 copay and at the plan coinsurance after the annual deductible is	Covered up to sixty (60) visits per calendar year, subject toa $20 copay and at the plan coinsurance after the annual deductible is satisfied.	Visit limits shared with in-network Covered up to sixty (60) visits per calendar year, subject to a $20 copay and at the plan coinsurance after the annual deductible is satisfied.

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Skilled Nursing Facility (SNF)	Covered up to sixty (60) days per Member per calendar year, at the plan coinsurance after the annual deductible is satisfied	Days shared with in-network. Covered up to sixty (60) days per Member per calendar year, at the plan coinsurance after the annual deductible is satisfied	Covered up to sixty (60) days per Member per calendar year at the plan coinsurance after the annual deductible is satisfied.	Covered up to sixty (60) days per Member per calendar year. subject to the plan coinsurance after the annual deductible is satisfied	Days shared with in-network. Covered up to sixty (60) days per Member per calendar year, at the plan coinsurance after the annual deductible is satisfied	Covered up to sixty (60) days per Member per calendar year. subject to the plan coinsurance after the annual deductible is satisfied	Days shared with in-network. Covered up to sixty (60) days per Member per calendar year, at the plan coinsurance after the annual deductible is satisfied
Sterilization (Vasectomy, Tubal Ligation)	Covered subject to a $25 copay and at the plan coinsurance after the annual deductible is satisfied. Procedures to reverse a sterilization are not covered.	Covered subject to a $25 copay and at the plan coinsurance after the annual deductible is satisfied. Procedures to reverse a sterilization are not covered.	Covered subject to a $20 copay and at the plan coinsurance after the annual deductible is satisfied. Procedures to reverse a sterilization are not covered.	Covered subject to $20 copay and at the plan coinsurance after the annual deductible is satisfied.. Procedures to reverse a sterilization are not covered.	Covered subject to a $20 coay and at the plan coinsurance after the annual deductible has been satisfied.. Procedures to reverse a sterilization are not covered.	Covered subject to $20 copay and at the plan coinsurance after the annual deductible is satisfied.. Procedures to reverse a sterilization are not covered.	Covered subject to a $20 copay and at the plan coinsurance after the annual deductible has been satisfied.. Procedures to reverse a sterilization are not covered.
Temporomandibular Joint (TMJ) Services Inpatient and Outpatient Services	$1,000 maximum per Member per calendar year, subject to $25 copay and at the plan coinsurance after the annual deductible is satisfied.	Shared with in-network. $1,000 maximum per Member per calendar year, subject to a $25 copay and at the plan coinsurance after the annual deductible is satisfied.	$1,000 maximum per Member per calendar year, subject to a $20 copay and at the plan coinsurance after the annual deductible is satisfied.	$1,000 maximum per Member per calendar year---- Inpatient $100 copay per day up to a maximum of 3 days per Member per admit.---- Outpatient $20 copay. All services subject to plan coinsurance after the annual deductible is satisfied.	Shared with in-network $1,000 maximum per Member per calendar year---- Inpatient $100 copay per day up to a maximum of 3 days per Member per admit.---- Outpatient $20 copay. All services subject to plan coinsurance after the annual deductible is satisfied.	$1,000 maximum per Member per calendar year---- Inpatient $100 copay per day up to a maximum of 3 days per Member per admit.---- Outpatient $20 copay. All services subject to coinsurance after the annual deductible is satisfied.	Shared with in-network $1,000 maximum per Member per calendar year---- Inpatient $100 copay per day up to a maximum of 3 days per Member per admit.---- Outpatient $20 copay. All services subject to coinsurance after the annual deductible is satisfied.
Lifetime Benefit	Covered up to $5,000 per Member	Covered up to $5,000 per Member	Covered up to $5,000 per Member	Covered up to $5,000 per Member	Covered up to $5,000 per Member	Covered up to $5,000 per Member	Covered up to $5,000 per Member
Tobacco Cessation							
Individual/Group Sessions	Covered in full.	Not Covered	Covered in full.	Covered in full.	Not Covered	Covered in full.	Not Covered
Approved Pharmacy Products	Covered in full when prescribed and dispensed as part of the GHO designated tobacco program.	Not Covered	Covered in full when prescribed and dispensed as part of the GHQ designated tobacco cessation program.	Covered in full when prescribed and dispensed as part of the GHO designated tobacco program.	Not Covered	Covered in full when prescribed and dispensed as part of the GHO designated tobacco program.	Not Covered

Limitations: Coverage for cosmetic services is limited to breast reconstruction following mastectomy, and reconstructive breast reduction on non-diseased breast.

Exclusions: Services or programs not provided or authorized by MHCN staff (except as specified); travel medications; investigational or experimental procedures, drugs and devices; dental care; arch supports including custom shoe modifications or inserts and their fittings except for therapeutic shoes, modifications and shoe inserts for severe diabetic foot disease; convalescent or custodial care; cardiac rehabilitation programs; services covered by first-party insurance; services covered by government and military programs; employment, license, immigration or insurance examinations or reports. Unless otherwise noted as covered, the following services are also excluded: diagnostic testing of sterility, infertility or sexual dysfunction; work-related conditions (including self-employment, L&I and worker's compensation. This list of exclusions does not address EVERY item and should not be regarded as all inclusive.