Benefit Summary

City of Redmond
Group Number: 0446300

GroupHealth.

Effective Date 1/1/2014	**Health Plan** Group Health	**Ref** RQ-73385

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	No annual deductible
Individual deductible carryover	Not applicable
Plan coinsurance	No plan coinsurance
Out-of-pocket limit	Individual out-of-pocket limit: $2,000 Family out-of-pocket limit: $4,000 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 Managed Health Care Network (MHCN) facility and ambulance services.
Pre-existing condition (PEC) **waiting period**	No PEC
Lifetime maximum	Unlimited
Outpatient services (Office visits)	$10 copay
Hospital services	**Inpatient services:** Covered in full **Outpatient surgery:** $10 copay
Prescription drugs (some injectable drugs may be covered under Outpatient services)	Formulary generic and/or brand $10 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 $10 copay
Ambulance services	Plan pays 80%, you pay 20%
Chemical dependency	**Inpatient:** Covered in full **Outpatient:** $10 copay

Devices, equipment and supplies • Durable medical equipment • Orthopedic appliances • Post-mastectomy bras limited to two (2) every six (6) months • Ostomy supplies • Prosthetic devices	Covered in full Covered in full
Diabetic supplies	Insulin, needles, syringes and lancets-see Prescription drugs. External insulin pumps, blood glucose monitors, testing reagents and supplies-see Devices, equipment and supplies. When Devices, equipment and supplies or Prescription drugs are covered and have benefit limits, diabetic supplies are not subject to these limits.
Diagnostic lab and X-ray services	**Inpatient:** Covered under Hospital services **Outpatient:** Covered in full High end radiology imaging services such as CT, MR and PET must be determined Medically Necessary and require prior authorization except when associated with Emergency care or inpatient services.
Emergency services (copay waived if admitted)	$75 copay at a designated facility $125 copay at a non designated facility
Hearing exams (routine)	$10 copay
Hearing hardware	Not covered
Home health services	Covered in full. No visit limit.
Hospice services	Covered in full
Infertility services	Not covered
Manipulative therapy	Covered up to 10 visits per calendar year without prior authorization $10 copay
Massage services	See Rehabilitation services
Maternity services	**Inpatient:** Covered in full **Outpatient:** $10 copay. Routine care not subject to outpatient services copay.
Mental Health	**Inpatient:** Covered in full **Outpatient:** $10 copay
Naturopathy	Covered up to 3 visits per medical diagnosis per calendar year without prior authorization; additional visits when approved by plan $10 copay
Newborn Services	Any applicable coinsurance applies to the newborn while both mother and baby are confined. Otherwise, all applicable inpatient cost shares apply. Office visits: See Outpatient Services; Routine well care: See Preventive care.
Obesity-related surgery (bariatric)	Covered at cost shares when medical criteria is met
Organ transplants Donor search & harvest applies to lifetime max	Unlimited, no waiting period **Inpatient:** Covered in full **Outpatient:** $10 copay
Preventive care Well-care physicals, immunizations, Pap smear exams, mammograms	$10 copay
Rehabilitation services (Occupational, speech, physical including services for neurodevelopmentally disabled children under the age of 7) Rehabilitation visits are a total of combined therapy visits per calendar year	**Inpatient:** 60 days per calendar year Covered in full **Outpatient:**60 visits per calendar year $10 copay
Skilled nursing facility	Covered in full up to 60 days per calendar year

Sterilization (vasectomy, tubal ligation)	**Inpatient:** Covered in full **Outpatient:** $10 copay
Temporomandibular Joint (TMJ) **services**	**Inpatient:** Covered in full **Outpatient:** $10 copay
Tobacco cessation counseling	Quit for Life Program - covered in full
Routine vision care (1 visit every 12 months)	$10 copay
Optical hardware Lenses, including contact lenses and frames	Not covered

Coverage provided by Group Health Cooperative