GROUP HEALTH OPTIONS INCORPORATED

ALLIANT SELECT HEALTH PLAN

Summary of Benefits

BURLINGTON NORTHERN SANTA FE **Effective: JANUARY 1, 2001**

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 for contract language.

Plan Coinsurance	No plan coinsurance.
Annual Deductible	No annual deductible.
Lifetime Maximum	$1,000,000 per Member.
Medical Center Visits • Office visits • Outpatient surgery • Radiation therapy, chemotherapy • Prenatal and postpartum visits, including prenatal testing for the detection of congenital disorders • Outpatient physical, occupational and restorative speech therapy services combined, including services for neurodevelopmentally disabled children age 6 and under are covered up to 60 visits per condition per calendar year • Chemical Dependency treatment (see benefit limits under Chemical Dependency section)	$15 Copayment per visit per Member.
Medical Center Visits (continued) Laboratory tests, x-ray services, home health care and hospice services	Covered in full. No copayment.
Hospital Preauthorization	Not required.
Hospital Care • Hospital room and board • Inpatient surgery and anesthesia • Intensive and coronary care unit • Laboratory and radiology services while in hospital • Drugs while in hospital • Inpatient physical, occupational and restorative speech therapy services combined, including services for neurodevelopmentally disabled children age 6 and under are covered up to 60 days per condition per calendar year • Delivery and associated hospital care, including home births for low risk pregnancies • Chemical Dependency treatment (see benefit limits under Chemical Dependency section) • Chemical dependency detoxification	Covered in full.

Outpatient Prescription Drugs	
Most drugs, including injectables, dietary formula for the treatment of phenylketonuria (PKU), diabetic supplies including insulin syringes, lancets, urine testing reagents and blood glucose monitoring reagents, and contraceptive drugs and devices and their fitting, which require a prescription	Covered subject to a maximum $15 copayment for a supply of 30 days or less of each prescription or refill when provided at an Alliance Network pharmacy and prescribed by an Alliant Network provider. (PKU formula is not subject to the copayment.) Some exclusions apply.
Tobacco Cessation	
• Individual/group session	Covered in full.
• Approved pharmacy products	Covered subject to the prescription drug copayment for a 30-day supply or less of each prescription or refill, when prescribed by an Alliant Network provider and obtained at an Alliant Network pharmacy.
Emergency Care	
• Services received at an Alliant network hospital emergency department	Covered subject to a $50 copayment per emergency visit per Member. Copayment is waived if Member is admitted directly from the emergency department.
• Services received at a non-Alliant hospital emergency department	Covered subject to a $50 copayment per emergency visit per Member.
Ambulance Services	
• Emergency ground/air transportation to an Alliant network facility	Covered at 80%.
• Alliant network-initiated non-emergency transfers	Covered in full.
Skilled Nursing Facility	
Full-time skilled nursing care in an AHCN-approved nursing facility	Covered in full in lieu of hospitalization in an acute care facility when authorized by an AHCN provider.
Devices, Equipment and Supplies	
Including durable medical equipment, prosthetics, orthopedic appliances, oxygen, ostomy supplies, breast prostheses, glucose monitors and external insulin pumps	Covered at 100% of charges if authorized in advance by an AHCN provider as medically necessary, and listed as covered in the AHCN's Durable Medical Equipment Formulary, Orthopedic Appliance Formulary, or Prosthetic Device Formulary.
Mental Health Care	
• Outpatient mental health services such as evaluation, crisis intervention, managed psychotherapy, intermittent care, psychological testing and consultation services	Covered up to 20 visits per Member per calendar year, subject to a $20 copayment per individual/family/couple visit and $10 copayment per group visit. Copayment does not apply to out-of-pocket limit.
• Inpatient mental health services	Covered at 80% up to 30 days per calendar year when referred in advance by an Alliant Network provider. Coinsurance does not apply to the out-of-pocket limit.
Chemical Dependency Treatment	
Inpatient and outpatient alcoholism and/or drug abuse services, including counseling and treatment	Covered up to $10,326 in any 24 consecutive months. All services are subject to applicable copayments.

Pre-Existing Conditions	
Care, medications, or medical advice received for medical conditions which existed within the three month period prior to the effective date of coverage	Covered in full (except as specified) after member has been continuously enrolled under a Virginia Mason-Group Health Alliance plan for three months, except as described below. Coverage is subject to applicable copayments. Coverage for PKU formula is not subject to the pre-existing condition waiting period. Pre-existing condition wait will be credited for a member whose date of application for coverage under this Alliant plan is within three months of termination of prior similar coverage, to the extent that the member has satisfied the pre-existing condition wait under such prior coverage.
Manipulative Therapy	
Self-referrals for manipulative therapy of the spine and extremities by an AHCN Provider	Covered up to 10 visits per Member per calendar year, subject to the applicable office visit copayment.
Out-of-Pocket Limit	
Out-of-pocket expenses for covered services	Limited to an aggregate maximum of $2,000 per Member and $4,000 per family per calendar year.
Preventive Care	
Well-child and well-adult care, most immunizations and vaccinations, routine health screening tests, and routine mammography services.	Covered in full. No copayment.
Routine Eye Examinations and Refractions	One exam covered per Member in any consecutive 12 month period, subject to the office visit copayment.
Organ Transplants	Covered up to a lifetime benefit maximum of $200,000, subject to applicable copayments.
Enteral Therapy	
Elemental and over-the-counter enteral formulas	Covered at 80%. Coinsurance does not apply to the out-of-pocket limit.
Podiatric Care	Covered subject to the office visit copayment when referred by an Alliant Network provider.

Limitations: Only kidney, simultaneous pancreas and kidney, cornea, heart, single lung, double lung, heart-lung, bone marrow and liver transplants are covered, up to a lifetime maximum of $200,000. High dose chemotherapy and stem cell support are covered when medically appropriate. Coverage for all transplants and growth hormone treatment, including follow-up care, is excluded until the member has been continuously enrolled under an Alliant plan for 12 months. Coverage for cosmetic services is limited to breast reconstruction following mastectomy performed inside the Alliant Network, and reconstructive breast reduction on non-diseased breast. External breast prostheses following mastectomy, limited to one per diseased breast every two years. Two post-mastectomy bras every six months are covered if medically necessary and authorized in advance by an Alliant Network provider.

Exclusions: Services or programs not provided or authorized by Alliant Network staff (except as specified); routine foot care; drugs not listed as covered in the Alliant Network Drug Formulary; drugs not requiring a prescription; travel medications; investigational or experimental procedures, drugs and devices; dental care; arch supports including custom shoe inserts and their fittings except for therapeutic shoe inserts for severe diabetic foot disease; procedures to reverse a sterilization; convalescent or custodial care; services covered by first-party insurance; services covered by government and military programs; employment, license, immigration or insurance examinations or reports.

Unless otherwise noted as covered, the following services are also excluded: diagnostic testing of sterility, infertility or sexual dysfunction; eyeglasses; contact lenses, including services associated with their fitting, except following cataract surgery within the Alliant Network; hearing aids; durable medical equipment; skilled nursing facility services; work-related conditions.

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OIC Mental Health Benefits Disclosure Rule

1. **"What are the steps that must be taken to have outpatient mental health services paid for by my plan?"**

   In order for outpatient mental health services to be covered by AHCN, the service must be pre-authorized and approved by AHCN's Medical Director or designee.

2. **"What information about my mental condition will anyone other than my mental health provider see?"**

   As a rule, information about your mental condition is not made available to anyone without an explicit release of information form signed by you or as allowed by Washington State law. Group Health Options, Inc. is an integrated delivery system, therefore, to ensure that you receive comprehensive, coordinated care, information concerning your mental health care would be provided at the appropriate level to AHCN clinicians outside of the Behavioral Health Services (BHS).

   Also, the appropriate level of administrative information about your treatment will be made available to those AHCN employees who determine that your treatment is a covered service and process claims for payment.

   Confidentiality of patient medical information is a legal and ethical right. No employee/ provider/contractor has the right to access, review or disclose patient information, except when necessary to fulfil their job responsibilities. Access, discussion, transmission, or disclosure of patient information, in any form, except in the regular course of business, is strictly prohibited.

3. **"Do I have to pay a higher co-pay, deductible or other charges than I pay for my other covered medical services to get mental health services under this plan?"**

   Co-pays, co-insurance, and deductible levels are determined by the plan chosen by your employer. Generally, the co-pays, deductibles and co-insurance for mental health counseling visits are higher than visits for general outpatient medical visits. Medication management services are considered medical services even when provided within the BHS and are covered at the same level as any other outpatient medical visits. Please refer to the attached Summary of Benefits for coverage details and a comparison of co-pays, co-insurance, and deductibles between mental health and general medical visits.

4. **"What is the maximum number of medically necessary inpatient days and outpatient visits I can get each year under this plan?"**

   The maximum number of possible inpatient days or outpatient visits is determined by the plan selected by your employer. However, an individual member's actual number of days and visits authorized by AHCN's BHS is determined by ensuring that the condition for which you are seeking services is "medically necessary". Determining "medical necessity" is AHCN's mechanism for ensuring that the amount of service is consistent with the determined need. Please refer to the attached Summary of Benefits to determine coverage limits.

5. **"What is the average number of outpatient visits this plan pays for people who have been provided mental health services?"**

AHCN's BHS statistical information indicates that the average number of visits is less than ten. However, based on individual needs, some patients receive fewer and others many more visits. Like the rest of the AHCN Delivery System, BHS provides services to patients based on their need for care, looking at preventive, acute/episodic and chronic needs.

For wellness/preventive care, including for people with life situational problems (i.e., marital counseling, child/parent services) that don't reach the level of a formal psychiatric diagnosis, the services are generally informational and brief. Patients with mild and uncomplicated major disorders (acute/episodic) may require periodic services spanning several weeks to a number of months while those with complicated major or otherwise chronic disorders, may be continuously seen over time. Again, many of these patients receive psychiatric medication management services within BHS, which are covered the same as any other medical visit.

6. **"In which of the following circumstances where I might need mental health services would I find them excluded or subject to restrictions or limitations other than medical necessity?"**

Although BHS mental health services are comprehensive as noted in response #5, there are some forms of behavioral health practices that are excluded from coverage. These include all forms of extensive psychotherapy; day treatment; custodial care; treatment of sexual disorders; specialty programs for mental health therapy which are not provided by Group Health Options, Inc.; court ordered treatment which is not medically necessary; and conditions for which improvement or stabilization cannot be expected.

Behavioral Health Services places priority on restoring social and occupational functioning, such as evaluation, crisis intervention, managed psychotherapy, intermittent care, psychological testing, and consultation services.

Behavioral Health Services, as may other AHCN healthcare providers, also provides the following services:

- necessary diagnostic testing to determine if a mental disorder exists;
- mental health services, for conditions regardless of their origin or cause (congenital, physical, environmental, etc.) depending upon medical necessity determinations;
- treatment for conditions resulting from self-inflicted harm, such as suicidal gestures;
- the psychiatric aspects of eating disorders;
- couple or marital therapy, but
- does not diagnose learning disabilities.

7. **"What is this plan's most common goal in financing treatment in adults? In children?"**

BHS' most common goal in financing treatment in adults and children for mental health care is to return people to their baseline, reasonable level of functioning. In the process of pursuing this goal, our efforts include stabilization and symptom management, and specifically for people with chronic problems, ongoing maintenance of their remission.