



GroupHealth

## Options Select Summary of Benefits

<b>SEIU Local 775 Plan B</b>	
<b>Effective Date</b> 8/1/2007	<b>Ref</b> 0762248004
This is a brief summary of benefits and limitations. THIS IS NOT A CONTRACT. 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.	
<b>Annual Deductible</b>	No annual deductible.
<b>Plan Coinsurance</b>	No plan coinsurance.
<b>Lifetime Maximum</b>	\$2,000,000 per Member.
<b>Hospital Services</b> Covered inpatient medical and surgical services, including acute chemical withdrawal (detoxification)	\$100 copayment per day up to a maximum of five (5) days per Member per calendar year; no copayment on additional days thereafter.
Covered outpatient hospital surgery (including ambulatory surgical centers)	\$25 copayment per Member per visit.
<b>Outpatient Services (Office Visits)</b> Covered outpatient medical and surgical services	\$10 copayment per Member per visit.
Allergy testing	Covered subject to the applicable outpatient services copayment.
Oncology (radiation therapy, chemotherapy)	Covered subject to the applicable outpatient services copayment.
<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 \$10 copayment for generic drugs or \$20 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 the applicable prescription drug cost share for each thirty (30) day supply or less.
Growth hormones	Not covered.
<b>Out-of-Pocket Limit (Stop Loss)</b>	No out-of-pocket limit.
<b>Acupuncture</b>	Covered subject to the applicable outpatient services copayment in accordance with GHO protocol when referred by a MHCN Provider.
<b>Ambulance Services</b> Emergency ground/air transport	\$50 copayment per trip.
Non-emergent ground/air interfacility transfer	Covered subject to a \$50 copayment per trip for MHCN-initiated transfers, except hospital-to-hospital ground transfers covered in full.

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<b>Chemical Dependency</b> Inpatient services	Covered subject to the applicable inpatient services copayment.
Outpatient services	Covered subject to the applicable outpatient services copayment.
Benefit period allowance	\$13,500 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.
<b>Devices, Equipment and Supplies (for home use)</b> Covered items include: <ul style="list-style-type: none"> <li>• Durable medical equipment</li> <li>• Orthopedic appliances</li> <li>• Post-mastectomy bras limited to two (2) every six (6) months</li>   <li>• Ostomy supplies</li> <li>• Prosthetic devices</li> </ul>	Not covered, except oxygen and oxygen equipment, ostomy supplies and post-mastectomy bras covered in full.  Not covered, except one breast prostheses per diseased breast covered in full once every two (2) years.
<b>Diabetic Supplies</b>	Needles, syringes, testing reagents and lancets covered subject to Tier 2 pharmacy copayment for each thirty (30) day supply. External insulin pumps, blood glucose monitors, testing reagents and supplies are covered in full.
<b>Diagnostic Laboratory and Radiology Services</b>	Covered in full.
<b>Emergency Services</b> At a MHCN Facility	Covered subject to a \$50 copayment per Member per emergency visit. 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.
At a non-MHCN Facility	Covered subject to a \$50 copayment per Member per emergency visit. 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. 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.
<b>Hearing Examinations and Hearing Aids</b>	Hearing examinations to determine hearing loss are covered subject to the applicable outpatient services copayment.  Hearing aids, including hearing aid examinations, are not covered.
<b>Home Health Services</b>	Covered in full. No visit limit.
<b>Hospice Services</b>	Covered in full.
<b>Infertility Services (including sterility)</b>	Not covered.
<b>Manipulative Therapy</b>	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 subject to the applicable outpatient services copayment.
<b>Maternity and Pregnancy Services</b> Delivery and associated hospital care	Covered subject to the inpatient services copayment.
Routine prenatal and postpartum care	Covered in full.

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<p><b>Mental Health Services</b> 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>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><b>Naturopathy</b></p>	<p>Covered subject to the outpatient services copayment in accordance with GHO protocol when referred by a MHCN Provider.</p>
<p><b>Optical Services</b> Routine eye examinations</p>	<p>Covered subject to the applicable outpatient services copayment once every twelve (12) months. Eye examinations, including contact lens examinations, for eye pathology are covered subject to the applicable outpatient services copayment 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 twenty-four (24) 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><b>Organ Transplants</b></p>	<p>Covered subject to applicable copayments. 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 twelve (12) months.</p>
<p><b>Pre-Existing Condition</b></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><b>Preventive Services</b> (well adult and well child physicals, immunizations, pap smears, mammograms)</p>	<p>Covered in full when in accordance with well-care schedule established by GHO. Excluded are physicals for travel, employment, insurance, license.</p>
<p><b>Rehabilitation Services</b> 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>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 outpatient services copayment for up to sixty (60) visits per calendar year.</p>
<p><b>Skilled Nursing Facility (SNF)</b></p>	<p>Covered in full up to sixty (60) days per Member per calendar year.</p>

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<b>Sterilization (vasectomy, tubal ligation)</b>	Covered subject to the applicable copayment. Procedures to reverse a sterilization are not covered.
<b>Temporomandibular Joint (TMJ) Services</b> Inpatient and outpatient TMJ services  Lifetime benefit maximum	Covered subject to the applicable copayment up to a \$1,000 maximum per Member per calendar year.  Covered up to \$5,000 per Member.
<b>Tobacco Cessation</b> Individual/group sessions  Approved pharmacy products	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.
<p><b>Limitations:</b> Coverage for cosmetic services is limited to breast reconstruction following mastectomy, and reconstructive breast reduction on non-diseased breast.</p> <p><b>Exclusions:</b> 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; 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.</p> <p>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&amp;I and worker's compensation).</p>	