

Benefit Summary

Kitsap County Deputy Sheriffs

Group Number: 1243200



Effective Date 1/1/2012 **Health Plan** Group Health

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: \$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.
Pre-existing condition (PEC) waiting period	No PEC
Lifetime maximum	Unlimited
Outpatient services (Office visits)	\$15 copay
Hospital services	Inpatient services: \$100 copay, per admit Outpatient surgery: \$15 copay
Prescription drugs (some injectable drugs may be covered under Outpatient services)	Formulary generic/formulary brand \$10/\$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
Ambulance services	Plan pays 80%, you pay 20%
Chemical dependency	Inpatient: \$100 copay, per admit Outpatient: \$15 copay

Skilled nursing facility	Covered in full up to 60 days per calendar year
Sterilization (vasectomy, tubal ligation)	Inpatient: \$100 copay, per admit Outpatient: \$15 copay
Temporomandibular Joint (TMJ) services	\$1,000 per calendar year; \$5,000 lifetime max Inpatient: \$100 copay, per admit Outpatient: \$15 copay
Tobacco cessation counseling	Quit for Life Program - covered in full
Routine vision care (1 visit every 12 months)	\$15 copay
Optical hardware Lenses, including contact lenses and frames	\$250 per 24 months

Coverage provided by Group Health Cooperative