



## WASHINGTON STATE BAR ASSOCIATION

Effective Date 6/1/06 to 6/1/07

**MEDICAL PLANS THROUGH GROUP HEALTH OPTIONS INC.**

THIS IS A BRIEF SUMMARY OF BENEFITS. THIS IS NOT A CONTRACT. FOR A DETAILED DESCRIPTION OF YOU BENEFITS, CONTACT YOUR BENEFITS ADMINISTRATOR

	<b>Options Select - HMO</b> Western Washington #61073 Eastern Washington #69282	<b>Options High - POS</b> Western Washington #61072 Eastern Washington #69281		<b>Options Low - POS</b> Western Washington #61802 Eastern Washington #69476		<b>Alliant Plus- POS</b> Western Washington #50929 or #52172 Eastern Washington #58139 or #58199	
	<b>Group Health Network</b>	<b>Inside Network</b>	<b>Outside Network</b>	<b>Inside Network</b>	<b>Outside Network</b>	<b>Inside Network</b>	<b>Outside Network</b>
		When care is provided or referred by the Managed Health Care Network (MHCN). <b>Benefit allowances utilized inside the Network cannot be duplicated outside the Network.</b>	When care is not provided by or referred by the Managed Health Care Network. <b>Benefit allowances utilized outside the Network cannot be duplicated inside the Network.</b>	When care is provided or referred by the Managed Health Care Network (MHCN). <b>Benefit allowances utilized inside the Network cannot be duplicated outside the Network.</b>	When care is not provided by or referred by the Managed Health Care Network. <b>Benefit allowances utilized outside the Network cannot be duplicated inside the Network.</b>	When care is provided or referred by the Managed Health Care Network (MHCN). <b>Benefit allowances utilized inside the Network cannot be duplicated outside the Network.</b>	When care is not provided by or referred by the Managed Health Care Network. <b>Benefit allowances utilized outside the Network cannot be duplicated inside the Network.</b>
<b>Annual Calendar Year Deductible</b>	\$200/member - \$600/family	No annual deductible	\$300/member - \$600/family	\$500/Member - \$1,500/family	\$1,000/Member - \$3,000/family	No annual deductible	\$300/member - \$600/family
<b>Plan Coinsurance</b>	No plan coinsurance	No plan coinsurance	70% of the Usual, Customary and Reasonable (UCR) charges are covered	80% after the annual deductible is satisfied	60% of the Usual, Customary and Reasonable (UCR) charges are covered after the annual deductible is satisfied	No plan coinsurance	70% of the Usual, Customary and Reasonable (UCR) charges are covered
<b>Lifetime Maximum</b>	\$2,000,000 per Member	\$2,000,000 per Member	\$2,000,000 per Member	\$2,000,000 per Member	\$2,000,000 per Member	\$2,000,000 per Member	\$2,000,000 per Member
<b>Hospital Services</b> Covered inpatient medical and surgical services, including acute chemical withdrawal (detoxification)	Covered in full after the annual deductible is satisfied	\$100 copayment per day up to a maximum of three (3) days per Member per admission; no copayment on additional days thereafter.	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 copayment per day up to a maximum of three (3) days per Member per admission; no copayment on additional days thereafter.	Covered at the plan coinsurance after the annual deductible is satisfied.
Covered outpatient hospital surgery (including ambulatory surgical centers)	Covered subject to the applicable outpatient services copayment after the annual deductible is satisfied	Covered subject to the outpatient services copayment.	Covered at the plan coinsurance after the annual deductible is satisfied.	Covered subject to the applicable outpatient services copayment and at the plan coinsurance after the annual deductible is satisfied.	Covered subject to the applicable outpatient services copayment and at the plan coinsurance after the annual deductible is satisfied.	Covered subject to the outpatient services copayment.	Covered at the plan coinsurance after the annual deductible is satisfied.

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<b>Outpatient Services (Office Visits)</b> Covered outpatient medical and surgical services	Covered subject to a \$20 copayment after the annual deductible is satisfied	\$20 copayment per Member per visit	Covered at the plan coinsurance after the annual deductible is satisfied.	Covered subject to a \$20 copayment and at the plan coinsurance after the annual deductible is satisfied	Covered subject to a \$25 copayment and at the plan coinsurance after the annual deductible is satisfied	\$20 copayment per Member per visit	Covered at the plan coinsurance after the annual deductible is satisfied.
Allergy testing	Covered subject to the applicable outpatient services copayment after the annual deductible is satisfied	Covered subject to the outpatient services copayment.	Covered at the plan coinsurance after the annual deductible is satisfied.	Covered subject to the applicable outpatient services copayment and at the plan coinsurance after the annual deductible is satisfied.	Covered subject to the outpatient services copayment and at the plan coinsurance after the annual deductible is satisfied	Covered subject to the outpatient services copayment.	Covered at the plan coinsurance after the annual deductible is satisfied.
Oncology (radiation therapy, chemotherapy)	Covered subject to the applicable outpatient services copayment after the annual deductible is satisfied	Covered subject to the outpatient services copayment.	Covered at the plan coinsurance after the annual deductible is satisfied.	Covered subject to the applicable outpatient services copayment and at the plan coinsurance after the annual deductible is satisfied	Covered subject to the outpatient services copayment and at the plan coinsurance after the annual deductible is satisfied	Covered subject to the outpatient services copayment.	Covered at the plan coinsurance after the annual deductible is satisfied.
<b>Drugs - Outpatient</b> (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 Managed Health Care Network's (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 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 copayment for generic drugs or \$40 copayment 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 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 copayment for generic drugs or \$35 copayment 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 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 copayment for generic drugs or \$40 copayment 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	Covered subject to \$5 discount from prescription drug cost share for each thirty (30) day supply or less.	Not Covered	Covered for a ninety (90) day supply subject to a \$30 copayment for generic drugs or a \$60 copayment for brand name drugs.	Not Covered	Covered subject to \$5 discount from the prescription drug cost share for each thirty (30) day supply or less.	Not Covered

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Growth hormones	Covered after the annual deductible is satisfied, subject to a twelve (12) month waiting period	Covered in full subject to a twelve (12) month waiting period.	Covered at the plan coinsurance after the annual deductible is satisfied, subject to a twelve (12) month waiting period.	Covered at the plan coinsurance after the annual deductible is satisfied, subject to a twelve (12) month waiting period.	Covered at the plan coinsurance after the annual deductible is satisfied, subject to a twelve (12) month waiting period.	Covered in full subject to a twelve (12) month waiting period.	Covered at the plan coinsurance after the annual deductible is satisfied, subject to a twelve (12) month waiting period.
<b>Out of Pocket Limit (Stop Loss)</b>	<p>Except as otherwise noted, total out-of-pocket expenses for the following Covered Services are included in the out-of-pocket limit:</p> <ul style="list-style-type: none"> <li>•Outpatient Services</li> <li>•Emergency Services at a MHCN or non-MHCN Facility</li> <li>•Ambulance Services</li> </ul> <p>Limited to an aggregate maximum of \$2,000 per Member and \$6,000 per family per calendar year</p>	<p>Except as otherwise noted, total out-of-pocket expenses for the following Covered Services are included in the out-of-pocket limit:</p> <ul style="list-style-type: none"> <li>•Inpatient &amp; Outpatient Services</li> <li>•Emergency Services at a MHCN Facility</li> <li>•Ambulance Services</li> </ul> <p>Limited to an aggregate maximum of \$2,000 per Member and \$4,000 per family per calendar year</p>	<p>Except as otherwise noted, total out-of-pocket expenses for the following Covered Services are included in the out-of-pocket limit:</p> <ul style="list-style-type: none"> <li>•Plan Coinsurance</li> <li>•Emergency Services at a non-MHCN Facility</li> </ul> <p>Limited to an aggregate maximum of \$3,000 per Member and \$6,000 per family per calendar year</p>	<p>Except as otherwise noted, total out-of-pocket expenses for the following Covered Services are included in the out-of-pocket limit:</p> <ul style="list-style-type: none"> <li>•Plan Coinsurance</li> <li>•Emergency Services at a MHCN Facility</li> <li>•Ambulance Services</li> </ul> <p>Limited to an aggregate maximum of \$2,000 per Member and \$6,000 per family per calendar year</p>	<p>Except as otherwise noted, total out-of-pocket expenses for the following Covered Services are included in the out-of-pocket limit:</p> <ul style="list-style-type: none"> <li>•Plan Coinsurance</li> <li>•Emergency Services at a non-MHCN Facility</li> </ul> <p>Limited to an aggregate maximum of \$6,000 per Member and \$18,000 per family per calendar year</p>	<p>Except as otherwise noted, total out-of-pocket expenses for the following Covered Services are included in the out-of-pocket limit:</p> <ul style="list-style-type: none"> <li>•Inpatient &amp; Outpatient Services</li> <li>•Emergency Services at a MHCN Facility</li> <li>•Ambulance Services</li> </ul> <p>Limited to an aggregate maximum of \$2,000 per Member and \$4,000 per family per calendar year</p>	<p>Except as otherwise noted, total out-of-pocket expenses for the following Covered Services are included in the out-of-pocket limit:</p> <ul style="list-style-type: none"> <li>•Plan Coinsurance</li> </ul> <p>Emergency Services at a non-MHCN Facility</p> <p>Limited to an aggregate maximum of \$3,000 per Member and \$6,000 per family per calendar year</p>
<b>Acupuncture</b>	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 the applicable outpatient services copayment after the annual deductible is satisfied. When approved by GHO, additional visits are covered subject to the applicable outpatient services copayment 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 the outpatient services copayment. When approved by GHO, additional visits are covered subject to the outpatient services copayment.	Covered 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, covered subject to the applicable outpatient services copayment and at the plan coinsurance after the annual deductible is satisfied. When approved by GHO, additional visits are covered subject to the applicable outpatient services copayment and at the plan coinsurance after the annual deductible is satisfied.	Covered subject to the outpatient services copayment 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 the outpatient services copayment. When approved by GHO, additional visits are covered subject to the outpatient services copayment.	Covered at the plan coinsurance after the annual deductible is satisfied.



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<b>Devices, Equipment and Supplies (for home use)</b>  Covered items include: •Orthopedic appliances •Durable medical equipment •Ostomy supplies •Post-mastectomy bras [limited to two (2) every six (6) months]  •Prosthetic devices	Covered at 50% up to \$5,000 (\$2,500 benefit maximum) per calendar year.  Covered at 50% up to \$40,000 (\$20,000 benefit maximum) per calendar year	Covered at 50% up to \$5,000 (\$2,500 benefit maximum) per calendar year.  Covered at 50% up to \$40,000 (\$20,000 benefit maximum) per calendar year	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 \$40,000 (\$20,000 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 \$40,000 (\$20,000 benefit maximum) per calendar year	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 \$40,000 (\$20,000 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 \$40,000 (\$20,000 benefit maximum) per calendar year	Covered at 50% up to \$5,000 (\$2,500 benefit maximum) per calendar year after the annual deductible is satisfied .  Covered at 50% up to \$40,000 (\$20,000 benefit maximum) per calendar year after the annual deductible is satisfied.
<b>Diabetic Supplies</b>	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.
<b>Diagnostic Laboratory and Radiology Services</b>	Covered in full after the annual deductible is satisfied	Covered in full.	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 in full.	Covered at the plan coinsurance after the annual deductible is satisfied

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<b>Emergency Services</b>							
At a MHCN Facility	\$75 copayment per Member per emergency visit after the annual deductible is satisfied. Copayment is waived if the Member is admitted as an inpatient to the hospital directly from the emergency department. Emergency admissions covered subject to applicable inpatient services cost share.	Covered subject to a \$75 copayment per Member per emergency visit at a MHCN Facility. Copayment is waived if the Member is admitted as an inpatient to the hospital directly from the emergency department.	Covered subject to \$125 deductible per Member per emergency visit at a non-MHCN Facility (world-wide). Deductible is waived if the Member is admitted as an inpatient to the hospital directly from emergency dept. Member must notify GHO within twenty-four (24) hours following admission & agree to have care managed by the MHCN to have inpatient services covered under the MHCN benefit level.	Covered subject to a \$75 copayment per Member per emergency visit at a MHCN Facility, then covered at the plan coinsurance after the annual deductible is satisfied. Copayment 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.	UCR charges covered subject to \$125 deductible per Member per emergency visit at a non-MHCN Facility (world-wide), & at the plan coinsurance after annual deductible. Ded. waived if Member admitted as inpatient to the hospital directly from emergency Dept. Emergency admissions covered subject to applicable inpatient services cost share. Member must notify GHO within twenty-four (24) hours following	Covered subject to a \$75 copayment per Member per emergency visit at a MHCN Facility. Copayment is waived if the Member is admitted as an inpatient to the hospital directly from the emergency department.	UCR charges covered subject to \$125 deductible per Member per emergency visit at a non-MHCN Facility (world-wide) Deductible is waived if Member admitted as inpatient to the hospital directly from emergency Dept. Member must notify GHO within twenty-four (24) hours following admission & agree to have care managed by the MHCN to have inpatient services covered under the MHCN benefit level. If Member does not notify GHO within twenty-four (24) hours following admission, or declines to have care managed by the MHCN, inpatient services covered at plan coinsurance after annual deductible is satisfied
At a Non-MHCN Facility	\$125 deductible per Member per emergency visit after annual deductible is satisfied. Deductible waived if 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. If Member is admitted to a non-MHCN Facility they should contact the Emergency Notification Line as indicated on their GHO identification card in order to be covered.		If Member does not notify GHO within 24 hours following admission or declines to have care managed by the MHCN all inpatient services are covered at the plan coinsurance after the annual deductible is satisfied.		admission & agree to have care managed by the MHCN to have inpatient services covered under the MHCN benefit level. If Member does not notify GHO within twenty-four (24) hours following admission, or declines to have care managed by the MHCN, inpatient services covered at plan coinsurance after annual deductible is satisfied.		

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<b>Hearing Examinations and Hearing Aids</b>	Hearing examinations to determine hearing loss are covered subject to the applicable outpatient services copayment 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 the outpatient services copayment.  Hearing aids, including hearing aid examinations are NOT covered.	Hearing examinations to determine hearing loss are covered 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 the applicable outpatient services copayment 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 the outpatient services copayment 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 the outpatient services copayment.  Hearing aids, including hearing aid examinations are NOT covered.	Hearing examinations to determine hearing loss are covered at the plan coinsurance after the annual deductible is satisfied.  Hearing aids, including hearing aid examinations are NOT covered.
<b>Home Health Services</b>	Covered in full. No visit limit.	Covered in full. No visit limit.	Covered at the plan coinsurance after the annual deductible is satisfied.	Covered in full. No visit limit.	Covered at the plan coinsurance after the annual deductible is satisfied.	Covered in full. No visit limit.	Covered at the plan coinsurance after the annual deductible is satisfied.
<b>Hospice Services</b>	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.	Covered in full.	Covered at the plan coinsurance after the annual deductible is satisfied.
<b>Infertility Services (Including Sterility)</b>	Not covered.	Not covered.	Not covered.	Not covered.	Not covered.	Not covered.	Not covered.
<b>Manipulative Therapy</b>	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 the applicable outpatient services copayment after the annual deductible is satisfied. When approved by GHO, additional manipulation visits are covered subject to the applicable outpatient services copayment 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 the applicable outpatient services copayment. When approved by GHO, additional manipulation visits are covered subject to the outpatient services copayment.	Manipulative therapy of the spine or extremities is covered up to a maximum of ten (10) visits per Member per calendar year, 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, covered subject to the applicable outpatient services copayment, then covered at the plan coinsurance after the annual deductible is satisfied. When approved by GHO, additional manipulation visits are covered subject to the applicable outpatient services copayment 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 the outpatient services copayment 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 the applicable outpatient services copayment. When approved by GHO, additional manipulation visits are covered subject to the outpatient services copayment.	Manipulative therapy of the spine or extremities is covered up to a maximum of ten (10) visits per Member per calendar year, at the plan coinsurance after the annual deductible is satisfied.

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<b>Maternity and Pregnancy Services</b>							
Delivery and associated hospital care	Covered in full after the annual deductible is satisfied	Covered subject to the applicable inpatient services copayment.	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 the applicable inpatient services copayment.	Covered at the plan coinsurance after the annual deductible is satisfied.
Routine prenatal and postpartum care	Covered subject to the applicable outpatient services copayment after the annual deductible is satisfied.	Covered subject to outpatient services copayment.	Covered at the plan coinsurance after the annual deductible is satisfied	Covered subject to the applicable outpatient services copayment and at the plan coinsurance after the annual deductible is satisfied	Covered subject to the outpatient services copayment and at the plan coinsurance after the annual deductible is satisfied	Covered subject to outpatient services copayment.	Covered at the plan coinsurance after the annual deductible is satisfied
<b>Mental Health Services</b>							
Inpatient Services	Subject to deductible 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, after the annual deductible is satisfied.	Subject to inpatient copayment 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. Copayment does not apply to the out-of-pocket limit	Subject to deductible and coinsurance up to twelve (12) days per Member per calendar year. Copayment does not apply to the out-of-pocket limit.	Subject to deductible and coinsurance up to twelve (12) days per Member per calendar year at a GHO approved mental health care facility. Coinsurance applies to the out-of-pocket limit	Subject to deductible and coinsurance up to twelve (12) days per Member per calendar year after the annual deductible is satisfied. Coinsurance applies to the out-of-pocket limit.	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.	Subject to deductible and coinsurance up to twelve (12) days per Member per calendar year. Coinsurance does not apply to the out-of-pocket limit.
Outpatient Services	Up to 20 visits, subject to deductible and outpatient copay cost. Copayment does apply to the out-of-pocket limit.	Up to 20 visits, subject to outpatient copay cost. Copayment does not apply to the out-of-pocket limit	Up to 20 visits, subject to deductible and coinsurance and any outpatient copay cost. Copayment does not apply to the out-of-pocket limit	Up to 20 visits, subject to deductible and coinsurance and any outpatient copay cost. Coinsurance does apply to the out-of-pocket limit	Up to 20 visits, subject to deductible and coinsurance and any outpatient copay cost. Copayment does not apply to the out-of-pocket limit	Up to 20 visits, outpatient copay cost. Copayment does not apply to the out-of-pocket limit	Up to 20 visits, subject to deductible and coinsurance. Coinsurance does not apply to the out-of-pocket limit

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<b>Naturopathy</b>	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 the applicable outpatient services copayment after the annual deductible is satisfied. When approved by GHO, additional visits are covered subject to the applicable outpatient services copayment 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 the outpatient services copayment. When approved by GHO, additional visits are covered subject to the outpatient services copayment.	Covered 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, covered subject to the applicable outpatient services copayment and at the plan coinsurance after the annual deductible is satisfied. When approved by GHO, additional visits are covered subject to the applicable outpatient services copayment and at the plan coinsurance after the annual deductible is satisfied.	Covered subject to the outpatient services copayment 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 the outpatient services copayment. When approved by GHO, additional visits are covered subject to the outpatient services copayment.	Covered at the plan coinsurance after the annual deductible is satisfied
<b>Optical Services</b> Routine Eye Examinations	Covered subject to the applicable outpatient services copayment once every twelve (12) months. Not subject to the annual deductible. Eye examinations, including contact lens examinations, for eye pathology are covered subject to the applicable outpatient services copayment after the annual deductible is satisfied as often as Medically Necessary.	Covered subject to the outpatient services copayment once every twelve (12) months. Eye examinations, including contact lens examinations, for eye pathology are covered subject to the outpatient services copayment as often as Medically Necessary.	Covered up to \$30 once every twelve (12) months. Eye examinations, including contact lens examinations, for eye pathology are covered at the plan coinsurance after the annual deductible is satisfied as often as Medically Necessary.	Covered subject to the applicable outpatient services copayment once every twelve (12) months, except as Medically Necessary. Not subject to the annual deductible or plan coinsurance.	Not covered. Eye examinations for eye pathology are covered when Medically Necessary.	Covered subject to the outpatient services copayment once every twelve (12) months. Eye examinations, including contact lens examinations, for eye pathology are covered subject to the outpatient services copayment as often as Medically Necessary.	Covered up to \$30 once every twelve (12) months. Eye examinations, including contact lens examinations, for eye pathology are covered at the plan coinsurance after the annual deductible is satisfied as often as Medically Necessary.

	<b>Options Select - HMO</b>	<b>Options High - POS</b>		<b>Options Low - POS</b>		<b>Alliant Plus-POS</b>	
Lenses, including contact lenses, and frames	<p>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.</p> <p>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.</p>	<p>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.</p> <p>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.</p>	<p>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.</p> <p>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.</p>	<p>Not Covered.</p> <p>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.</p>	<p>Not Covered.</p> <p>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.</p>	<p>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.</p> <p>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.</p>	<p>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.</p> <p>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.</p>

	Options Select - HMO	Options High - POS		Options Low - POS		Alliant Plus-POS	
<b>Organ Transplants</b>	Covered up to a lifetime maximum of \$200,000 (including donor costs up to \$50,000), 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 twelve (12) months.	Covered up to a lifetime maximum of \$200,000 (including donor costs up to \$50,000) subject to applicable copayments. 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 twelve (12) months.	Covered up to a lifetime maximum of \$200,000 (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 twelve (12) months. Transplant services must be received at a facility authorized in advance by GHO.	Covered up to a lifetime maximum of \$200,000 (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 twelve (12) months.	Covered up to a lifetime maximum of \$200,000 (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 twelve (12) months. Transplant services must be received at a facility authorized in advance by GHO.	Covered up to a lifetime maximum of \$200,000 (including donor costs up to \$50,000) subject to applicable copayments. 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 twelve (12) months.	Covered up to a lifetime maximum of \$200,000 (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 twelve (12) months. Transplant services must be received at a facility authorized in advance by GHO.
<b>Pre-Existing Condition</b>	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 Select - HMO	Options High - POS		Options Low - POS		Alliant Plus-POS	
<b>Preventive Services</b> (Well-Adult and Well-Child Physicals, Immunizations, pap Smears, Mammograms)	Covered subject to the applicable outpatient services copayment 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 the applicable outpatient services copayment after the annual deductible is satisfied.	Covered subject to the outpatient services copayment when in accordance with the well-care schedule established by GHO. Excluded are physicals for travel, employment, insurance, license, etc.	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 the applicable outpatient services copayment and at the plan coinsurance after the annual deductible is satisfied. 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 the applicable outpatient services copayment 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 the outpatient services copayment when in accordance with the well-care schedule established by GHO. Excluded are physicals for travel, employment, insurance, license, etc.	Covered at the plan coinsurance up to \$150 maximum 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.
<b>Rehabilitation Services</b> Inpatient physical, occupational and restorative speech therapy services combined, including services for neurodevelopmentally disabled children age six (6) and under	Covered in full for up to sixty (60) days per calendar year after the annual deductible is satisfied.	Covered up to sixty (60) days per calendar year, subject to the applicable inpatient services copayment	Covered 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, at the plan coinsurance after the annual deductible is satisfied.	Covered 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 the applicable inpatient services copayment	Covered up to sixty (60) days per calendar year, 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 the outpatient services copayment after the annual deductible is satisfied.	Covered up to sixty (60) visits per calendar year, subject to the outpatient services copayment.	Covered up to sixty (60) visits per calendar year, at the plan coinsurance after the annual deductible is satisfied.	Covered up to sixty (60) visits per calendar year, subject to the applicable outpatient services copayment and at the plan coinsurance after the annual deductible is satisfied.	Covered up to sixty (60) visits per calendar year, subject to the applicable outpatient services copayment and at the plan coinsurance after the annual deductible is satisfied.	Covered up to sixty (60) visits per calendar year, subject to the outpatient services copayment	Covered up to sixty (60) visits per calendar year, at the plan coinsurance after the annual deductible is satisfied.

	Options Select - HMO	Options High - POS		Options Low - POS		Alliant Plus-POS	
<b>Skilled Nursing Facility (SNF)</b>	Covered in full up to sixty (60) days per Member per calendar year after the annual deductible is satisfied.	Covered in full up to sixty (60) days per Member per calendar year.	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, at the plan coinsurance after the annual deductible is satisfied	Covered in full up to sixty (60) days per Member per calendar year.	Covered up to sixty (60) days per Member per calendar year, at the plan coinsurance after the annual deductible is satisfied
<b>Sterilization (Vasectomy, Tubal Ligation)</b>	Covered subject to the applicable copayment after the annual deductible is satisfied. Procedures to reverse a sterilization are not covered.	Covered subject to applicable copayment. Procedures to reverse a sterilization are not covered.	Covered at the plan coinsurance after the annual deductible is satisfied. Procedures to reverse a sterilization are not covered.	Covered subject to the applicable outpatient services copayment and at the plan coinsurance after the annual deductible is satisfied. Procedures to reverse a sterilization are not covered.	Covered subject to the outpatient services copayment and at the plan coinsurance after the annual deductible is satisfied. Procedures to reverse a sterilization are not covered.	Covered subject to the applicable copayment. Procedures to reverse a sterilization are not covered.	Covered at the plan coinsurance after the annual deductible is satisfied. Procedures to reverse a sterilization are not covered.
<b>Temporomandibular Joint (TMJ) Services</b>  Inpatient and Outpatient Services  Lifetime benefit	\$1,000 maximum per Member per calendar year, subject to the applicable copayment after the annual deductible is satisfied.  Covered up to \$5,000 per Member.	\$1,000 maximum per Member per calendar year, subject to applicable copayment.  Covered up to \$5,000 per Member	\$1,000 maximum per Member per calendar year at the plan coinsurance after the annual deductible is satisfied.  Covered up to \$5,000 per Member	\$1,000 maximum per Member per calendar year, subject to the applicable outpatient services copayment and at the plan coinsurance after the annual deductible is satisfied. Covered up to \$5,000 per Member	\$1,000 maximum per Member per calendar year, subject to the applicable outpatient services copayment and at the plan coinsurance after the annual deductible is satisfied. Covered up to \$5,000 per Member	\$1,000 maximum per Member per calendar year, subject to applicable copayment.  Covered up to \$5,000 per Member	Covered at the plan coinsurance up to a \$1,000 maximum per Member per calendar year, after the annual deductible is satisfied.  Covered up to \$5,000 per Member.
<b>Tobacco Cessation</b>  Individual/Group Sessions  Approved Pharmacy Products	Covered in full.  Covered to the lesser of the MHCN's charge or the applicable prescription drug cost share for a supply of thirty (30) days or less of a prescription or refill when prescribed by a MHCN Provider and obtained at a MHCN Facility.	Covered in full.  Covered subject to the lesser of the MHCN's charge or the applicable prescription drug cost share for a supply of thirty (30) days or less of a prescription or refill when prescribed by a MHCN Provider and obtained at a MHCN Facility	Not Covered  Not Covered	Covered in full.  Covered subject to the lesser of the MHCN's charge or the applicable prescription drug cost share for a supply of thirty (30) days or less of a prescription or refill when prescribed by a MHCN Provider and obtained at a MHCN Facility	Not Covered  Not Covered	Covered in full.  Covered subject to the lesser of the MHCN's charge or the applicable prescription drug cost share for a supply of thirty (30) days or less of a prescription or refill when prescribed by a MHCN Provider and obtained at a MHCN Facility	Not Covered  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).