



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.ghc.org or by calling 1-888-901-4636.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| What is the overall deductible ? | \$0 | See the chart starting on page 2 for your costs for services this plan covers. |
| Are there other deductibles for specific services? | No. | You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers. |
| Is there an out-of-pocket limit on my expenses? | Yes, \$750 individual/\$1,500 family | The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |
| What is not included in the out-of-pocket limit ? | Premiums, balance-billed charges, benefit-specific coinsurances, prescription drug copayments, deductible, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit . |
| Does this plan use a network of providers ? | Yes. See www.ghc.org or call 1-888-901-4636 for a list of in-network providers. | If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers . |
| Do I need a referral to see a specialist ? | Yes. See www.ghc.org or call 1-888-901-4636 for a list of specialist providers. | This plan will pay some or all of the costs to see a specialist for covered services but only if you have the plan's permission before you see the specialist . |
| Are there services this plan doesn't cover? | Yes. | Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services . |

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If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.ghc.org or call 1-888-901-4636 to request a copy.



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

| Common Medical Event | Services You May Need | Your Cost If You Use a Network Provider | Your Cost If You Use a Non-network Provider | Limitations & Exceptions |
|--|--|---|---|---|
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | No charge | Not covered | _____none_____ |
| | Specialist visit | No charge | Not covered | _____none_____ |
| | Other practitioner office visit | No charge for manipulative therapy, acupuncture and naturopathy | Not covered | Manipulative therapy limited to 10 visits per calendar year, acupuncture limited to 8 visits per medical diagnosis per calendar year, additional visits are covered with Preauthorization, and naturopathy limited to 3 visits per medical diagnosis per calendar year, additional visits are covered with Preauthorization or will not be covered. |
| | Preventive care/screening/immunization | No charge | Not covered | Services must be in accordance with the Group Health well-care schedule. |
| If you have a test | Diagnostic test (x-ray, blood work) | No charge | Not covered | _____none_____ |
| | Imaging (CT/PET scans, MRIs) | No charge | Not covered | High end radiology imaging services such as CT, MRI and PET require preauthorization or will not be covered. |
| If you need drugs to treat your illness or condition | Preferred generic drugs | \$3 copayment | Not covered | Covers up to a 30-day supply |
| | Preferred brand drugs | \$3 copayment | Not covered | Covers up to a 30-day supply |
| | Non-preferred generic/brand drugs | Not covered | Not covered | _____none_____ |
| | Mail-order drugs | Member pays the | Available when | Covers up to a 90-day supply |

| Common Medical Event | Services You May Need | Your Cost If You Use a Network Provider | Your Cost If You Use a Non-network Provider | Limitations & Exceptions |
|--|--|---|---|---|
| More information about <u>prescription drug coverage</u> is available at www.ghc.org . | | prescription drug cost share for each 30 day supply | dispensed through the Group Health designated mail order service. | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | No charge | Not covered | _____none_____ |
| | Physician/surgeon fees | No charge | Not covered | _____none_____ |
| If you need immediate medical attention | Emergency room services | \$25 copayment | \$75 copayment | Notify Group Health within 24 hours of admission, or as soon thereafter as medically possible. Copay is waived if admitted. |
| | Emergency medical transportation | 20% benefit specific coinsurance | 20% benefit specific coinsurance | _____none_____ |
| | Urgent care | No charge | No charge | _____none_____ |
| If you have a hospital stay | Facility fee (e.g., hospital room) | No charge | Not covered | Non-emergency inpatient services require preauthorization or will not be covered. |
| | Physician/surgeon fee | Included with Facility fee | Not covered | Non-emergency inpatient services require preauthorization or will not be covered. |
| If you have mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services | No charge | Not covered | _____none_____ |
| | Mental/Behavioral health inpatient services | No charge | Not covered | Non-emergency inpatient services require preauthorization or will not be covered. |
| | Substance use disorder outpatient services | No charge | Not covered | _____none_____ |
| | Substance use disorder inpatient services | No charge | Not covered | Non-emergency inpatient services require preauthorization or will not be covered. |
| If you are pregnant | Prenatal and postnatal care | No charge | Not covered | Routine prenatal and postnatal care is not subject to the co-pay. |
| | Delivery and all inpatient services | No charge | Not covered | Notify Group Health within 24 hours of admission, or as soon thereafter as medically possible. |

| Common Medical Event | Services You May Need | Your Cost If You Use a Network Provider | Your Cost If You Use a Non-network Provider | Limitations & Exceptions |
|---|---------------------------|---|---|---|
| If you need help recovering or have other special health needs | Home health care | No charge | Not covered | Requires preauthorization or will not be covered. |
| | Rehabilitation services | No charge/ outpatient No charge/ inpatient | Not covered | Limited to 60 visits per calendar year/outpatient. Limited to 60 days per calendar year/inpatient. (combined limit with Habilitation services) Requires preauthorization or will not be covered. |
| | Habilitation services | No charge/ outpatient No charge/ inpatient | Not covered | Limited to 60 visits per calendar year/outpatient. Limited to 60 days per calendar year/inpatient. (combined limit with Rehabilitation services) Requires preauthorization or will not be covered. |
| | Skilled nursing care | No charge | Not covered | Limited to 60 days per calendar year. Requires preauthorization or will not be covered. |
| | Durable medical equipment | 20% benefit-specific coinsurance | Not covered | Requires preauthorization or will not be covered. |
| | Hospice service | No charge | Not covered | Requires preauthorization or will not be covered. |
| If your child needs dental or eye care | Eye exam | No charge | Not covered | Limited to one exam every 12 months |
| | Glasses | No charge | Not covered | Members age 19 and over limited to \$100 every 24 months, Members age 18 and below limited to 1 pair of frames and lenses every 24 months. |
| | Dental check-up | Not covered | Not covered | _____none_____ |

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- | | | |
|-------------------------|--|------------------------|
| • Cosmetic surgery | • Most coverage provided outside the United States. See www.ghc.org | • Private-duty nursing |
| • Dental care (Adult) | • Non-emergency care when traveling outside the U.S. | • Routine foot care |
| • Infertility treatment | | • Weight loss programs |
| • Long-term care | | |

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- | | | |
|---------------------|---|----------------------------|
| • Acupuncture | • Chiropractic care (if prescribed for rehabilitation purposes) | • Hearing Aids |
| • Bariatric surgery | | • Routine eye care (Adult) |

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-888-901-4636. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: The Washington Office of Insurance Commissioner at : <http://www.insurance.wa.gov/your-insurance/health-insurance/appeal/>. The Insurance Consumer Hotline at 1-800-562-6900 or access to a page to email the same office: <http://www.insurance.wa.gov/your-insurance/email-us/>. Or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-901-4636.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$7,330
- Patient pays \$210

Sample care costs:

| | |
|----------------------------|----------------|
| Hospital charges (mother) | \$2,700 |
| Routine obstetric care | \$2,100 |
| Hospital charges (baby) | \$900 |
| Anesthesia | \$900 |
| Laboratory tests | \$500 |
| Prescriptions | \$200 |
| Radiology | \$200 |
| Vaccines, other preventive | \$40 |
| Total | \$7,540 |

Patient pays:

| | |
|----------------------|--------------|
| Deductibles | \$0 |
| Copays | \$10 |
| Coinsurance | \$0 |
| Limits or exclusions | \$200 |
| Total | \$210 |

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$5,100
- Patient pays \$300

Sample care costs:

| | |
|--------------------------------|----------------|
| Prescriptions | \$2,900 |
| Medical Equipment and Supplies | \$1,300 |
| Office Visits and Procedures | \$700 |
| Education | \$300 |
| Laboratory tests | \$100 |
| Vaccines, other preventive | \$100 |
| Total | \$5,400 |

Patient pays:

| | |
|----------------------|--------------|
| Deductibles | \$0 |
| Copays | \$200 |
| Coinsurance | \$20 |
| Limits or exclusions | \$80 |
| Total | \$300 |

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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