

Effective Date 1/1/2011**Health Plan** Group Health**Ref** RQ-39083

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.

Group Health believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act of 2010. Questions regarding this status may be directed to Customer Service (888) 901-4636. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or <http://www.dol.gov/ebsa/healthreform>.

Benefits	Inside Network
Plan deductible	Individual deductible: \$200 per calendar year Family deductible: \$600 per calendar year
Individual deductible carryover	4th quarter carryover applies
Plan coinsurance	No plan coinsurance
Out-of-pocket limit	Individual out-of-pocket limit: \$2,000 Family out-of-pocket limit: \$6,000 Out-of-pocket expenses for the following covered services are included in the out-of-pocket limit: Outpatient services, emergency services at a GHC or non-GHC facility, ambulance services.
Pre-existing condition (PEC) waiting period	No PEC
Lifetime maximum	Unlimited
Outpatient services (Office visits)	\$15 copay, deductible applies
Hospital services	Inpatient services: Deductible applies Outpatient surgery: \$15 copay, deductible applies
Prescription drugs (some injectable drugs may be covered under Outpatient services)	Formulary generic/formulary brand \$15/\$30 copay per 30 day supply
Prescription mail order	2 x prescription cost share per 90 day supply
Acupuncture	Self-referred up to 8 visits per medical diagnosis per calendar year; additional visits when approved by the plan \$15 copay, deductible applies
Ambulance services	Plan pays 80%, you pay 20%
Chemical dependency	Inpatient: Deductible applies Outpatient: \$15 copay, deductible applies
Devices, equipment and supplies	
<ul style="list-style-type: none"> • Durable medical equipment • Orthopedic appliances • Post-mastectomy bras limited to two (2) every six (6) months 	Covered at 80%
<ul style="list-style-type: none"> • Ostomy supplies • Prosthetic devices 	Covered at 80%

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.
Diagnostic lab and X-ray services	Inpatient: Covered under Hospital services Outpatient: Deductible applies 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 applies
Hearing exams (routine)	\$15 copay, deductible applies
Hearing hardware	\$1,000 per ear every 36 months
Home health services	Covered in full. No visit limit.
Hospice services	Covered in full
Infertility services	Not covered
Manipulative therapy	Self-referred up to 10 visits per calendar year \$15 copay, deductible applies
Massage services	See Rehabilitation services
Maternity services	Inpatient: Deductible applies Outpatient: \$15 copay, deductible applies
Mental Health	Inpatient: Deductible applies Outpatient: \$15 copay, deductible applies
Naturopathy	Self-referred up to 3 visits per medical diagnosis per calendar year; additional visits when approved by plan \$15 copay, deductible applies
Obesity-related surgery (bariatric)	Covered at cost shares when medical criteria is met
Organ transplants Donor search & harvest applies to lifetime max	Unlimited, no waiting period Inpatient: Deductible applies Outpatient: \$15 copay, deductible applies
Preventive care Well-care physicals, immunizations, Pap smear exams, mammograms	\$15 copay (deductible waived)
Rehabilitation services (Occupational, speech, physical including services for neurodevelopmentally disabled children age six and under) Rehabilitation visits are a total of combined therapy visits per calendar year	Inpatient: 60 days per calendar year Deductible applies Outpatient: 60 visits per calendar year \$15 copay, deductible applies
Skilled nursing facility	Up to 60 days per calendar year, deductible applies
Sterilization (vasectomy, tubal ligation)	Inpatient: Deductible applies Outpatient: \$15 copay, deductible applies
Temporomandibular Joint (TMJ) services	\$1,000 per calendar year; \$5,000 lifetime max Inpatient: Deductible applies Outpatient: \$15 copay, deductible applies
Tobacco cessation See pharmacy benefit for associated drug coverage	Covered in full
Routine vision care (1 visit every 12 months)	\$15 copay, deductible waived
Optical hardware Lenses, including contact lenses and frames	Not covered