



Options Health Plan Summary of Benefits

University Of Puget Sound		
Effective Date 1/1/2004		Ref 0406072005
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	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 preauthorized by GHO at least seventy-two (72) hours in advance.
Annual Deductible	No annual deductible.	\$300 per Member or \$600 per family unit per calendar year.
Plan Coinsurance	No plan coinsurance.	80% of the Usual, Customary and Reasonable (UCR) charges are covered.
Lifetime Maximum	No lifetime maximum.	No lifetime maximum.
Hospital Services Covered inpatient medical and surgical services, including acute chemical withdrawal (detoxification)	\$100 copayment per Member per admission.	Covered at the plan coinsurance after the annual deductible is satisfied.
Covered outpatient hospital surgery (including ambulatory surgical centers)	Covered subject to the outpatient services copayment.	Covered at the plan coinsurance after the annual deductible is satisfied.
Outpatient Services (Office Visits) Covered outpatient medical and surgical services	\$15 copayment per Member per visit.	Covered at the plan coinsurance after the annual deductible is satisfied.
Allergy testing	Covered subject to the outpatient services copayment.	Covered at the plan coinsurance after the annual deductible is satisfied.
Oncology (radiation therapy, chemotherapy)	Covered subject to the outpatient services copayment.	Covered 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 Group Health Options (GHO) drug formulary	Covered subject to the lesser of the MHCN's charge or a \$10 copayment for generic drugs or \$20 copayment for brand name drugs.	Covered subject to a \$15 copayment for generic drugs or \$25 copayment for brand name drugs.

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Over-the-counter drugs and medicines	Not covered.	Not covered.
Allergy serum	Covered subject to the prescription drug copayment for each thirty (30) day supply.	Covered subject to the prescription drug copayment for each thirty (30) day supply.
Injectables	Injections that can be self-administered are subject to the prescription drug copayment.	Injections that can be self-administered are subject to the prescription drug copayment.
Mail order drugs and medicines	Covered subject to the prescription drug copayment for each thirty (30) day supply.	Not covered.
Growth hormones	Covered subject to a twelve (12) month waiting period.	Covered subject to a twelve (12) month waiting period.
Out-of-Pocket Limit (Stop Loss)	<p>Except as otherwise noted, total out-of-pocket expenses for the following Covered Services are included in the Stop Loss:</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 \$1,000 per Member and \$2,000 per family per calendar year.</p>	<p>Except as otherwise noted, total out-of-pocket expenses for the following Covered Services are included in the Stop Loss:</p> <ul style="list-style-type: none"> • Plan coinsurance • Emergency Services at a non-MHCN Facility <p>Limited to an aggregate maximum of \$2,000 per Member and \$4,000 per family per calendar year.</p>
Acupuncture	Self-referrals to a MHCN Provider covered up to a maximum of five (5) visits per Member per medical diagnosis per calendar year, subject to the outpatient services copayment. When approved by GHO, additional visits are covered subject to the outpatient services copayment.	Covered at the plan coinsurance after the annual deductible is satisfied.
Ambulance Services Emergency ground/air transport	Covered at 80%.	Covered at 80%.
Non-emergent ground/air interfacility transfer	Covered at 80% for MHCN-initiated transfers, except hospital-to-hospital ground transfers covered in full.	When Medically Necessary and prescribed by the attending physician, transport from one medical facility to the nearest facility equipped to render further Medically Necessary treatment is covered at 80%. Services are not subject to annual deductible. Coinsurance does not apply to out-of-pocket limit.
Chemical Dependency Inpatient Services	Covered subject to the applicable inpatient copayment.	Covered at the plan coinsurance after the annual deductible is satisfied.
Outpatient Services	Covered subject to the applicable outpatient services copayment.	Covered at the plan coinsurance after the annual deductible is satisfied.

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<p style="text-align: center;">Benefit Period Allowance</p>	<p>\$11,841 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 twenty-four (24) month maximum.</p>	<p>\$11,841 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 twenty-four (24) month maximum.</p>
<p>Devices, Equipment and Supplies (for home use) Covered items include:</p> <ul style="list-style-type: none"> • Orthopedic appliances • Durable medical equipment • Ostomy supplies • Post-mastectomy bras [limited to two (2) every six (6) months] • Prosthetic devices 	<p>Covered at 80%.</p> <p>Covered at 80%.</p>	<p>Covered at 80% after the annual deductible is satisfied. Coinsurance does not apply to out-of-pocket limit.</p> <p>Covered at 80% after the annual deductible is satisfied. Coinsurance does not apply to out-of-pocket limit.</p>
<p>Diabetic Supplies</p>	<p>Insulin, needles, syringes and lancets covered under Drugs-Outpatient. External insulin pumps, blood glucose monitors, testing reagents and supplies covered under Devices, Equipment and Supplies. When Devices/Equipment have a dollar maximum, diabetic supplies are not subject to this maximum benefit limit.</p>	<p>Insulin, needles, syringes and lancets covered under Drugs-Outpatient. External insulin pumps, blood glucose monitors, testing reagents and supplies covered under Devices, Equipment and Supplies. When Devices/Equipment have a dollar maximum, diabetic supplies are not subject to this maximum benefit limit.</p>
<p>Diagnostic Laboratory and Radiology Services</p>	<p>Covered in full.</p>	<p>Covered at the plan coinsurance after the annual deductible is satisfied.</p>
<p>Emergency Services</p>	<p>\$75 copayment per Member per emergency visit at a MHCN Facility. Copayment is waived if Member is admitted as an inpatient to the hospital directly from the emergency department.</p>	<p>UCR charges are covered subject to a \$125 deductible per Member per emergency visit at a non-MHCN Facility (world-wide). Deductible is not waived if the Member is admitted as an inpatient to the hospital from the emergency department. 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 level of benefits. 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 at the plan coinsurance after the annual deductible is satisfied.</p>
<p>Hearing Examinations and Hearing Aids</p>	<p>Hearing examinations to determine hearing loss are covered subject to the outpatient services copayment.</p> <p>Hearing aids, including hearing aid examinations, are not covered.</p>	<p>Hearing examinations to determine hearing loss are covered at the plan coinsurance after the annual deductible is satisfied.</p> <p>Hearing aids, including hearing aid examinations, are not covered.</p>

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Infertility Services (Including Sterility)	Not covered.	Not covered.
Manipulative Therapy	Self-referrals to a MHCN provider for manipulative therapy of the spine covered up to a maximum of ten (10) visits per Member per calendar year, subject to the applicable outpatient services copayment. When approved by GHO, additional visits are covered subject to the outpatient services copayment.	Manipulative therapy of the spine covered up to a maximum of ten (10) visits per Member per calendar year, at the plan coinsurance after the annual deductible is satisfied.
Maternity and Pregnancy Services Delivery and associated hospital care	Covered subject to the applicable inpatient copayment.	Covered at the plan coinsurance after the annual deductible is satisfied.
Routine prenatal and postpartum care	Covered subject to the outpatient services copayment.	Covered at the plan coinsurance after the annual deductible is satisfied.
Mental Health Services Inpatient Services	Covered at 80% up to twelve (12) days per Member per calendar year at a MHCN-approved mental health care facility when authorized in advance by the MHCN. Coinsurance does not apply to out-of-pocket limit.	Covered up to twelve (12) days per Member per calendar year at the plan coinsurance after the annual deductible is satisfied. Coinsurance does not apply to out-of-pocket limit.
Outpatient Services	Covered subject to a \$20 copayment per individual session and a \$10 copayment per Member per group session for up to twenty (20) visits per Member per calendar year. Copayments do not apply to out-of-pocket limit.	Covered at 50% of UCR charges up to twenty (20) visits per Member per calendar year, after the annual deductible is satisfied. Coinsurance does not apply to out-of-pocket limit.
Naturopathy	Self-referrals to a MHCN Provider covered up to a maximum of two (2) visits per Member per medical diagnosis per calendar year, subject to the outpatient services copayment. When approved by GHO, additional visits are covered subject to the outpatient services copayment.	Covered at the plan coinsurance, after the annual deductible is satisfied.
Optical Services Routine eye examinations	Routine eye examinations covered subject to the outpatient services copayment once every twelve (12) months, except as Medically Necessary.	Routine eye examinations are not covered. Eye examinations for eye pathology are covered when Medically Necessary.
Lenses, including contact lenses, and frames	Not covered. One contact lens per diseased eye is covered following cataract surgery when in lieu of an intraocular lens, provided the Member has been continuously enrolled by GHO since such surgery.	Not covered. Contact lens after cataract surgery covered when in lieu of intraocular lens at the plan coinsurance after the annual deductible is satisfied.

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<p>Organ Transplants</p>	<p>Covered up to a lifetime maximum of \$200,000 per Member, subject to applicable copayments. Coverage for all transplants, including follow-up care, is excluded until the Member has been continuously enrolled under a GHO plan for twelve (12) months.</p>	<p>Covered up to a lifetime maximum of \$200,000 per Member, at the plan coinsurance 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 plan for twelve (12) months. Transplant services must be received at a facility authorized in advance by GHO.</p>
<p>Pre-Existing Condition</p>	<p>Covered with no wait, subject to applicable copayments.</p>	<p>Covered with no wait, at the plan coinsurance after the annual deductible is satisfied.</p>
<p>Preventive Services (Well Adult and Well Child Physicals, Immunizations, Pap Smears, Mammograms)</p>	<p>Covered in full when in accordance with the well-care schedule established by the MHCN. Excluded are physicals for travel, employment, insurance, license, etc. Services provided during a preventive care visit which are not in accordance with the well-care schedule are subject to the outpatient services copayment.</p>	<p>Covered to a maximum of \$150 per Member and \$300 per family per calendar year, at the plan coinsurance. Routine mammography services are covered at the plan coinsurance after the annual deductible is satisfied. Excluded are physicals for travel, employment, insurance, license, etc.</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 up to sixty (60) days per condition per calendar year, subject to the inpatient copayment.</p>	<p>Covered up to sixty (60) days per condition per calendar year, at the plan coinsurance 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 up to sixty (60) visits per condition per calendar year, subject to the outpatient services copayment.</p>	<p>Covered up to sixty (60) visits per condition per calendar year, at the plan coinsurance after the annual deductible is satisfied.</p>
<p>Skilled Nursing Facility (SNF)</p>	<p>Covered in full up to a maximum of sixty (60) days per Member per calendar year.</p>	<p>Covered up to a maximum of sixty (60) days per Member per calendar year, at the plan coinsurance 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 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 Lifetime Maximum Benefit</p>	<p>\$1,000 maximum per Member per calendar year. \$5,000 per Member.</p>	<p>\$1,000 maximum per Member per calendar year. \$5,000 per Member.</p>

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<p>Tobacco Cessation Individual/Group Sessions</p> <p>Approved Pharmacy Products</p>	<p>Covered in full.</p> <p>Covered subject to the lesser of the MHCN's charge or the prescription drug copayment 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 pharmacy.</p>	<p>Not covered.</p> <p>Not covered.</p>
<p>Limitations</p>	<p>Coverage for cosmetic services is limited to breast reconstruction following mastectomy, and reconstructive breast reduction on non-diseased breast.</p>	<p>Coverage for cosmetic services is limited to breast reconstruction following mastectomy, and reconstructive breast reduction on non-diseased breast.</p>
<p>Exclusions</p>	<p>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 except for therapeutic shoes, modifications and shoe inserts for severe diabetic foot disease; 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&I and worker's compensation).</p>	<p>Travel medications; investigational or experimental procedures, drugs and devices; dental care; arch supports including custom shoe modifications or inserts and their fittings except for therapeutic shoes, modifications and shoe inserts for severe diabetic foot disease; convalescent or custodial care; cardiac rehabilitation programs; services of unlicensed practitioners; 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&I and worker's compensation); routine eye examinations; most preventive care services.</p>