Benefit Summary

City of Spokane LEOFF II Police/Local 270 PA Group Number: 4925700,4983000



Effective Date 1/1/2025 | Health Plan | Core HMO | Ref | RQ-198232

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 |
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| Plan deductible | No annual deductible |
| Individual deductible carryover | Not applicable |
| Plan coinsurance | No plan coinsurance |
| Out-of-pocket limit | Individual out-of-pocket limit: \$2,000 Family out-of-pocket limit: \$4,000 Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit: All cost shares for covered services |
| Pre-existing condition (PEC) waiting period | No PEC |
| Lifetime maximum | Unlimited |
| Outpatient services (Office visits) | \$5 copay |
| Hospital services | Inpatient services: Covered in full Outpatient surgery: \$5 copay |
| Prescription drugs (some injectable drugs may be covered under Outpatient services) | Preferred generic/preferred brand \$10/\$30 copay per 30 day supply |
| Prescription mail order | 3 x prescription cost share per 90 day supply |
| Acupuncture | Covered up to 8 visits per medical diagnosis per calendar year without prior authorization; additional visits when approved by the plan \$5 copay |
| Ambulance services | Covered in full |
| Chemical dependency | Inpatient: Covered in full Outpatient: \$5 copay |
| Devices, equipment and supplies Durable medical equipment Orthopedic appliances Post-mastectomy bras limited to two (2) every six (6) months Ostomy supplies Prosthetic devices | Covered in full |
| 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. |

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