

# Benefit Summary

## City Of Seattle - Local 77 - IBEW

### Group Number: 0471500



<b>Effective Date</b> 1/1/2023	<b>Health Plan</b> Core HMO	<b>Ref</b> RQ-181188
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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	Inside Network
<b>Plan deductible</b>	No annual deductible
<b>Individual deductible carryover</b>	Not applicable
<b>Plan coinsurance</b>	No plan coinsurance
<b>Out-of-pocket limit</b>	Individual out-of-pocket limit: \$750 Family out-of-pocket limit: \$1,500  Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit:  All cost shares for covered services
<b>Pre-existing condition (PEC) waiting period</b>	No PEC
<b>Lifetime maximum</b>	Unlimited
<b>Outpatient services (Office visits)</b>	\$10 copay
<b>Hospital services</b>	<b>Inpatient services:</b> Covered in full <b>Outpatient surgery:</b> \$10 copay
<b>Prescription drugs (some injectable drugs may be covered under Outpatient services)</b>	Preferred generic/preferred brand \$10 copay per 30 day supply
<b>Prescription mail order</b>	3 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 \$10 copay
<b>Ambulance services</b>	Plan pays 80%, you pay 20%
<b>Chemical dependency</b>	<b>Inpatient:</b> Covered in full <b>Outpatient:</b> \$10 copay
<b>Devices, equipment and supplies</b>	Covered at 80% <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>
<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> Covered in full  High end radiology imaging services such as CT, MRI and PET must be determined Medically Necessary and require prior authorization 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
<b>Hearing exams</b> (routine)	\$10 copay
<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>	Covered up to 10 visits per calendar year without prior authorization \$10 copay
<b>Massage services</b>	See Rehabilitation services
<b>Maternity services</b>	<b>Inpatient:</b> Covered in full <b>Outpatient:</b> \$10 copay. Routine care not subject to outpatient services copay.
<b>Mental Health</b>	<b>Inpatient:</b> Covered in full <b>Outpatient:</b> \$10 copay
<b>Naturopathy</b>	Covered up to 3 visits per medical diagnosis per calendar year without prior authorization; additional visits when approved by the plan \$10 copay
<b>Newborn Services</b>	Any applicable coinsurance applies to the newborn while both mother and baby are confined. Otherwise, all applicable inpatient cost shares apply. Office visits: See Outpatient Services; Routine well care: See Preventive care.
<b>Obesity-related surgery (bariatric)</b>	Covered at cost shares when medical criteria is met
<b>Organ transplants</b>	Unlimited, no waiting period  <b>Inpatient:</b> Covered in full <b>Outpatient:</b> \$10 copay
<b>Preventive care</b> 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
<b>Rehabilitation services</b>  Rehabilitation visits are a total of combined therapy visits per calendar year	<b>Inpatient:</b> 60 days per calendar year. Services with mental health diagnoses are covered with no limit Covered in full <b>Outpatient:</b> 60 visits per calendar year. Services with mental health diagnoses are covered with no limit \$10 copay
<b>Skilled nursing facility</b>	Covered in full up to 60 days per calendar year
<b>Sterilization</b> (vasectomy, tubal ligation)	<b>Inpatient:</b> Covered in full <b>Outpatient:</b> \$10 copay <b>Outpatient Surgery:</b> See Hospital services; Outpatient surgery section  Women's sterilization procedures are covered in full.
<b>Temporomandibular Joint (TMJ) services</b>	<b>Inpatient:</b> Covered in full <b>Outpatient:</b> \$10 copay
<b>Tobacco cessation counseling</b>	Covered in full
<b>Routine vision care</b> (1 visit every 12 months)	\$10 copay
<b>Optical hardware</b> Lenses, including contact lenses and frames	Not covered
<b>Virtual Care</b> Including Telemedicine, Telephone Services and Online (E-Visits)	Covered in full