

Benefit Summary

Seattle Police Officers' Guild - Deductible Plan

Group Number: 0476400



Effective Date 1/1/2012	Health Plan Group Health	Ref RQ-51650
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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
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)	\$20 copay, deductible applies
Hospital services	Inpatient services: Deductible applies Outpatient surgery: \$20 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 \$20 copay, deductible applies
Ambulance services	Plan pays 80%, you pay 20%
Chemical dependency	Inpatient: Deductible applies Outpatient: \$20 copay, deductible applies

Sterilization (vasectomy, tubal ligation)	Inpatient: Deductible applies Outpatient: \$20 copay, deductible applies
Temporomandibular Joint (TMJ) services	\$1,000 per calendar year; \$5,000 lifetime max Inpatient: Deductible applies Outpatient: \$20 copay, deductible applies
Tobacco cessation counseling	Covered in full
Routine vision care (1 visit every 12 months)	\$20 copay, deductible waived
Optical hardware Lenses, including contact lenses and frames	Not covered

Coverage provided by Group Health Cooperative

RQ-51650