



Alliant Plus Summary of Benefits

PLATINUM: No Riders		
Effective Date 1/1/2008		Ref 0877777768
<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.
Annual Deductible	No annual deductible.	\$200 per Member or \$400 per family unit per calendar year.
Plan Coinsurance	No plan coinsurance.	80% of the Usual, Customary and Reasonable (UCR) charges are covered.
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)	\$200 copayment per Member per admission.	\$200 copayment per Member per admission and 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.	Covered subject to the applicable outpatient services cost share.
Outpatient Services (Office Visits) Covered outpatient medical and surgical services	\$20 copayment per Member per visit. \$40 copayment per Member per specialty care visit.	\$20 copayment per Member per visit and at the plan coinsurance after the annual deductible is satisfied. \$40 copayment per Member per specialty care visit and at the plan coinsurance after the annual deductible is satisfied.
Allergy testing	Covered subject to the applicable outpatient services copayment.	Covered subject to the applicable outpatient services cost share.
Oncology (radiation therapy, chemotherapy)	Covered subject to the applicable outpatient services copayment.	Covered subject to the applicable outpatient services cost share.

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<p>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</p>	<p>Covered subject to the lesser of the MHCN's charge or a \$20 copayment for generic drugs or \$40 copayment for brand name drugs.</p>	<p>Covered subject to a \$25 copayment for generic drugs or \$45 copayment for brand name drugs.</p>
<p>Over-the-counter drugs and medicines</p>	<p>Not covered.</p>	<p>Not covered.</p>
<p>Allergy serum</p>	<p>Covered subject to the applicable prescription drug cost share for each thirty (30) day supply.</p>	<p>Covered subject to the applicable prescription drug cost share for each thirty (30) day supply.</p>
<p>Injectables</p>	<p>Injections that can be self-administered are subject to the applicable prescription drug cost share.</p>	<p>Injections that can be self-administered are subject to the applicable prescription drug cost share.</p>
<p>Mail order drugs and medicines</p>	<p>Covered subject to a \$5 discount from the applicable prescription drug cost share for each thirty (30) day supply or less.</p>	<p>Not covered.</p>
<p>Growth hormones</p>	<p>Covered in full subject to a twelve (12) month waiting period.</p>	<p>Covered at the plan coinsurance after the annual deductible is satisfied, subject to a twelve (12) month waiting period.</p>
<p>Out-of-Pocket Limit</p>	<p>Limited to an aggregate maximum of \$2,000 per Member or \$4,000 per family per calendar year. 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"> • Inpatient services • Outpatient services • Emergency services at a MHCN Facility • Ambulance services 	<p>Limited to an aggregate maximum of \$2,000 per Member or \$4,000 per family per calendar year. 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"> • Plan coinsurance • Emergency services at a non-MHCN Facility
<p>Acupuncture</p>	<p>Covered subject to the applicable outpatient services copayment 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.</p>	<p>Covered subject to the applicable outpatient services cost share.</p>
<p>Ambulance Services Emergency ground/air transport Non-emergent ground/air interfacility transfer</p>	<p>Covered at 80%. Covered at 80% for MHCN-initiated transfers, except hospital-to-hospital ground transfers covered in full.</p>	<p>Covered at 80%. 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.</p>	<p>Covered subject to the applicable inpatient services cost share.</p>

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Outpatient services	Covered subject to the applicable outpatient services copayment.	Covered subject to the applicable outpatient services cost share.
Benefit period allowance	<p>\$14,000 maximum per Member per any twenty-four (24) consecutive calendar month period.</p> <p>Acute detoxification covered as any other medical service. Charges incurred are not subject to the twenty-four (24) month maximum.</p>	<p>\$14,000 maximum per Member per any twenty-four (24) consecutive calendar month period.</p> <p>Acute detoxification covered as any other medical service. Charges incurred are not subject to the twenty-four (24) month maximum.</p>
<p>Devices, Equipment and Supplies (for home use)</p> <p>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 • Ostomy supplies • Prosthetic devices 	<p>Covered at 80% up to \$5,000 (\$4,000 maximum benefit) per calendar year.</p> <p>Covered at 80% up to \$40,000 (\$32,000 maximum benefit) per calendar year.</p>	<p>Covered at 80% up to \$5,000 (\$4,000 maximum benefit) per calendar year after the annual deductible is satisfied.</p> <p>Covered at 80% up to \$40,000 (\$32,000 maximum benefit) per calendar year after the annual deductible is satisfied.</p>
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.
Diagnostic Laboratory and Radiology Services	Covered in full.	Covered at the plan coinsurance after the annual deductible is satisfied.
Emergency Services	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. Emergency admissions are covered subject to the applicable inpatient services cost share.	Covered subject to a \$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 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.

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<p>Hearing Examinations and Hearing Aids</p>	<p>Hearing examinations to determine hearing loss are covered subject to the applicable outpatient services copayment.</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 cost share.</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 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. When approved by GHO, additional manipulation visits are covered.</p>	<p>Covered subject to the applicable outpatient services cost share for manipulative therapy of the spine or extremities up to a maximum of ten (10) visits per Member per calendar year.</p>
<p>Maternity and Pregnancy Services Delivery and associated hospital care</p>	<p>Covered subject to the applicable inpatient services copayment.</p>	<p>Covered subject to the applicable inpatient services cost share.</p>
<p>Routine prenatal and postpartum care</p>	<p>Covered subject to the applicable outpatient services copayment.</p>	<p>Covered subject to the applicable outpatient services cost share.</p>
<p>Mental Health Services Inpatient services</p>	<p>Covered subject to the applicable inpatient services copayment for up to twelve (12) days per Member per calendar year at a GHO-approved mental health care facility.</p>	<p>Covered subject to the applicable inpatient services cost share for up to twelve (12) days per Member per calendar year.</p>
<p>Outpatient services</p>	<p>Covered subject to the applicable outpatient services copayment for up to twenty (20) visits per Member per calendar year.</p>	<p>Covered subject to the applicable outpatient services cost share for up to twenty (20) visits per Member per calendar year.</p>
<p>Naturopathy</p>	<p>Covered subject to the applicable outpatient services copayment 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.</p>	<p>Covered subject to the applicable outpatient services cost share.</p>
<p>Optical Services Routine eye examinations</p>	<p>Covered subject to the applicable outpatient services copayment once every twelve (12) months, except as Medically Necessary.</p>	<p>Not covered. Eye examinations, for eye pathology are covered when Medically Necessary.</p>
<p>Lenses, including contact lenses, and frames</p>	<p>Not covered.</p> <p>One contact lens per diseased eye, when in lieu of an intraocular lens, is covered in full 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>

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<p>Organ Transplants</p>	<p>Covered subject to the applicable copayment up to a \$250,000 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.</p>	<p>Covered at the plan coinsurance up to a \$250,000 lifetime benefit maximum (including organ acquisition, matching and 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 enrolled 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.</p>
<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. Excluded are physicals for travel, employment, insurance or license.</p>	<p>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 or license.</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 for up to sixty (60) days per calendar year.</p>	<p>Covered subject to the applicable inpatient services cost share for up to sixty (60) days per calendar year.</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 for up to sixty (60) visits per calendar year.</p>	<p>Covered subject to the applicable outpatient services cost share for up to sixty (60) visits per calendar year.</p>
<p>Skilled Nursing Facility (SNF)</p>	<p>Covered in full up to sixty (60) days per Member per calendar year.</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 copayment. Procedures to reverse a sterilization are not covered.</p>	<p>Covered subject to the applicable cost share. Procedures to reverse a sterilization are not covered.</p>

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<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 up to a \$1,000 combined maximum per Member per calendar year.</p> <p>Covered up to a \$5,000 combined maximum per Member.</p>	<p>Covered subject to the applicable cost share up to a \$1,000 combined maximum per Member per calendar year.</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>