Benefit Summary

Washington State Bar Association - Low Plan
Group Number: 6180200 / 6947600

GroupHealth.

Effective Date 6/1/2013	**Health Plan** Options	**Ref** RQ-68104

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: $750 per calendar year Family deductible: $2,250 per calendar year	Shared with in-network
Individual deductible carryover	4th quarter carryover applies	4th quarter carryover applies
Plan coinsurance	Plan pays 80%, you pay 20%	Plan pays 60%, you pay 40% of the Usual, Customary and Reasonable (UCR) charges.
Out-of-pocket limit	Individual out-of-pocket limit: $4,000 Family out-of-pocket limit: $12,000 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	Same as in-network maximum
Outpatient services (Office visits)	$25 copay, deductible and coinsurance apply	$25 copay, deductible and coinsurance apply
Hospital services	**Inpatient services:** Deductible and coinsurance apply **Outpatient surgery:** $25 copay, deductible and coinsurance apply	**Inpatient services:** Deductible and coinsurance apply **Outpatient surgery:** $25 copay, deductible and coinsurance apply
Prescription drugs (some injectable drugs may be covered under Outpatient services)	Formulary generic/formulary brand/non-formulary $15/$30/$50 copay per 30 day supply	Formulary generic/formulary brand/non-formulary $20/$35/$55 copay per 30 day supply
Prescription mail order	2 x prescription cost share per 90 day supply	Not covered
Acupuncture	Covered up to 8 visits per medical diagnosis per calendar year without prior authorization; additional visits when approved by the plan $25 copay, deductible and coinsurance apply	$25 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:** $25 copay, deductible and coinsurance apply	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $25 copay, deductible and coinsurance apply

Devices, equipment and supplies • Durable medical equipment • Orthopedic appliances • Post-mastectomy bras limited to two (2) every six (6) months	Covered at 50%	Covered at 50%, deductible applies
• Ostomy supplies • Prosthetic devices	Covered at 50%	Covered at 50%, deductible applies
Diabetic supplies	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.	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.
Diagnostic lab and X-ray services	**Inpatient:** Covered under Hospital services **Outpatient:** Deductible and coinsurance apply High end radiology imaging services such as CT, MR and PET must be determined Medically Necessary and require prior authorization except when associated with Emergency care or inpatient services.	**Inpatient:** Covered under Hospital services **Outpatient:** Deductible and coinsurance apply High end radiology imaging services such as CT, MR and PET must be determined Medically Necessary and require prior authorization except when associated with Emergency care or inpatient services.
Emergency services (copay waived if admitted)	$75 copay Deductible and coinsurance apply	$75 copay In-network deductible and coinsurance apply
Hearing exams (routine)	$25 copay, deductible and coinsurance apply	$25 copay, deductible and coinsurance apply
Hearing hardware	Not covered	Not covered
Home health services	Covered in full. No visit limit.	No visit limit Deductible and coinsurance apply
Hospice services	Covered in full	Deductible and coinsurance apply
Infertility services	Not covered	Not covered
Manipulative therapy	Covered up to 10 visits per calendar year without prior authorization $25 copay, deductible and coinsurance apply	Visit limits shared with in-network $25 copay, deductible and coinsurance apply
Massage services	See Rehabilitation services	See Rehabilitation services
Maternity services	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $25 copay, deductible and coinsurance apply. Routine care not subject to outpatient services copay.	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $25 copay, deductible and coinsurance apply. Routine care not subject to outpatient services copay.
Mental Health	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $25 copay, deductible and coinsurance apply	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $25 copay, deductible and coinsurance apply
Naturopathy	Covered up to 3 visits per medical diagnosis per calendar year without prior authorization; additional visits when approved by plan $25 copay, deductible and coinsurance apply	$25 copay, deductible and coinsurance apply
Newborn Services	Initial hospital stay: See Hospital Services; Office visits: See Outpatient Services; Routine well care: See Preventive care. Any applicable cost share for newborn services is separate from that of the mother.	Initial hospital stay: See Hospital Services; Office visits: See Outpatient Services; Routine well care: See Preventive care. Any applicable cost share for newborn services is separate from that of the mother.
Obesity-related surgery (bariatric)	Not covered	Not covered
Organ transplants Donor search & harvest applies to lifetime max	Unlimited, no waiting period **Inpatient:** Deductible and coinsurance apply **Outpatient:** $25 copay, deductible and coinsurance apply	Shared with in-network **Inpatient:** Deductible and coinsurance apply **Outpatient:** $25 copay, deductible and coinsurance apply
Preventive care Well-care physicals, immunizations, Pap smear exams, mammograms	Covered in full Women's preventive care services (including contraceptive drugs and devices and sterilization) are covered in full.	Not covered Women's preventive care services (including contraceptive drugs and devices and sterilization) are subject to the applicable Preventive Care cost share and benefit maximums. Routine mammograms: Deductible and coinsurance apply

Rehabilitation services (Occupational, speech, physical including services for neurodevelopmentally disabled members) 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 $25 copay, deductible and coinsurance apply	**Inpatient:** Day limits shared with in-network Deductible and coinsurance apply **Outpatient:** Visit limits shared with in-network $25 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:** $25 copay, deductible and coinsurance apply Women's sterilization procedures are covered in full.	**Inpatient:** Deductible and coinsurance apply **Outpatient:** $25 copay, deductible and coinsurance apply Women's sterilization procedures are covered subject to the applicable Preventive Care cost share and benefit maximums.
Temporomandibular Joint (TMJ) **services**	$1,000 per calendar year; $5,000 lifetime max **Inpatient:** Deductible and coinsurance apply **Outpatient:** $25 copay, deductible and coinsurance apply	Shared with in-network **Inpatient:** Deductible and coinsurance apply **Outpatient:** $25 copay, deductible and coinsurance apply
Tobacco cessation counseling	Quit for Life Program - covered in full	Applicable cost shares apply
Routine vision care (1 visit every 12 months)	$25 copay, deductible and coinsurance waived	Not covered
Optical hardware Lenses, including contact lenses and frames	Not covered	Not covered