

Benefit Summary
Musicians Association of Seattle Tiered Plan
Group Number: 0495400



Effective Date 4/1/2010	Health Plan Group Health	Ref RQ-22658
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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 contact our Sales or Customer Service Departments or refer to the plan contract.

Benefits	Inside Network
Plan deductible (PCY) - per calendar year	Individual deductible: \$500 Family deductible: \$1500
Plan coinsurance	Plan pays 80%, you pay 20%
Pre-existing condition (PEC) waiting period	3 Months
Out-of-pocket limit	Individual out-of-pocket limit: \$2000 Family out-of-pocket limit: \$6000
Lifetime Maximum	\$2 million
Outpatient Services (Office visits - OV)	\$30 copay, deductible and coinsurance apply
Hospital services	Inpatient services: Deductible and coinsurance apply Outpatient surgery: \$30 copay, deductible and coinsurance apply
Prescription drugs	Formulary generic/formulary brand \$20/\$40 copay
Prescription mail order	2 x prescription cost share per 90 day supply
Acupuncture	Self-referred up to 8 visits per medical diagnosis PCY; additional visits when approved by plan \$30 copay, deductible and coinsurance apply
Ambulance Services	80/20% coinsurance
Chemical Dependency	Outpatient: \$30 copay, deductible and coinsurance apply Inpatient: Deductible and coinsurance apply
Devices, equipment and supplies (DME prosthetics)	DME-50% up to \$5,000 (\$2,500 max. benefit PCY); Prosthetics-50% up to \$40,000 (\$20,000 max. benefit PCY)
Diagnostic lab and X-ray services (outpatient)	Deductible and coinsurance apply High end radiology imaging services such as CT, MR and PET must be determined Medically Necessary and require preauthorization except when associated with Emergency care or inpatient services.
Emergency Services (copay waived if admitted)	\$100 copay at a designated facility \$150 copay at a non designated facility Deductible and coinsurance apply
Growth hormone	Covered at pharmacy cost share; no wait
Hearing exams (Routine)	\$30 copay, deductible and coinsurance apply
Hearing hardware	Not covered
Home health	Covered in full. No visit limit.
Infertility services	Not covered
Manipulative therapy	Self-referred up to 10 visits PCY \$30 copay, deductible and coinsurance apply
Maternity services	Outpatient: \$30 copay, deductible and coinsurance apply Inpatient: Deductible and coinsurance apply
Mental Health	Outpatient: \$30 copay, deductible and coinsurance apply Inpatient: Deductible and coinsurance apply
Naturopathy	Self-referred up to 3 visits per medical diagnosis PCY; additional visits when approved by plan \$30 copay, deductible and coinsurance apply
Obesity-related surgery (bariatric) When medically necessary and authorized lifetime max	Not covered

Organ transplants Donor search & harvest rolls to lifetime max	\$350,000 lifetime max; includes donor search & harvest of \$50,000; 6 month wait, time credit available Outpatient: \$30 copay, deductible and coinsurance apply Inpatient: Deductible and coinsurance apply
Preventive care Well-care physicals, immunizations, Pap smear exams, mammograms	\$30 copay (deductible and coinsurance waived)
Rehabilitation services (Occupational, speech, physical-including massage) Rehab visits are a total of combined therapy visits PCY	Outpatient: 60 visits PCY \$30 copay, deductible and coinsurance apply Inpatient: 60 days PCY Deductible and coinsurance apply
Skilled nursing facility (PCY)	Up to 60 days, deductible and coinsurance apply
Sterilization (vasectomy, tubal ligation)	\$30 copay, deductible and coinsurance apply
Temporomandibular Joint (TMJ) Services	\$1,000 PCY; \$5,000 lifetime max Outpatient: \$30 copay, deductible and coinsurance apply Inpatient: Deductible and coinsurance apply
Tobacco Cessation See pharmacy benefit for associated drug coverage	Free & Clear Program - covered in full
Vision care Routine vision exam (1 visit every 12 months) No limit for medically necessary eye visits	\$30 copay, deductible and coinsurance waived
Optical Hardware Lenses, including contact lenses, and frames	Not covered

