

# Benefit Summary

## Toppenish School District - Options PPO

### Plan

Group Number: 8061600



<b>Effective Date</b> 1/1/2011	<b>Health Plan</b> Options PPO	<b>Ref</b> RQ-39400
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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.

Benefits	Preferred Provider Network (PPN)	Non-Preferred Provider Network
<b>Plan deductible</b>	Individual deductible: \$200 per calendar year Family deductible: \$600 per calendar year	Individual deductible: \$400 per calendar year Family deductible: \$1,200 per calendar year
<b>Individual deductible carryover</b>	4th quarter carryover applies	4th quarter carryover applies
<b>Plan coinsurance</b>	Plan pays 90%, you pay 10%	Plan pays 70%, you pay 30% of the Usual, Customary and Reasonable (UCR) charges.
<b>Out-of-pocket limit</b>	Individual out-of-pocket limit: \$1,500 Family out-of-pocket limit: \$4,500  Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit:  Plan coinsurance, emergency services at a Preferred Provider Network (PPN) facility and ambulance services.	Individual out-of-pocket limit: No limit Family out-of-pocket limit: No limit
<b>Pre-existing condition (PEC) waiting period</b>	No PEC	Same as preferred provider network
<b>Lifetime maximum</b>	Unlimited	Shared with preferred provider maximum
<b>Outpatient services (Office visits)</b>	No copay, deductible and coinsurance apply	No copay, deductible and coinsurance apply
<b>Hospital services</b>	<b>Inpatient services:</b> Deductible and coinsurance apply <b>Outpatient surgery:</b> \$75 copay, deductible and coinsurance apply	<b>Inpatient services:</b> Deductible and coinsurance apply <b>Outpatient surgery:</b> \$75 copay, deductible and coinsurance apply
<b>Prescription drugs (some injectable drugs may be covered under Outpatient services)</b>	Formulary generic/formulary brand/non-formulary \$10/\$25/\$50 copay	Formulary generic/formulary brand/non-formulary \$15/\$30/\$55 copay
<b>Prescription mail order</b>	2 x prescription cost share per 90 day supply	Not covered
<b>Acupuncture</b>	12 visits per calendar year No copay, deductible and coinsurance apply	Shared with preferred provider visit limit No copay, deductible and coinsurance apply
<b>Ambulance services</b>	Deductible and coinsurance	Same as preferred provider benefit
<b>Chemical dependency</b>	<b>Inpatient:</b> Deductible and coinsurance apply <b>Outpatient:</b> No copay, deductible and coinsurance apply	<b>Inpatient:</b> Deductible and coinsurance apply <b>Outpatient:</b> No 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> <li>• Ostomy supplies</li> <li>• Prosthetic devices</li> </ul>	<p>Covered in full</p> <p>Covered in full</p>	<p>Covered in full, deductible applies</p> <p>Covered in full, deductible applies</p>
<b>Diabetic supplies</b>	<p>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.</p>	<p>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.</p>
<b>Diagnostic lab and X-ray services</b>	<p><b>Inpatient:</b> Covered under Hospital services <b>Outpatient:</b> Deductible and coinsurance apply</p>	<p><b>Inpatient:</b> Covered under Hospital services <b>Outpatient:</b> Deductible and coinsurance apply</p>
<b>Emergency services</b> (copay waived if admitted)	<p>\$100 copay Deductible and coinsurance apply</p>	<p>\$100 copay Deductible and coinsurance apply</p>
<b>Hearing exams (routine)</b>	<p>No copay, deductible and coinsurance apply</p>	<p>No copay, deductible and coinsurance apply</p>
<b>Hearing hardware</b>	<p>Not covered</p>	<p>Not covered</p>
<b>Home health services</b>	<p>Covered in full up to 130 visits total per calendar year</p>	<p>Shared with preferred provider visit limit Deductible and coinsurance apply</p>
<b>Hospice services</b>	<p>Covered in full</p>	<p>Deductible and coinsurance apply</p>
<b>Infertility services</b>	<p>Not covered</p>	<p>Not covered</p>
<b>Manipulative therapy</b>	<p>24 visits per calendar year No copay, deductible and coinsurance apply</p>	<p>Shared with preferred provider visit limit No copay, deductible and coinsurance apply</p>
<b>Massage services</b>	<p>12 visits per calendar year No copay, deductible and coinsurance apply</p>	<p>Shared with preferred provider visit limit No copay, deductible and coinsurance apply</p>
<b>Maternity services</b>	<p><b>Inpatient:</b> Deductible and coinsurance apply <b>Outpatient:</b> No copay, deductible and coinsurance apply</p>	<p><b>Inpatient:</b> Deductible and coinsurance apply <b>Outpatient:</b> No copay, deductible and coinsurance apply</p>
<b>Mental Health</b>	<p><b>Inpatient:</b> Deductible and coinsurance apply <b>Outpatient:</b> No copay, deductible and coinsurance apply</p>	<p><b>Inpatient:</b> Deductible and coinsurance apply <b>Outpatient:</b> No copay, deductible and coinsurance apply</p>
<b>Naturopathy</b>	<p>12 visits per calendar year No copay, deductible and coinsurance apply</p>	<p>Shared with preferred provider visit limit No copay, deductible and coinsurance apply</p>
<b>Obesity-related surgery (bariatric)</b>	<p>Not covered</p>	<p>Not covered</p>
<b>Organ transplants</b> Donor search & harvest applies to lifetime max	<p>Unlimited, no waiting period</p> <p><b>Inpatient:</b> Deductible and coinsurance apply <b>Outpatient:</b> No copay, deductible and coinsurance apply</p>	<p>Not covered</p>
<b>Preventive care</b> Well-care physicals, immunizations, Pap smear exams, mammograms	<p>Covered in full</p>	<p>No copay (deductible and coinsurance waived)</p> <p>Routine mammograms: Deductible and coinsurance apply</p>
<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	<p><b>Inpatient:</b> 60 days per calendar year Deductible and coinsurance apply <b>Outpatient:</b> 60 visits per calendar year No copay, deductible and coinsurance apply</p>	<p><b>Inpatient:</b> Day limits shared with preferred provider benefit limit Deductible and coinsurance apply <b>Outpatient:</b> Visit limits shared with preferred provider benefit limit No copay, deductible and coinsurance apply</p>
<b>Skilled nursing facility</b>	<p>Up to 60 days per calendar year, deductible and coinsurance apply</p>	<p>Day limits shared with preferred provider benefit, deductible and coinsurance apply</p>
<b>Sterilization</b> (vasectomy, tubal ligation)	<p><b>Inpatient:</b> Deductible and coinsurance apply <b>Outpatient:</b> No copay, deductible and coinsurance apply</p>	<p><b>Inpatient:</b> Deductible and coinsurance apply <b>Outpatient:</b> No copay, deductible and coinsurance apply</p>

<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> No copay, deductible and coinsurance apply	Shared with preferred provider benefit <b>Inpatient:</b> Deductible and coinsurance apply <b>Outpatient:</b> No copay, deductible and coinsurance apply
<b>Tobacco cessation</b> See pharmacy benefit for associated drug coverage	Free & Clear Program - covered in full	Not Covered
<b>Routine vision care</b> (1 visit every 12 months)	No copay, deductible waived Coinsurance applies	No copay, deductible and coinsurance apply
<b>Optical hardware</b> Lenses, including contact lenses and frames	\$200 per 12 months Not subject to deductible and coinsurance	Shared with preferred provider benefit

Coverage provided by Group Health Options, Inc.

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