

Benefit Summary  
 Snoqualmie Valley School District - Deductible Plan  
 Group Number: 1146900



<b>Effective Date</b> 10/1/2010	<b>Health Plan</b> Group Health	<b>Ref</b> RQ-33601
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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.

<b>Benefits</b>	<b>Inside Network</b>
<b>Plan deductible</b>	Individual deductible: \$500 per calendar year Family deductible: \$1,500 per calendar year
<b>Individual deductible carryover</b>	4th quarter carryover applies
<b>Plan coinsurance</b>	Plan pays 80%, you pay 20%
<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:  Plan coinsurance, 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>	\$20 copay, deductible and coinsurance apply
<b>Hospital services</b>	<b>Inpatient services:</b> Deductible and coinsurance apply <b>Outpatient surgery:</b> \$20 copay, deductible and coinsurance apply
<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>	2 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 \$20 copay, deductible and coinsurance apply
<b>Ambulance services</b>	Plan pays 80%, you pay 20%
<b>Chemical dependency</b>	<b>Inpatient:</b> Deductible and coinsurance apply <b>Outpatient:</b> \$20 copay, deductible and coinsurance apply
<b>Devices, equipment and supplies</b>	
<ul style="list-style-type: none"> <li>• Durable medical equipment</li> <li>• Orthopedic appliances</li> <li>• Post-mastectomy bras limited to two (2) every six (6) months</li> </ul>	Covered at 80%
<ul style="list-style-type: none"> <li>• Ostomy supplies</li> <li>• Prosthetic devices</li> </ul>	Covered at 80%
<b>Diabetic supplies</b>	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.
<b>Diagnostic lab and X-ray services</b>	<b>Inpatient:</b> Covered under Hospital services <b>Outpatient:</b> Deductible and coinsurance apply  High end radiology imaging services such as CT, MR and PET must be determined Medically Necessary and require preauthorization except when associated with Emergency care or inpatient services.

<b>Emergency services</b> (copay waived if admitted)	\$75 copay at a designated facility \$75 copay at a non designated facility Deductible and coinsurance apply
<b>Hearing exams (routine)</b>	\$20 copay, deductible and coinsurance apply
<b>Hearing hardware</b>	Not covered
<b>Home health services</b>	Covered in full. No visit limit.
<b>Hospice services</b>	Covered in full
<b>Infertility services</b>	Not covered
<b>Manipulative therapy</b>	Self-referred up to 10 visits per calendar year \$20 copay, deductible and coinsurance apply
<b>Massage services</b>	See Rehabilitation services
<b>Maternity services</b>	<b>Inpatient:</b> Deductible and coinsurance apply <b>Outpatient:</b> \$20 copay, deductible and coinsurance apply
<b>Mental Health</b>	<b>Inpatient:</b> Deductible and coinsurance apply <b>Outpatient:</b> \$20 copay, deductible and coinsurance apply
<b>Naturopathy</b>	Self-referred up to 3 visits per medical diagnosis per calendar year; additional visits when approved by plan \$20 copay, deductible and coinsurance apply
<b>Obesity-related surgery (bariatric)</b>	Not covered
<b>Organ transplants</b> Donor search & harvest applies to lifetime max	\$350,000 lifetime max; includes donor search & harvest of \$50,000; 6 month wait, time credit available <b>Inpatient:</b> Deductible and coinsurance apply <b>Outpatient:</b> \$20 copay, deductible and coinsurance apply
<b>Preventive care</b> Well-care physicals, immunizations, Pap smear exams, mammograms	Covered in full
<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 Deductible and coinsurance apply <b>Outpatient:</b> 60 visits per calendar year \$20 copay, deductible and coinsurance apply
<b>Skilled nursing facility</b>	Up to 60 days per calendar year, deductible and coinsurance apply
<b>Sterilization</b> (vasectomy, tubal ligation)	<b>Inpatient:</b> Deductible and coinsurance apply <b>Outpatient:</b> \$20 copay, deductible and coinsurance apply
<b>Temporomandibular Joint (TMJ) services</b>	\$1,000 per calendar year; \$5,000 lifetime max <b>Inpatient:</b> Deductible and coinsurance apply <b>Outpatient:</b> \$20 copay, deductible and coinsurance apply
<b>Tobacco cessation</b> See pharmacy benefit for associated drug coverage	Free & Clear Program - covered in full
<b>Routine vision care</b> (1 visit every 12 months)	\$20 copay, deductible and coinsurance waived
<b>Optical hardware</b> Lenses, including contact lenses and frames	Not covered