



## Options Health Plan Summary of Benefits

**NASRO**

**Effective: July 1, 2003**

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.

	<b>Inside Options Network</b> When care is provided by or referred by the Options Managed Care Network.	<b>Outside Options Network</b> When care is not provided by or referred by the Options Managed Care Network.
<b>Hospital Admission Certification</b>	Not required.	Required. If authorization not obtained, the Member will be responsible for an additional 20% of total hospital charges, up to \$500.
<b>Annual Deductible</b>	No annual deductible.	\$200 per Member and \$400 per family per calendar year.
<b>Lifetime Maximum</b>	No lifetime maximum.	
<b>Plan Coinsurance</b>	No plan coinsurance.	80% of Usual, Customary and Reasonable (UCR) charges are covered.
<b>Out-of-Pocket Limit (Stop Loss)</b>	<p>Out-of-pocket expenses for covered services (as noted below) are limited to an aggregate maximum of 2,000 per Member and \$4,000 per family per calendar year.</p> <ul style="list-style-type: none"> <li>• Inpatient services (except as otherwise noted)</li> <li>• Outpatient services (except as otherwise noted)</li> <li>• Emergency care services</li> <li>• Ambulance services</li> </ul>	<p>Out-of-pocket expenses for covered services (as noted below) are limited to an aggregate maximum of \$2,000 per Member and \$4,000 per family per calendar year, after which the plan coinsurance no longer applies.</p> <ul style="list-style-type: none"> <li>• Plan coinsurance</li> </ul>
<b>Acupuncture</b>	Self-referrals to a MHCN provider covered up to a maximum of 5 visits per medical diagnosis per calendar year, subject to the outpatient services copayment.	Covered subject to the plan coinsurance after the annual deductible is satisfied.

<p><b>Ambulance Services</b></p>	<p>Emergency (ground/air) ambulance transportation to an Options Network facility is covered at 80%. Options Network-initiated non-emergency transfers are covered in full.</p>	<p>Emergency (ground/air) ambulance transportation to a non-Options Network facility is covered at 80%. Transfers from one medical facility to the nearest facility equipped to render further treatment, when medically necessary and prescribed by the attending provider, is covered at 80%. Services are not subject to annual deductible. Coinsurance does not apply to out-of-pocket limit.</p>
<p><b>Chemical Dependency Treatment</b> Inpatient and outpatient alcoholism and/or drug abuse services, including counseling and treatment.</p>	<p>Covered up to \$11,285 any 24 consecutive months. All services are subject to applicable copayments.</p>	<p>Covered up to \$11,285 any 24 consecutive months. All services are subject to the annual deductible and plan coinsurance.</p>
<p><b>Devices, Equipment and Supplies</b> Including durable medical equipment, prosthetics, orthopedic appliances, oxygen, ostomy supplies, breast prostheses, glucose monitors and external insulin pumps</p>	<p>Covered at 80% of charges if medically necessary and listed as covered in the Options Network Durable Medical Equipment Formulary, Orthopedic Appliance Formulary or Prosthetic Device Formulary. Coinsurance does not apply to out-of-pocket limit.</p>	<p>Covered at 80% of usual, customary, and reasonable charges if medically necessary and authorized in advance by the Member's provider, subject to the annual deductible. Coinsurance does not apply to out-of-pocket limit.</p>
<p><b>Diagnostic Lab and X-ray</b></p>	<p>Covered in full.</p>	<p>Covered subject to the annual deductible and plan coinsurance.</p>
<p><b>Emergency Services</b></p>	<p>When provided at an Options Network hospital emergency department, care is covered subject to a \$75 Copayment per Emergency visit per Member. Copayment is waived if Member is admitted directly from the Emergency department.</p>	<p>When provided at a non-Options Network hospital, outpatient emergency care (world-wide) is covered subject to the lesser of the emergency room charge or a \$125 deductible. Deductible is not waived if Member is admitted directly from the Emergency department. Services are not subject to the annual deductible.</p>
<p><b>Hearing Examinations/Aids</b></p>	<p>Hearing examinations covered subject to the outpatient services copayment. Hearing aids not covered.</p>	<p>Hearing examinations covered subject to the annual deductible and plan coinsurance. Hearing aids not covered.</p>
<p><b>Home Health/Hospice</b></p>	<p>Covered in full.</p>	<p>Covered subject to the annual deductible and plan coinsurance.</p>

<p><b>Hospital Care</b></p> <ul style="list-style-type: none"> <li>• Hospital room and board</li> <li>• Inpatient surgery and anesthesia</li> <li>• Intensive and coronary care unit</li> <li>• Delivery and associated hospital care, including home births for low risk pregnancies</li> <li>• Laboratory and radiology services while in hospital</li> <li>• Drugs while in hospital</li> <li>• Chemical dependency detoxification</li> </ul>	<p>Covered in full.</p>	<p>Covered subject to the annual deductible and plan coinsurance.</p>
<p><b>Manipulative Therapy</b></p>	<p>Self-referrals for manipulative therapy of the spine by Options Network providers are covered in accordance with Group Health Options (GHO) protocol up to 10 visits per Member per calendar year, subject to the outpatient services copayment.</p>	<p>Manipulative therapy of the spine are covered up to 10 visits per Member per calendar year, subject to the plan coinsurance and annual deductible.</p>
<p><b>Mental Health Care</b></p> <ul style="list-style-type: none"> <li>• Outpatient mental health services such as evaluation, crisis intervention, managed psychotherapy, intermittent care, psychological testing and consultation services.</li> </ul>	<p>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.</p>	<p>Covered at 50% of Usual, Customary, and Reasonable charges up to a maximum of twenty (20) visits per Member per calendar year for services provided by a licensed provider or psychologist, community mental health agency, or master's level therapist. Covered services are subject to the annual deductible. Coinsurance does not apply to the out-of-pocket limit.</p>
<ul style="list-style-type: none"> <li>• Inpatient mental health services</li> </ul>	<p>Covered at 80% up to 12 days per calendar year when referred in advance by an Options Network provider. Coinsurance does not apply to the out-of-pocket limit.</p>	<p>Covered up to 12 days per calendar year, subject to the annual deductible and plan coinsurance. Coinsurance does not apply to the out-of-pocket limit.</p>
<p><b>Naturopathy</b></p>	<p>Self-referrals to a MHCN provider covered up to a maximum of 2 visits per medical diagnosis per calendar year, subject to the outpatient services copayment.</p>	<p>Covered subject to the plan coinsurance after the annual deductible is satisfied.</p>
<p><b>Optical Care</b></p> <ul style="list-style-type: none"> <li>• Routine eye examinations and refractions</li> <li>• Eyeglass lenses and frames, or cosmetic contact lenses, including exams associated with their fitting, in lieu of standard eyeglass lenses and frames</li> </ul>	<p>One exam covered per Member in any consecutive 12 month period, subject to the outpatient services copayment.</p> <p>Not covered.</p>	<p>Not covered.</p> <p>Not covered.</p>

<p><b>Organ Transplants</b> (Only kidney, simultaneous pancreas and kidney, cornea, heart, single lung, double lung, heart-lung, bone marrow and liver)</p>	<p>Covered up to a lifetime benefit maximum of \$200,000 subject to applicable cost shares. Coverage for all transplants, including follow-up care, is excluded until the Member has been continuously enrolled under a GHO plan for 12 months.</p> <p>Note: \$200,000 limit is a combined in and out of network total benefit maximum.</p>	<p>Covered up to a lifetime benefit maximum of \$200,000 subject to applicable cost shares. Coverage for all transplants, including follow-up care, is excluded until the Member has been continuously enrolled under a GHO plan for 12 months.</p> <p>Note: \$200,000 limit is a combined in and out of network total benefit maximum.</p>
<p><b>Outpatient Prescription Drugs</b></p> <ul style="list-style-type: none"> <li>• Legend drugs (a drug which by law requires a provider's prescription), including injectables and dietary formula for the treatment of phenylketonuria (PKU), and diabetic supplies including insulin syringes, lancets, urine testing reagents and blood glucose monitoring reagents when listed as covered in the GHO drug formulary.</li> <li>• Allergy serum</li> <li>• Contraceptive drugs and devices and their fitting</li> </ul>	<p>Covered subject to a maximum of \$10 copayment for a supply of 30 days or less of each prescription or refill when provided at an Options Network pharmacy and prescribed by an Options Network provider (PKU formula is not subject to the copayment.) Some exclusions apply. Copayment does not apply to out-of-pocket limit.</p> <p>Covered subject to the outpatient prescription drug copayment for each 30 day supply. Copayment does not apply to out-of-pocket limit.</p> <p>Covered subject to the prescription drug copayment (including birth control pills and DepoProvera). Copayment does not apply to out-of-pocket limit.</p>	<p>Covered subject to the plan coinsurance or a \$15 copayment, whichever is greater, for a 30-day supply or less of each prescription or refill. Cost-share does not apply to the out-of-pocket limit.</p> <p>Covered subject to the prescription drug copayment for each 30 day supply. Copayment does not apply to out-of-pocket limit.</p> <p>Covered, including birth control pills and DepoPrevera, subject to the outpatient prescription drug copayment. Copayment does not apply to out-of-pocket limit.</p> <p>Services are not subject to the annual deductible.</p>
<p><b>Outpatient Services</b></p> <ul style="list-style-type: none"> <li>• Office visits</li> <li>• Allergy testing</li> <li>• Radiation therapy, chemotherapy</li> <li>• Prenatal and postpartum visits, including prenatal testing for the detection of congenital disorders</li> <li>• Outpatient surgery</li> </ul>	<p>\$10 Copayment per visit per Member.</p>	<p>Covered subject to the annual deductible and plan coinsurance.</p>
<p><b>Podiatric Care</b></p>	<p>Covered subject to the outpatient services copayment when referred by an Options Network provider. Routine foot care is excluded.</p>	<p>Covered subject to the annual deductible and plan coinsurance. Routine foot care is excluded.</p>

<p><b>Pre-Existing Conditions</b></p> <p>Care, medication, or medical advice received for medical conditions which existed within the three month period prior to the effective date of coverage.</p>	<p>Covered (except as specified) subject to applicable copayments after Member has been continuously enrolled under a GHO plan for three months, except as described below. Coverage for PKU formula 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, to the extent that the Member has satisfied the pre-existing condition wait under such prior coverage.</p>	<p>Covered (except as specified) subject to the annual deductible and coinsurance after Member has been continuously enrolled under a GHO plan for three months, except as described below. Coverage for PKU formula 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, to the extent that the Member has satisfied the pre-existing condition wait under such prior coverage.</p>
<p><b>Prenatal Care</b></p>	<p>See Outpatient Services.</p>	<p>See Outpatient Services.</p>
<p><b>Preventive Care</b></p> <ul style="list-style-type: none"> <li>• Well-child and well-adult care</li> <li>• Most immunizations and vaccinations</li> <li>• Routine health screening tests</li> <li>• Routine mammography services</li> </ul>	<p>Covered in full.</p>	<p>Not covered, except for routine mammography services subject to the annual deductible and plan coinsurance.</p>
<p><b>Rehabilitation Services</b></p> <ul style="list-style-type: none"> <li>• Inpatient physical, occupational and speech therapy services combined including services for neurodevelopmentally disabled children age six and under, and associated hospital services, up to 60 days per condition per calendar year</li> <li>• Outpatient physical, occupational and speech therapy services combined, including services for neurodevelopmentally disabled children age six and under, up to 60 visits per condition per calendar year</li> </ul>	<p>Covered subject to the applicable hospital inpatient care copayment.</p> <p>Covered subject to the outpatient services copayment.</p>	<p>Covered subject to the annual deductible and plan coinsurance.</p> <p>Covered subject to the annual deductible and plan coinsurance.</p>
<p><b>Skilled Nursing Facility</b></p> <p>Full time skilled nursing care in a GHO-approved nursing facility.</p>	<p>Covered up to sixty (60) days per Member per calendar year.</p>	<p>Covered up to sixty (60) days per Member per calendar year, subject to the annual deductible and plan coinsurance.</p>
<p><b>Sterilization Services</b> (vasectomy, tubal ligation)</p>	<p>Covered subject to the applicable copayment. Procedures to reverse a sterilization are not covered.</p>	<p>Covered subject to the annual deductible and plan coinsurance. Procedures to reverse a sterilization are not covered.</p>

<p><b>Temporomandibular Joint (TMJ) Services</b></p> <ul style="list-style-type: none"> <li>• Inpatient and outpatient TMJ services when Medically Necessary authorized by GHO</li> <li>• Lifetime Maximum Benefit</li> </ul>	<p>\$1,000 maximum per Member per calendar year, subject to the applicable cost shares.</p> <p>\$5,000 per Member.</p>	<p>\$1,000 maximum per Member per calendar year, subject to the applicable cost shares.</p> <p>\$5,000 per Member.</p>
<p><b>Tobacco Cessation</b></p> <ul style="list-style-type: none"> <li>• Individual/group session</li> <li>• Approved pharmacy products</li> </ul>	<p>Covered in full.</p> <p>Groups purchasing outpatient prescription drug coverage, will be covered subject to the lesser of the Options Network's charge or the outpatient prescription drug copayment for a 30-day supply or less of each prescription or refill, when prescribed by an Options Network provider and obtained at an Options Network pharmacy. Groups not purchasing outpatient prescription drug coverage may be subject to a charge.</p>	<p>Not covered.</p> <p>Not covered.</p>
<p><b>Well-Adult Care</b></p>	<p>See Preventive Care.</p>	<p>See Preventive Care.</p>
<p><b>Well-Child Care</b></p>	<p>See Preventive Care.</p>	<p>See Preventive Care.</p>

<b>Limitations</b>	<p>Coverage for growth hormone treatment is excluded until the Member has been continuously enrolled under a GHO plan for 12 months. Coverage for cosmetic services is limited to breast reconstruction following mastectomy performed inside the Options Network, and reconstructive breast reduction on non-diseased breast. External breast prostheses following mastectomy, limited to one per diseased breast every two years.</p>	<p>Coverage for growth hormone treatment is excluded until the Member has been continuously enrolled under a GHO plan for 12 months. Coverage for cosmetic services is limited to breast reconstruction following mastectomy, and reconstructive breast reduction on non-diseased breast, subject to the plan coinsurance. External breast prostheses following mastectomy, limited to one per diseased breast every two years. All covered services listed are subject to the annual deductible.</p>
<b>Exclusions</b>	<p>Services or programs not provided or authorized by Options Network staff (except as specified); drugs not listed as covered in the Options Network Drug Formulary; drugs not requiring a prescription; 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; eyeglasses; contact lenses, including services associated with their fitting, except following cataract surgery within the Options Network; hearing aids; work-related conditions (including injuries or illnesses incurred as a result of self-employment).</p>	<p>Most preventive care services; 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; services of unlicensed practitioners; 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; routine eye exams and refractions; eyeglasses; contact lenses, including services associated with their fitting; hearing aids; work-related conditions (including injuries or illnesses incurred as a result of self-employment).</p>