

Benefit Summary

City of Seattle - Early Retirees Deductible Plan

Group Number: 0961100 / 4961100



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| Effective Date 1/1/2012 | Health Plan Group Health | Ref RQ-47554 |
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This is a brief summary of benefits. THIS IS NOT A CONTRACT OR CERTIFICATE OF COVERAGE. All benefit descriptions, including alternative care, are for medically necessary services. The Member will be charged the lesser of the cost share for the covered service or the actual charge for that service. For full coverage provisions, including limitations, please refer to your certificate of coverage.

In accordance with the Patient Protection and Affordable Care Act of 2010,

- The lifetime maximum on the dollar value of covered essential health benefits no longer applies. Members whose coverage ended by reason of reaching a lifetime limit under this plan are eligible to enroll in this plan, and
- Dependent children who are under the age of twenty-six (26) are eligible to enroll in this plan.

Group Health believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act of 2010. Questions regarding this status may be directed to Customer Service (888) 901-4636. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or <http://www.dol.gov/ebsa/healthreform>.

| Benefits | Inside Network |
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| Plan deductible | Individual deductible: \$200 per calendar year Family deductible: \$600 per calendar year |
| Individual deductible carryover | 4th quarter carryover applies |
| Plan coinsurance | No plan coinsurance |
| Out-of-pocket limit | Individual out-of-pocket limit: \$2,000 Family out-of-pocket limit: \$6,000 Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit: Outpatient services, emergency services at a GHC or non-GHC facility, ambulance services. |
| Pre-existing condition (PEC) waiting period | No PEC |
| Lifetime maximum | Unlimited |
| Outpatient services (Office visits) | \$15 copay, deductible applies |
| Hospital services | Inpatient services: Deductible applies Outpatient surgery: \$15 copay, deductible applies |
| Prescription drugs (some injectable drugs may be covered under Outpatient services) | Formulary generic/formulary brand \$15/\$30 copay per 30 day supply |
| Prescription mail order | 2 x prescription cost share per 90 day supply |
| Acupuncture | Covered up to 8 visits per medical diagnosis per calendar year without prior authorization; additional visits when approved by the plan \$15 copay, deductible applies |
| Ambulance services | Plan pays 80%, you pay 20% |
| Chemical dependency | Inpatient: Deductible applies Outpatient: \$15 copay, deductible applies |

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| Sterilization (vasectomy, tubal ligation) | Inpatient: Deductible applies Outpatient: \$15 copay, deductible applies |
| Temporomandibular Joint (TMJ) services | \$5,000 lifetime max Inpatient: Deductible applies Outpatient: \$15 copay, deductible applies |
| Tobacco cessation counseling | Covered in full |
| Routine vision care (1 visit every 12 months) | \$15 copay, deductible waived |
| Optical hardware Lenses, including contact lenses and frames | Not covered |

Coverage provided by Group Health Cooperative

RQ-47554