



## Group Health Summary of Benefits

<b>Wa Fire Commissioners Association</b>	
<b>Effective Date</b> 1/1/2008	<b>Ref</b> 0802874003
<p>This is a brief summary of benefits and limitations. THIS IS NOT A CONTRACT. The Member will be charged the lesser of the cost share for the covered service or the actual charge for that service. For a more detailed description of your benefits and exclusions, refer to your certificate of coverage or contact your employer or benefits administrator. Benefit descriptions in this document are subject to Washington and federal regulations and may change.</p>	
<b>Annual Deductible</b>	No annual deductible.
<b>Plan Coinsurance</b>	No plan coinsurance.
<b>Lifetime Maximum</b>	\$2,000,000 per Member.
<b>Hospital Services</b> Covered inpatient medical and surgical services, including acute chemical withdrawal (detoxification)	Covered in full.
Covered outpatient hospital surgery (including ambulatory surgical centers)	Covered subject to the applicable outpatient services copayment.
<b>Outpatient Services (Office Visits)</b> Covered outpatient medical and surgical services	Covered subject to the lesser of GHC's charge or a \$5 copayment per Member per visit.
Allergy testing	Covered subject to the applicable outpatient services copayment.
Oncology (radiation therapy, chemotherapy)	Covered subject to the applicable outpatient services copayment.
<b>Drugs – Outpatient</b> (including mental health drugs, contraceptive drugs and devices and diabetic supplies) Prescription drugs, medicines, supplies and devices for a supply of thirty (30) days or less when listed in the GHC drug formulary	Covered subject to the lesser of GHC's charge or a \$5 copayment.
Over-the-counter drugs and medicines	Not covered.
Allergy serum	Covered subject to the applicable prescription drug cost share for each thirty (30) day supply.
Injectables	Injections that can be self-administered are subject to the applicable prescription drug cost share.
Mail order drugs and medicines	Covered subject to the applicable prescription drug cost share for each thirty (30) day supply or less.
Growth hormones	Covered in full subject to a twelve (12) month waiting period.
<b>Out-of-Pocket Limit</b>	Limited to an aggregate maximum of \$1,000 per Member or \$2,000 per family per calendar year. Except as otherwise noted, total out-of-pocket expenses for the following Covered Services are included in the out-of-pocket limit: <ul style="list-style-type: none"> <li>• Inpatient services</li> <li>• Outpatient services</li> <li>• Emergency services at a GHC or non-GHC Facility</li> <li>• Ambulance services</li> </ul>

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<b>Acupuncture</b>	Covered subject to the applicable outpatient services copayment for self-referrals to a GHC Provider up to a maximum of eight (8) visits per Member per medical diagnosis per calendar year. When approved by GHC, additional visits are covered.
<b>Ambulance Services</b> Emergency ground/air transport	Covered at 80%.
Non-emergent ground/air interfacility transfer	Covered at 80% for GHC-initiated transfers, except hospital-to-hospital ground transfers covered in full.
<b>Chemical Dependency</b> Inpatient services	Covered subject to the applicable inpatient services copayment.
Outpatient services	Covered subject to the applicable outpatient services copayment.
Benefit period allowance	\$14,000 maximum per Member per any twenty-four (24) consecutive calendar month period.  Acute detoxification covered as any other medical service. Charges incurred are not subject to the twenty-four (24) month maximum.
<b>Devices, Equipment and Supplies (for home use)</b> Covered items include:	
<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> </ul>	Covered at 80%.
<ul style="list-style-type: none"> <li>• Ostomy supplies</li> <li>• Prosthetic devices</li> </ul>	Covered at 80%.
<b>Diabetic Supplies</b>	Insulin, needles, syringes and lancets - see Drugs-Outpatient. External insulin pumps, blood glucose monitors, testing reagents and supplies - see Devices, Equipment and Supplies. When Devices, Equipment and Supplies have a dollar maximum, diabetic supplies are not subject to this maximum benefit limit.
<b>Diagnostic Laboratory and Radiology Services</b>	Covered in full.
<b>Emergency Services</b> At a GHC Facility	Covered subject to a \$75 copayment per Member per emergency visit. Copayment is waived if the Member is admitted as an inpatient to the hospital directly from the emergency department. Emergency admissions are covered subject to the applicable inpatient services cost share.
At a non-GHC Facility	Covered subject to a \$125 deductible per Member per emergency visit. Deductible is waived if the Member is admitted as an inpatient to the hospital directly from the emergency department. Emergency admissions are covered subject to the applicable inpatient services cost share. If the Member is admitted to a non-GHC Facility they should contact the Emergency Notification Line as indicated on their GHC identification card in order to be covered.
<b>Hearing Examinations and Hearing Aids</b>	Hearing examinations to determine hearing loss are covered subject to the applicable outpatient services copayment.  Hearing aids, including hearing aid examinations, are not covered.
<b>Home Health Services</b>	Covered in full. No visit limit.
<b>Hospice Services</b>	Covered in full.

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<b>Infertility Services (including sterility)</b>	Not covered.
<b>Manipulative Therapy</b>	Covered subject to the applicable outpatient services copayment for self-referrals to a GHC Provider for manipulative therapy of the spine and extremities up to a maximum of ten (10) visits per Member per calendar year. When approved by GHC, additional manipulation visits are covered.
<b>Maternity and Pregnancy Services</b> Delivery and associated hospital care	Covered subject to the applicable inpatient services copayment.
Routine prenatal and postpartum care	Covered subject to the applicable outpatient services copayment.
<b>Mental Health Services</b> Inpatient services	Covered subject to the applicable inpatient services cost share for up to thirty (30) days per Member per calendar year at a GHC-approved mental health care facility.
Outpatient services	Covered subject to the applicable outpatient services copayment for up to twenty (20) visits per Member per calendar year.
<b>Naturopathy</b>	Covered subject to the applicable outpatient services copayment for self-referrals to a GHC Provider up to a maximum of three (3) visits per Member per medical diagnosis per calendar year. When approved by GHC, additional visits are covered.
<b>Optical Services</b> Routine eye examinations	Covered subject to the applicable outpatient services copayment once every twelve (12) months. Eye examinations, including contact lens examinations, for eye pathology are covered subject to the applicable outpatient services copayment as often as Medically Necessary.
Lenses, including contact lenses, and frames	<p>Eyeglass lenses and frames; or contact lenses, including exams associated with their fitting covered up to \$100 per Member per any consecutive twelve (12) month period.</p> <p>Contact lenses following cataract surgery, when in lieu of an intraocular lens, are covered in full provided the Member has been continuously covered by GHC since such surgery. Contact lenses for eye pathology are covered in full. Replacement of these lenses are covered once within a twelve (12) month period and only when needed due to a change in the Member's medical condition.</p>
<b>Organ Transplants</b>	Covered subject to the applicable copayment up to a \$250,000 lifetime benefit maximum (including organ acquisition, matching and donor costs up to \$50,000). Coverage for all transplants, including follow-up care, is excluded until the Member has been continuously enrolled under a GHC or Group Health Options (GHO) plan for six (6) months.
<b>Pre-Existing Condition</b>	<p>Covered (except as specified) subject to the applicable cost share after the Member has been continuously covered under a GHC plan for three (3) consecutive months, except as described below. Coverage for PKU formula, maternity and breast reconstruction following a mastectomy is not subject to the pre-existing condition waiting period.</p> <p>Pre-existing condition wait will be credited for a Member whose date of application for coverage under this GHC plan is within ninety (90) days of termination of prior similar coverage, provided the Member has satisfied the pre-existing condition wait under such prior coverage.</p>

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<p><b>Preventive Services</b> (well adult and well child physicals, immunizations, pap smears, mammograms)</p>	<p>Covered subject to the applicable outpatient services copayment when in accordance with the well-care schedule established by GHC. Excluded are physicals for travel, employment, insurance or license.</p>
<p><b>Rehabilitation Services</b> Inpatient physical, occupational and restorative speech therapy services combined, including services for neurodevelopmentally disabled children age six (6) and under</p>	<p>Covered subject to the applicable inpatient services copayment for up to sixty (60) days per calendar year.</p>
<p>Outpatient physical, occupational and restorative speech therapy services combined, including services for neurodevelopmentally disabled children age six (6) and under</p>	<p>Covered subject to the applicable outpatient services copayment for up to sixty (60) visits per calendar year.</p>
<p><b>Skilled Nursing Facility (SNF)</b></p>	<p>Covered in full up to sixty (60) days per Member per calendar year.</p>
<p><b>Sterilization (vasectomy, tubal ligation)</b></p>	<p>Covered subject to the applicable copayment. Procedures to reverse a sterilization are not covered.</p>
<p><b>Temporomandibular Joint (TMJ) Services</b> Inpatient and outpatient TMJ services  Lifetime benefit maximum</p>	<p>Covered subject to the applicable copayment up to a \$1,000 maximum per Member per calendar year.  Covered up to a \$5,000 combined maximum per Member.</p>
<p><b>Tobacco Cessation</b> Individual/group sessions  Approved pharmacy products</p>	<p>Covered in full.  Covered in full when prescribed and dispensed as part of the GHC-designated tobacco cessation program.</p>