

# Benefit Summary

## Kitsap County Main County Value Plan

### Group Number: 1275900



**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.

Benefits	Inside Network
<b>Plan deductible</b>	Individual deductible: \$350 per calendar year Family deductible: \$1,050 per calendar year
<b>Individual deductible carryover</b>	4th quarter carryover applies
<b>Plan coinsurance</b>	No plan coinsurance
<b>Out-of-pocket limit</b>	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.
<b>Pre-existing condition (PEC) waiting period</b>	No PEC
<b>Lifetime maximum</b>	Unlimited
<b>Outpatient services (Office visits)</b>	\$30 copay, deductible applies
<b>Hospital services</b>	<b>Inpatient services:</b> \$350 copay, per day for up to 3 days per admit Deductible applies <b>Outpatient surgery:</b> \$100 copay, deductible applies
<b>Prescription drugs (some injectable drugs may be covered under Outpatient services)</b>	Formulary generic/formulary brand \$20/\$40 copay per 30 day supply
<b>Prescription mail order</b>	2 x prescription cost share per 90 day supply
<b>Acupuncture</b>	Covered up to 8 visits per medical diagnosis per calendar year without prior authorization; additional visits when approved by the plan \$30 copay, deductible applies
<b>Ambulance services</b>	Plan pays 80%, you pay 20%
<b>Chemical dependency</b>	<b>Inpatient:</b> \$350 copay, per day for up to 3 days per admit Deductible applies <b>Outpatient:</b> \$30 copay, deductible applies



<b>Rehabilitation services</b> (Occupational, speech, physical including services for neurodevelopmentally disabled children age six and under) Rehabilitation visits are a total of combined therapy visits per calendar year	<b>Inpatient:</b> 60 days per calendar year \$350 copay, per day for up to 3 days per admit Deductible applies <b>Outpatient:</b> 60 visits per calendar year \$30 copay, deductible applies
<b>Skilled nursing facility</b>	Up to 60 days per calendar year, deductible applies
<b>Sterilization</b> (vasectomy, tubal ligation)	<b>Inpatient:</b> \$350 copay, per day for up to 3 days per admit Deductible applies <b>Outpatient:</b> \$30 copay, deductible applies
<b>Temporomandibular Joint (TMJ) services</b>	\$1,000 per calendar year; \$5,000 lifetime max <b>Inpatient:</b> \$350 copay, per day for up to 3 days per admit Deductible applies <b>Outpatient:</b> \$30 copay, deductible applies
<b>Tobacco cessation counseling</b>	Quit for Life Program - covered in full
<b>Routine vision care</b> (1 visit every 12 months)	\$30 copay, deductible waived
<b>Optical hardware</b> Lenses, including contact lenses and frames	\$150 per 24 months Not subject to deductible

Coverage provided by Group Health Cooperative