

# Benefit Summary

## City of Seattle - Medicare Retirees

### Group Number: 0335500 / 4335500



<b>Effective Date</b> 1/1/2011	<b>Health Plan</b> Group Health	<b>Ref</b> RQ-39086
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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>.

<b>Benefits</b>	<b>Inside Network</b>
<b>Plan deductible</b>	No annual deductible
<b>Individual deductible carryover</b>	Not applicable
<b>Plan coinsurance</b>	No plan coinsurance
<b>Out-of-pocket limit</b>	Individual out-of-pocket limit: \$1,000 Family out-of-pocket limit: \$2,000  Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit:  Inpatient services, outpatient services, emergency services at a GHC or non-GHC facility, ambulance services.
<b>Pre-existing condition (PEC) waiting period</b>	No PEC
<b>Lifetime maximum</b>	Unlimited
<b>Outpatient services (Office visits)</b>	\$15 copay
<b>Hospital services</b>	<b>Inpatient services:</b> \$100 copay, per day for up to 3 days per admit  <b>Outpatient surgery:</b> \$15 copay
<b>Prescription drugs (some injectable drugs may be covered under Outpatient services)</b>	Formulary generic/formulary brand \$15/\$30 copay per 30 day supply
<b>Prescription mail order</b>	3 x prescription cost share per 90 day supply
<b>Acupuncture</b>	Self-referred up to 8 visits per medical diagnosis per calendar year; additional visits when approved by the plan \$15 copay
<b>Ambulance services</b>	Plan pays 80%, you pay 20%
<b>Chemical dependency</b>	<b>Inpatient:</b> \$100 copay, per day for up to 3 days per admit  <b>Outpatient:</b> \$15 copay



<b>Sterilization</b> (vasectomy, tubal ligation)	<b>Inpatient:</b> \$100 copay, per day for up to 3 days per admit <b>Outpatient:</b> \$15 copay
<b>Temporomandibular Joint (TMJ) services</b>	\$1,000 per calendar year; \$5,000 lifetime max <b>Inpatient:</b> \$100 copay, per day for up to 3 days per admit <b>Outpatient:</b> \$15 copay
<b>Tobacco cessation</b> See pharmacy benefit for associated drug coverage	Covered in full
<b>Routine vision care</b> (1 visit every 24 months)	\$15 copay
<b>Optical hardware</b> Lenses, including contact lenses and frames	Choice of one of the following: One pair of standard single vision, lenticular, or non-blended bifocal, trifocal lenses, covered up to the following allowance: Single vision lenses - maximum \$75 allowance once every 24 months. Bifocal lenses - maximum \$118 allowance once every 24 months. Trifocal or lenticular - maximum \$118 allowance once every 24 months. One pair of cosmetic contact lenses covered with a \$135 maximum allowance once every 24 months. Frames covered up to \$100 once every 24 months.