



Options Select Summary of Benefits

SILVER: No Riders	
Effective Date 1/1/2008	Ref 0877777776
<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>	
“Welcome” Outpatient Service Waiver	First four (4) visits per calendar year covered subject to the applicable outpatient services copayment. Subsequent visits covered subject to the applicable outpatient services copayment and at the plan coinsurance after the annual deductible is satisfied. First four (4) visit benefit does not apply to emergency services.
Annual Deductible	\$1,000 per Member or \$3,000 per family unit per calendar year.
Plan Coinsurance	70% after the annual deductible is satisfied.
Lifetime Maximum	\$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 outpatient hospital surgery (including ambulatory surgical centers)	Covered subject to the applicable outpatient services copayment 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 copayment and at the plan coinsurance after the annual deductible is satisfied. Covered subject to a \$50 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 and at the plan coinsurance after the annual deductible is satisfied.
Oncology (radiation therapy, chemotherapy)	Covered subject to the applicable outpatient services copayment 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 Managed Health Care Network’s (MHCN’s) charge or a \$20 copayment for generic drugs or \$40 copayment for brand name drugs.
Over-the-counter drugs and medicines	Not covered.
Allergy serum	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.
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.

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Growth hormones	Covered at the plan coinsurance after the annual deductible is satisfied, subject to a twelve (12) month waiting period.
Out-of-Pocket Limit	Limited to an aggregate maximum of \$2,000 per Member or \$6,000 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: <ul style="list-style-type: none"> • Plan coinsurance • Emergency services at a MHCN or non-MHCN Facility • Ambulance services
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, after the annual deductible is satisfied. When approved by GHO, additional visits are covered.
Ambulance Services Emergency ground/air transport Non-emergent ground/air interfacility transfer	Covered at 80%. Covered at 80% for MHCN-initiated transfers, except hospital-to-hospital ground transfers covered in full.
Chemical Dependency Inpatient services	Covered subject to the applicable inpatient services copayment and at the plan coinsurance after the annual deductible is satisfied.
Outpatient services	Covered subject to the applicable outpatient services copayment and at the plan coinsurance after the annual deductible is satisfied.
Benefit period allowance	\$14,000 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.
Devices, Equipment and Supplies (for home use) Covered items include: <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 	Covered at 80% up to \$5,000 (\$4,000 maximum benefit) per calendar year. Covered at 80% up to \$40,000 (\$32,000 maximum benefit) per calendar year.
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.
Diagnostic Laboratory and Radiology Services	Covered in full up to first \$500 per calendar year, then covered at the plan coinsurance after the annual deductible is satisfied. Services received while in an emergency setting are covered at the plan coinsurance after the annual deductible is satisfied.

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<p>Emergency Services At a MHCN Facility</p>	<p>Covered subject to a \$75 copayment per Member per emergency visit, 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.</p>
<p>At a non-MHCN Facility</p>	<p>Covered subject to a \$125 deductible per Member per emergency visit, then covered at the plan coinsurance after the annual deductible is satisfied. 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. If the 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.</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 after the annual deductible is satisfied.</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>Hospice Services</p>	<p>Covered in full.</p>
<p>Infertility Services (including sterility)</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, after the annual deductible is satisfied. When approved by GHO, additional manipulation visits are covered.</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>Routine prenatal and postpartum care</p>	<p>Covered subject to the applicable outpatient services copayment and at the plan coinsurance after the annual deductible is satisfied.</p>
<p>Mental Health Services Inpatient services</p>	<p>Covered subject to the applicable inpatient services cost share for up to twelve (12) days per Member per calendar year at a GHO-approved mental health care facility.</p>
<p>Outpatient services</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 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, after the annual deductible is satisfied. When approved by GHO, additional visits are covered.</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. Not subject to the annual deductible or plan coinsurance.</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 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 and 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.</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>Preventive Services (well adult and well child physicals, immunizations, pap smears, mammograms)</p>	<p>Covered subject to the applicable outpatient services copayment and at the plan coinsurance when in accordance with the well-care schedule established by the GHO. Not subject to the annual deductible. 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 copayment and at the plan coinsurance after the annual deductible is satisfied.</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>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, after the annual deductible is satisfied.</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>Sterilization (vasectomy, tubal ligation)</p>	<p>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.</p>
<p>Temporomandibular Joint (TMJ) Services 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 maximum per Member per calendar year, after the annual deductible is satisfied.</p> <p>Covered up to a \$5,000 combined maximum per Member.</p>
<p>Tobacco Cessation 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>