GroupHealth

Group Health Cooperative: City Of Seattle

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 1/1/2017 to 1/1/2018
Coverage for: Group | **Plan Type:** HMO

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, **$2,000** individual/**$4,000** 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 except ambulance, 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**.

- **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	$15 copayment	Not covered	_____none_____
	Specialist visit	$15 copayment	Not covered	_____none_____
	Other practitioner office visit	$15 copayment for manipulative therapy, acupuncture and naturopathy	Not covered	Manipulative therapy limited to 10 visits per calendar year, and naturopathy limited to 3 visits per medical diagnosis per calendar year, additional visits are covered with Preauthorization or will not be covered. Acupuncture limited to 8 visits per medical diagnosis per calendar year, additional visits are covered with Preauthorization.
	Preventive care/screening/immunization	$15 copayment	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	$15 copayment	Not covered	Covers up to a 30-day supply
	Preferred brand drugs	$30 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 **prescription drug coverage** 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	$15 copayment	Not covered	_____none_____
If you need immediate medical attention	Emergency room services	$100 copayment	$150 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	$15 copayment	$150 copayment	_____none_____
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 copayment per admit	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	$15 copayment	Not covered	_____none_____
	Mental/Behavioral health inpatient services	$200 copayment per admit	Not covered	Non-emergency inpatient services require preauthorization or will not be covered.
	Substance use disorder outpatient services	$15 copayment	Not covered	_____none_____
	Substance use disorder inpatient services	$200 copayment per admit	Not covered	Non-emergency inpatient services require preauthorization or will not be covered.
If you are pregnant	Prenatal and postnatal care	$15 copayment	Not covered	Routine prenatal and postnatal care is not subject to the co-pay.
	Delivery and all inpatient services	$200 copayment per admit	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	$15 copayment/ outpatient $200 copayment per admit/ inpatient	Not covered	Limited to 60 visits per calendar year/outpatient. Limited to 60 days per calendar year/inpatient. (combined limit with Habilitation services). Services with mental health diagnoses are covered with no limit. Requires preauthorization or will not be covered.
	Habilitation services	$15 copayment/ outpatient $200 copayment per admit/ inpatient	Not covered	Limited to 60 visits per calendar year/outpatient. Limited to 60 days per calendar year/inpatient. (combined limit with Rehabilitation services). Services with mental health diagnoses are covered with no limit. 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	$15 copayment	Not covered	Limited to one exam every 12 months
	Glasses	Not covered	Not covered	_____none_____
	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 • Dental care (Adult) • Glasses • Infertility treatment	• Long-term care • Most coverage provided outside the United States. See www.ghc.org • Non-emergency care when traveling outside the U.S.	• Private-duty nursing • Routine foot care • Weight loss programs

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 • Bariatric surgery	• Chiropractic care (if prescribed for rehabilitation purposes)	• Hearing Aids • 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** $7,140
- **Patient pays** $400

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	$200
Coinsurance	$0
Limits or exclusions	$200
Total	**$400**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,200
- **Patient pays** $1,200

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	$1,100
Coinsurance	$20
Limits or exclusions	$80
Total	**$1,200**

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.

Questions: Call 1-888-901-4636 or visit us at www.ghc.org.
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.