



Alliant Plus Summary of Benefits

| | | |
|---|--|--|
| HIIT-Bronze | | |
| Effective Date 1/1/2010 | | Ref 1077777723 |
| <p>This is a brief summary of benefits and limitations. THIS IS NOT A CONTRACT. The Member will be charged the lesser of the cost share for the covered service or the actual charge for that service. For a more detailed description of your benefits and exclusions, refer to your certificate of coverage or contact your employer or benefits administrator. Benefit descriptions in this document are subject to Washington and federal regulations and may change.</p> | | |
| Benefit | Inside Network | Outside Network |
| 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. |
| Hospital Admission Certification | Not required. | All scheduled inpatient hospital admissions must be authorized by GHO at least seventy-two (72) hours in advance. |
| "Welcome" Outpatient Service Waiver | No "Welcome" Outpatient Service Waiver. | Not applicable. |
| Annual Deductible | \$3,000 per Member or \$9,000 per family unit per calendar year. Annual deductible does not apply to outpatient services. | Shared with in-network. Annual deductible does not apply to outpatient services. |
| Plan Coinsurance | 80% 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. | \$2,000,000 per Member. |
| 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 outpatient hospital surgery (including ambulatory surgical centers) | Covered subject to the applicable outpatient services copayment and at the plan coinsurance. Annual deductible does not apply to outpatient services. | Covered subject to the applicable outpatient services copayment and at the plan coinsurance. Annual deductible does not apply to outpatient services. |
| Outpatient Services (Office Visits) Covered outpatient medical and surgical services | Covered subject to a \$25 copayment and at the plan coinsurance. Annual deductible does not apply to outpatient services. Covered subject to a \$50 copayment per Member per specialty care visit and at the plan coinsurance. Annual deductible does not apply to outpatient services. | Covered subject to a \$25 copayment and at the plan coinsurance. Annual deductible does not apply to outpatient services. Covered subject to a \$50 copayment per Member per specialty care visit and at the plan coinsurance. Annual deductible does not apply to outpatient services. |

Alliant Plus Summary of Benefits

Page 2 of 7

| | | |
|--|---|---|
| Allergy testing | Covered subject to the applicable outpatient services copayment and at the plan coinsurance. Annual deductible does not apply to outpatient services. | Covered subject to the applicable outpatient services copayment and at the plan coinsurance. Annual deductible does not apply to outpatient services. |
| Oncology (radiation therapy, chemotherapy) | Covered subject to the applicable outpatient services copayment and at the plan coinsurance. Annual deductible does not apply to outpatient services. | Covered subject to the applicable outpatient services copayment and at the plan coinsurance. Annual deductible does not apply to outpatient services. |
| 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 \$20 copayment for generic drugs or \$40 copayment for brand name drugs. Dispensing of a generic drug is required unless a brand drug is Medically Necessary. | Covered subject to a \$25 copayment for generic drugs or \$45 copayment for brand name drugs. Dispensing of a generic drug is required unless a brand drug is Medically Necessary. |
| Over-the-counter drugs and medicines | Not covered. | Not covered. |
| Allergy serum | Covered subject to the applicable outpatient services copayment and at the plan coinsurance. Annual deductible does not apply to outpatient services. | Covered subject to the applicable outpatient services copayment and at the plan coinsurance. Annual deductible does not apply to outpatient services. |
| 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. |
| Mail order drugs and medicines | Covered subject to a \$5 discount from the applicable prescription drug cost share for each thirty (30) day supply or less. | Not covered. |
| Growth hormones | Covered subject to the applicable prescription drug cost share. | Covered subject to the applicable prescription drug cost share. |
| Out-of-Pocket Limit | Limited to an aggregate maximum of \$5,000 per Member or \$15,000 per family per calendar year. Except as otherwise noted, the following out-of-pocket expenses apply to the out-of-pocket limit: Plan coinsurance, emergency care copayment at a MHCN Facility and ambulance coinsurance/copayment. | Out-of-pocket limit is shared with in-network. Except as otherwise noted, the following out-of-pocket expenses apply to the out-of-pocket limit: Plan coinsurance, emergency care deductible at a non-MHCN Facility and ambulance coinsurance. |
| Acupuncture | Covered subject to the applicable outpatient services copayment and at the plan coinsurance for self-referrals to a MHCN Provider up to a maximum of eight (8) visits per Member per medical diagnosis per calendar year. When approved by GHO, additional visits are covered. Annual deductible does not apply to outpatient services. | Covered subject to the applicable outpatient services copayment and at the plan coinsurance. Annual deductible does not apply to outpatient services. |

Alliant Plus Summary of Benefits

Page 3 of 7

| | | |
|---|---|---|
| <p>Ambulance Services Emergency ground/air transport</p> <p>Non-emergent ground/air interfacility transfer</p> | <p>Covered at 80%.</p> <p>Covered at 80% for MHCN-initiated transfers, except hospital-to-hospital ground transfers covered in full.</p> | <p>Covered at 80%.</p> <p>Covered at 80% for transport from one medical facility to the nearest facility equipped to render further Medically Necessary treatment when prescribed by the attending physician. Services are not subject to the annual deductible.</p> |
| <p>Chemical Dependency Inpatient services</p> | <p>Covered subject to the applicable inpatient services copayment and at the plan coinsurance after the annual deductible is satisfied.</p> | <p>Covered subject to the applicable inpatient services copayment and at the plan coinsurance after the annual deductible is satisfied.</p> |
| <p>Outpatient services</p> | <p>Covered subject to the applicable outpatient services copayment and at the plan coinsurance. Annual deductible does not apply to outpatient services.</p> | <p>Covered subject to the applicable outpatient services copayment and at the plan coinsurance. Annual deductible does not apply to outpatient services.</p> |
| <p>Devices, Equipment and Supplies (for home use) Covered items include:</p> <ul style="list-style-type: none"> • Durable medical equipment • Orthopedic appliances • Post-mastectomy bras limited to two (2) every six (6) months <ul style="list-style-type: none"> • Ostomy supplies • Prosthetic devices | <p>Covered at 50% up to \$5,000 (\$2,500 maximum benefit) per calendar year.</p> <p>Covered at 50% up to \$40,000 (\$20,000 maximum benefit) per calendar year.</p> | <p>Covered at 50% up to \$5,000 (\$2,500 maximum benefit) per calendar year after the annual deductible is satisfied.</p> <p>Covered at 50% up to \$40,000 (\$20,000 maximum benefit) per calendar year after the annual deductible is satisfied.</p> |
| <p>Diabetic Supplies</p> | <p>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.</p> | <p>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.</p> |
| <p>Diagnostic Laboratory and Radiology Services</p> | <p>Covered at the plan coinsurance after the annual deductible is satisfied. Annual deductible does not apply to outpatient services.</p> | <p>Covered at the plan coinsurance after the annual deductible is satisfied. Annual deductible does not apply to outpatient services. Prior authorization is required for CTs, MRIs and PETs.</p> |

Alliant Plus Summary of Benefits

Page 4 of 7

| | | |
|--|---|---|
| <p>Emergency Services</p> | <p>Covered subject to a \$150 copayment per Member per emergency visit at a MHCN Facility and 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.</p> | <p>Covered subject to a \$200 copayment per Member per emergency visit at a non-MHCN Facility (world-wide) and at the MHCN plan coinsurance after the MHCN 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. 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 under 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 are covered subject to the applicable inpatient services cost share.</p> |
| <p>Hearing Examinations and Hearing Aids</p> | <p>Hearing examinations to determine hearing loss are covered subject to the applicable outpatient services copayment and at the plan coinsurance. Annual deductible does not apply to outpatient services.</p> <p>Hearing aids, including hearing aid examinations, are not covered.</p> | <p>Hearing examinations to determine hearing loss are covered subject to the applicable outpatient services copayment and at the plan coinsurance. Annual deductible does not apply to outpatient services.</p> <p>Hearing aids, including hearing aid examinations, are not covered.</p> |
| <p>Home Health Services</p> | <p>Covered in full. No visit limit.</p> | <p>Covered at the plan coinsurance after the annual deductible is satisfied.</p> |
| <p>Hospice Services</p> | <p>Covered in full.</p> | <p>Covered at the plan coinsurance after the annual deductible is satisfied.</p> |
| <p>Infertility Services (including sterility)</p> | <p>Not covered.</p> | <p>Not covered.</p> |
| <p>Manipulative Therapy</p> | <p>Covered subject to the applicable outpatient services copayment and at the plan coinsurance for self-referrals to a MHCN Provider for manipulative therapy of the spine and extremities up to a maximum of ten (10) visits per Member per calendar year. Annual deductible does not apply to outpatient services.</p> | <p>Covered subject to the applicable outpatient services copayment and at the plan coinsurance for manipulative therapy of the spine or extremities up to a maximum of ten (10) visits per Member per calendar year. Annual deductible does not apply to outpatient services.</p> |
| <p>Maternity and Pregnancy Services Delivery and associated hospital care</p> | <p>Covered subject to the applicable inpatient services copayment and at the plan coinsurance after the annual deductible is satisfied.</p> | <p>Covered subject to the applicable inpatient services copayment and at the plan coinsurance after the annual deductible is satisfied.</p> |
| <p>Routine prenatal and postpartum care</p> | <p>Routine care covered at the plan coinsurance. Annual deductible does not apply to outpatient services.</p> | <p>Routine care covered at the plan coinsurance. Annual deductible does not apply to outpatient services.</p> |
| <p>Mental Health Services Inpatient services</p> | <p>Covered subject to the applicable inpatient services cost share at a GHO-approved mental health care facility.</p> | <p>Covered subject to the applicable inpatient services cost share.</p> |

Alliant Plus Summary of Benefits

Page 5 of 7

| | | |
|---|--|---|
| Outpatient services | Covered subject to the applicable outpatient services cost share. Annual deductible does not apply to outpatient services. | Covered subject to the applicable outpatient services cost share. Annual deductible does not apply to outpatient services. |
| Naturopathy | Covered subject to the applicable outpatient services copayment and at the plan coinsurance for self-referrals to a MHCN Provider up to a maximum of three (3) visits per Member per medical diagnosis per calendar year. When approved by GHO, additional visits are covered. Annual deductible does not apply to outpatient services. | Covered subject to the applicable outpatient services copayment and at the plan coinsurance. Annual deductible does not apply to outpatient services. |
| Optical Services Routine eye examinations | Covered subject to the applicable outpatient services copayment once every twelve (12) months, except as Medically Necessary. Annual deductible does not apply to outpatient services. | Not covered. Eye examinations for eye pathology are covered when Medically Necessary. Annual deductible does not apply to outpatient services. |
| 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. |
| Organ Transplants | Covered subject to the applicable cost share up to a \$350,000 lifetime benefit maximum (including organ acquisition, matching and donor costs up to \$50,000). Coverage for all transplants, including follow-up care, is excluded until the Member has been continuously enrolled under a GHO or Group Health Cooperative (GHC) plan for six (6) months. This benefit wait period will be reduced by the length of time the Member had immediate prior creditable coverage. Annual deductible does not apply to outpatient services. | Covered subject to the applicable cost share up to a \$350,000 lifetime benefit maximum (including organ acquisition, matching and donor costs up to \$50,000). Coverage for all transplants, including follow-up care, is excluded until the Member has been continuously enrolled under a GHO or Group Health Cooperative (GHC) plan for six (6) months. This benefit wait period will be reduced by the length of time the Member had immediate prior creditable coverage. Transplant services must be received at a facility authorized in advance by GHO. Annual deductible does not apply to outpatient services. |

Alliant Plus Summary of Benefits

Page 6 of 7

| | | |
|--|---|---|
| <p>Pre-Existing Condition</p> | <p>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.</p> <p>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.</p> | <p>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.</p> <p>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.</p> |
| <p>Preventive Services (well adult and well child physicals, immunizations, pap smears, mammograms)</p> | <p>Covered subject to the applicable outpatient services copayment when in accordance with the well-care schedule established by GHO. Not subject to the plan coinsurance. Excluded are physicals for travel, employment, insurance or license. 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 cost share. Annual deductible does not apply to outpatient services.</p> | <p>Covered subject to the applicable outpatient services copayment when in accordance with the well-care schedule established by GHO. Not subject to the plan coinsurance. Excluded are physicals for travel, employment, insurance or license. 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 cost share. Annual deductible does not apply to outpatient services.</p> |
| <p>Rehabilitation Services Inpatient physical, occupational and restorative speech therapy services combined, including services for neurodevelopmentally disabled children age six (6) and under</p> | <p>Covered subject to the applicable inpatient services copayment and at the plan coinsurance for up to sixty (60) days per calendar year, after the annual deductible is satisfied.</p> | <p>Covered subject to the applicable inpatient services copayment and at the plan coinsurance for up to sixty (60) days per calendar year, after the annual deductible is satisfied.</p> |
| <p>Outpatient physical, occupational and restorative speech therapy services combined, including services for neurodevelopmentally disabled children age six (6) and under</p> | <p>Covered subject to the applicable outpatient services copayment and at the plan coinsurance for up to sixty (60) visits per calendar year. Annual deductible does not apply to outpatient services.</p> | <p>Covered subject to the applicable outpatient services copayment and at the plan coinsurance for up to sixty (60) visits per calendar year. Annual deductible does not apply to outpatient services.</p> |
| <p>Skilled Nursing Facility (SNF)</p> | <p>Covered at the plan coinsurance up to sixty (60) days per Member per calendar year, after the annual deductible is satisfied.</p> | <p>Covered at the plan coinsurance up to sixty (60) days per Member per calendar year, after the annual deductible is satisfied.</p> |
| <p>Sterilization (vasectomy, tubal ligation)</p> | <p>Covered subject to the applicable outpatient services copayment and at the plan coinsurance. Annual deductible does not apply to outpatient services. Procedures to reverse a sterilization are not covered.</p> | <p>Covered subject to the applicable outpatient services copayment and at the plan coinsurance. Annual deductible does not apply to outpatient services. Procedures to reverse a sterilization are not covered.</p> |

Alliant Plus Summary of Benefits

Page 7 of 7

| | | |
|--|---|---|
| <p>Temporomandibular Joint (TMJ) Services</p> <p>Inpatient and outpatient TMJ services</p> <p>Lifetime benefit maximum</p> | <p>Covered subject to the applicable copayment and at the plan coinsurance up to a \$1,000 combined maximum per Member per calendar year, after the annual deductible is satisfied. Annual deductible does not apply to outpatient services.</p> <p>Covered up to a \$5,000 combined maximum per Member.</p> | <p>Covered subject to the applicable copayment and at the plan coinsurance up to a \$1,000 combined maximum per Member per calendar year, after the annual deductible is satisfied. Annual deductible does not apply to outpatient services.</p> <p>Covered up to a \$5,000 combined maximum per Member.</p> |
| <p>Tobacco Cessation</p> <p>Individual/group sessions</p> <p>Approved pharmacy products</p> | <p>Covered in full.</p> <p>Covered in full when prescribed and dispensed as part of the GHO-designated tobacco cessation program.</p> | <p>Not covered.</p> <p>Not covered.</p> |