

Benefit Summary

Toppenish School District - CRISP 500 Plan

Group Number: 8062800



Effective Date 1/1/2011 **Health Plan** Options **Ref** RQ-39401

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	Outside Network
Plan deductible	Individual deductible: \$500 per calendar year Family deductible: \$1,500 per calendar year	Shared with in-network
Individual deductible carryover	4th quarter carryover does not apply	4th quarter carryover does not apply
Plan coinsurance	Plan pays 80%, you pay 20%	Plan pays 60%, you pay 40% of the Usual, Customary and Reasonable (UCR) charges.
Deductible and/or coinsurance waiver riders	1st 4 visits per calendar year are not subject to deductible and/or coinsurance. Lab and xray services covered in full up to \$500 combined per calendar year.	Same as in-network
Out-of-pocket limit	Individual out-of-pocket limit: \$3,000 Family out-of-pocket limit: \$9,000 Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit: Plan coinsurance, emergency services at a Managed Health Care Network (MHCN) facility and ambulance services.	Out-of-pocket limit is shared with in-network Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit: Plan coinsurance, emergency services at a non-Managed Health Care Network (MHCN) facility and ambulance services.
Pre-existing condition (PEC) waiting period	No PEC	Same as in-network
Lifetime maximum	Unlimited	Shared with in-network maximum
Outpatient services (Office visits)	\$30 copay, deductible and coinsurance apply	\$30 copay, deductible and coinsurance apply
Hospital services	Inpatient services: Deductible and coinsurance apply Outpatient surgery: \$30 copay, deductible and coinsurance apply	Inpatient services: Deductible and coinsurance apply Outpatient surgery: \$30 copay, deductible and coinsurance apply
Prescription drugs (some injectable drugs may be covered under Outpatient services)	Formulary generic/formulary brand \$20/\$40 copay per 30 day supply	Formulary generic/formulary brand \$25/\$45 copay per 30 day supply
Prescription mail order	2 x prescription cost share per 90 day supply	Not covered
Acupuncture	Self-referred up to 8 visits per medical diagnosis per calendar year; additional visits when approved by the plan \$30 copay, deductible and coinsurance apply	\$30 copay, deductible and coinsurance apply
Ambulance services	Plan pays 80%, you pay 20%	Same as in-network
Chemical dependency	Inpatient: Deductible and coinsurance apply Outpatient: \$30 copay, deductible and coinsurance apply	Inpatient: Deductible and coinsurance apply Outpatient: \$30 copay, deductible and coinsurance apply

Rehabilitation services (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	Inpatient: 60 days per calendar year Deductible and coinsurance apply Outpatient: 60 visits per calendar year \$30 copay, deductible and coinsurance apply	Inpatient: Day limits shared with in-network Deductible and coinsurance apply Outpatient: Visit limits shared with in-network \$30 copay, deductible and coinsurance apply
Skilled nursing facility	Up to 60 days per calendar year, deductible and coinsurance apply	Day limits shared with in-network benefit, deductible and coinsurance apply
Sterilization (vasectomy, tubal ligation)	Inpatient: Deductible and coinsurance apply Outpatient: \$30 copay, deductible and coinsurance apply	Inpatient: Deductible and coinsurance apply Outpatient: \$30 copay, deductible and coinsurance apply
Temporomandibular Joint (TMJ) services	\$1,000 per calendar year; \$5,000 lifetime max Inpatient: Deductible and coinsurance apply Outpatient: \$30 copay, deductible and coinsurance apply	Shared with in-network Inpatient: Deductible and coinsurance apply Outpatient: \$30 copay, deductible and coinsurance apply
Tobacco cessation See pharmacy benefit for associated drug coverage	Free & Clear Program - covered in full	Not Covered
Routine vision care (1 visit every 12 months)	\$30 copay, deductible and coinsurance waived	\$30 copay, deductible and coinsurance waived
Optical hardware Lenses, including contact lenses and frames	\$200 per 12 months Not subject to deductible and coinsurance	Shared with in-network