



Alliant Plus Summary of Benefits

HIHIT-Silver Pre-deductible Plan		
Effective Date 1/1/2010		Ref 1077777748
<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.
Pre-Deductible Coverage	Covered Services are covered at the plan coinsurance up to a pre-deductible coverage limit of \$1,000 per Member or \$3,000 per family unit per calendar year (benefit amount varies based on the plan coinsurance). Annual deductible does not apply during the pre-deductible coverage period.	Shared with in-network.
Annual Deductible	\$1,500 per Member or \$4,500 per family unit per calendar year.	Shared with in-network.
Plan Coinsurance	70%, which applies during the pre-deductible coverage period and after the annual deductible is satisfied.	50% of the Usual, Customary and Reasonable (UCR) charges, which applies during the pre-deductible coverage period and 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)	Deductible and coinsurance apply.	Deductible and coinsurance apply.
Covered outpatient hospital surgery (including ambulatory surgical centers)	Deductible and coinsurance apply.	Deductible and coinsurance apply.
Outpatient Services (Office Visits) Covered outpatient medical and surgical services	Deductible and coinsurance apply.	Deductible and coinsurance apply.
Allergy testing	Deductible and coinsurance apply.	Deductible and coinsurance apply.

Alliant Plus Summary of Benefits

Page 2 of 6

Oncology (radiation therapy, chemotherapy)	Deductible and coinsurance apply.	Deductible and coinsurance apply.
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. Not subject to pre-deductible coverage limit and cost shares do not apply to out-of-pocket limit. Dispensing of a generic drug is required unless a brand drug is Medically Necessary.	Covered subject to the lesser of the allowed charge or a \$25 copayment for generic drugs or \$45 copayment for brand name drugs. Not subject to pre-deductible coverage limit and cost shares do not apply to out-of-pocket limit. 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	Deductible and coinsurance apply.	Deductible and coinsurance apply.
Injectables	Injections that can be self-administered are subject to the lesser of the MHCN's charge or the applicable prescription drug cost share. Not subject to pre-deductible coverage limit and cost shares do not apply to out-of-pocket limit.	Injections that can be self-administered are subject to the lesser of the MHCN's charge or the applicable prescription drug cost share. Not subject to pre-deductible coverage limit and cost shares do not apply to out-of-pocket limit.
Mail order drugs and medicines	Covered subject to the lesser of the MHCN's charge or two (2) times the applicable prescription drug cost share (as set forth above) for each ninety (90) day supply or less for mail order prescription drugs. Not subject to pre-deductible coverage limit and cost shares do not apply to out-of-pocket limit.	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: <ul style="list-style-type: none"> • Annual deductible • Plan coinsurance 	Shared with in-network.
Acupuncture	Deductible and coinsurance apply 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.	Deductible and coinsurance apply.
Ambulance Services Emergency ground/air transport Non-emergent ground/air interfacility transfer	Deductible and coinsurance apply.	Deductible and coinsurance apply.
Chemical Dependency Inpatient services	Deductible and coinsurance apply.	Deductible and coinsurance apply.

Alliant Plus Summary of Benefits

Page 3 of 6

Outpatient services	Deductible and coinsurance apply.	Deductible and coinsurance apply.
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 • Ostomy supplies • Prosthetic devices 	Deductible and coinsurance apply up to \$5,000 per calendar year. Deductible and coinsurance apply up to \$40,000 per calendar year.	Deductible and coinsurance apply up to \$5,000 per calendar year. Deductible and coinsurance apply up to \$40,000 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 or Drugs-Outpatient are covered and have benefit limits, diabetic supplies are not subject to these limits.	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 or Drugs-Outpatient are covered and have benefit limits, diabetic supplies are not subject to these limits.
Diagnostic Laboratory and Radiology Services	Deductible and coinsurance apply.	Deductible and coinsurance apply. Prior authorization is required for CTs, MRIs and PETs.
Emergency Services	Deductible and coinsurance apply.	MHCN deductible and coinsurance apply. 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.
Hearing Examinations and Hearing Aids	Deductible and coinsurance apply to hearing examinations to determine hearing loss. Hearing aids, including hearing aid examinations, are not covered.	Deductible and coinsurance apply to hearing examinations to determine hearing loss. Hearing aids, including hearing aid examinations, are not covered.
Home Health Services	Deductible and coinsurance apply. No visit limit.	Deductible and coinsurance apply.
Hospice Services	Covered in full. Not subject to pre-deductible coverage limit.	Deductible and coinsurance apply.
Infertility Services (including sterility)	Not covered.	Not covered.
Manipulative Therapy	Deductible and coinsurance apply 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.	Deductible and coinsurance apply for manipulative therapy of the spine or extremities up to a maximum of ten (10) visits per Member per calendar year.

Alliant Plus Summary of Benefits

Page 4 of 6

<p>Maternity and Pregnancy Services Delivery and associated hospital care</p>	<p>Deductible and coinsurance apply.</p>	<p>Deductible and coinsurance apply.</p>
<p>Routine prenatal and postpartum care</p>	<p>Deductible and coinsurance apply.</p>	<p>Deductible and coinsurance apply.</p>
<p>Mental Health Services Inpatient services</p>	<p>Deductible and coinsurance apply at a GHO-approved mental health care facility.</p>	<p>Deductible and coinsurance apply.</p>
<p>Outpatient services</p>	<p>Deductible and coinsurance apply.</p>	<p>Deductible and coinsurance apply.</p>
<p>Naturopathy</p>	<p>Deductible and coinsurance apply 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>Deductible and coinsurance apply.</p>
<p>Optical Services Routine eye examinations</p>	<p>Deductible and coinsurance apply once every twelve (12) months. Deductible and coinsurance apply to eye examinations, including contact lens examinations, for eye pathology as often as Medically Necessary.</p>	<p>Deductible and coinsurance apply once every twelve (12) months. Deductible and coinsurance apply to eye examinations, including contact lens examinations, for eye pathology as often as Medically Necessary.</p>
<p>Lenses, including contact lenses, and frames</p>	<p>Eyeglass lenses and frames; or contact lenses, including exams associated with their fitting covered up to \$200 per Member per any consecutive twelve (12) month period. Not subject to pre-deductible coverage limit.</p> <p>Deductible and coinsurance apply to contact lenses following cataract surgery, when in lieu of an intraocular lens, provided the Member has been continuously covered by GHO since such surgery. Deductible and coinsurance apply to contact lenses for eye pathology. 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 \$200 per Member in any consecutive twelve (12) month period. Not subject to pre-deductible coverage limit.</p> <p>Deductible and coinsurance apply to contact lenses following cataract surgery, when in lieu of an intraocular lens, provided the Member has been continuously covered by GHO since such surgery. Deductible and coinsurance apply to contact lenses for eye pathology. 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>Organ Transplants</p>	<p>Deductible and coinsurance apply 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 the agreement for six (6) months. This benefit wait period will be reduced by the length of time the Member had immediate prior creditable coverage</p>	<p>Deductible and coinsurance apply 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 the agreement 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.</p>

Alliant Plus Summary of Benefits

Page 5 of 6

<p>Pre-Existing Condition</p>	<p>Covered (except as specified) after the Member has been continuously covered under the 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 the length of time met under prior similar coverage for a Member whose date of application for coverage under this GHO plan is within ninety (90) days of termination of prior similar coverage.</p>	<p>Covered (except as specified) 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 the length of time met under prior similar coverage for a Member whose date of application for coverage under this GHO plan is within ninety (90) days of termination of prior similar coverage.</p>
<p>Preventive Services (well adult and well child physicals, immunizations, pap smears, mammograms)</p>	<p>Deductible and coinsurance apply when in accordance with the well-care schedule established by GHO. Excluded are physicals for travel, employment, insurance or license.</p>	<p>Deductible and coinsurance apply up to a \$300 maximum per Member (\$600 maximum per family) per calendar year. Deductible and coinsurance apply to routine mammography services. 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>Deductible and coinsurance apply for up to sixty (60) days per calendar year.</p>	<p>Deductible and coinsurance apply 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>Deductible and coinsurance apply for up to sixty (60) visits per calendar year.</p>	<p>Deductible and coinsurance apply for up to sixty (60) visits per calendar year.</p>
<p>Skilled Nursing Facility (SNF)</p>	<p>Deductible and coinsurance apply for up to sixty (60) days per Member per calendar year.</p>	<p>Deductible and coinsurance apply for up to sixty (60) days per Member per calendar year.</p>
<p>Sterilization (vasectomy, tubal ligation)</p>	<p>Deductible and coinsurance apply. Procedures to reverse a sterilization are not covered.</p>	<p>Deductible and coinsurance apply. 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>Deductible and coinsurance apply 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>Deductible and coinsurance apply 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>

Alliant Plus
Summary of Benefits

Page 6 of 6

<p>Tobacco Cessation</p> <p>Individual/group sessions</p> <p>Approved pharmacy products</p>	<p>Covered in full. Not subject to pre-deductible coverage limit.</p> <p>Covered in full when prescribed and dispensed as part of the GHO-designated tobacco cessation program. Not subject to pre-deductible coverage limit.</p>	<p>Not covered.</p> <p>Not covered.</p>
--	---	---