

**Effective Date** 1/1/2011**Health Plan** Group Health**Ref** RQ-39398

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.

Benefits	Inside Network
<b>Plan deductible</b>	Individual deductible: \$100 per calendar year Family deductible: \$300 per calendar year
<b>Individual deductible carryover</b>	4th quarter carryover applies
<b>Plan coinsurance</b>	Plan pays 80%, you pay 20%
<b>Deductible and/or coinsurance waiver riders</b>	Deductible does not apply to outpatient services
<b>Out-of-pocket limit</b>	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: Plan coinsurance, emergency services at a GHC or non-GHC facility, ambulance services.
<b>Pre-existing condition (PEC) waiting period</b>	No PEC
<b>Lifetime maximum</b>	Unlimited
<b>Outpatient services (Office visits)</b>	\$20 copay, deductible does not apply Coinsurance applies
<b>Hospital services</b>	<b>Inpatient services:</b> Deductible and coinsurance apply <b>Outpatient surgery:</b> \$20 copay, deductible does not apply Coinsurance applies
<b>Prescription drugs</b> (some injectable drugs may be covered under Outpatient services)	Formulary generic/formulary brand/non-formulary \$15/\$25/\$45 copay per 30 day supply
<b>Prescription mail order</b>	2 x prescription cost share per 90 day supply
<b>Acupuncture</b>	Self-referred up to 8 visits per medical diagnosis per calendar year; additional visits when approved by the plan \$20 copay, deductible does not apply Coinsurance applies
<b>Ambulance services</b>	Plan pays 80%, you pay 20%
<b>Chemical dependency</b>	<b>Inpatient:</b> Deductible and coinsurance apply <b>Outpatient:</b> \$20 copay, deductible does not apply Coinsurance applies



<b>Sterilization</b> (vasectomy, tubal ligation)	<b>Inpatient:</b> Deductible and coinsurance apply <b>Outpatient:</b> \$20 copay, deductible does not apply Coinsurance applies
<b>Temporomandibular Joint (TMJ) services</b>	\$1,000 per calendar year; \$5,000 lifetime max <b>Inpatient:</b> Deductible and coinsurance apply <b>Outpatient:</b> \$20 copay, deductible does not apply Coinsurance applies
<b>Tobacco cessation</b> See pharmacy benefit for associated drug coverage	Free & Clear Program - covered in full
<b>Routine vision care</b> (1 visit every 12 months)	\$20 copay, deductible and coinsurance waived
<b>Optical hardware</b> Lenses, including contact lenses and frames	\$100 per 12 months Not subject to deductible and coinsurance

Coverage provided by Group Health Cooperative

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