GroupHealth

Group Health Options, Inc.: Hanford Employee Welfare Trust

Coverage Period: 1/1/2015 to 1/1/2016

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

Coverage for: Group | **Plan Type:** POS

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?	**$150** individual in-network/**$300** family in-network per calendar year **$250** individual out-of-network/**$500** family out-of-network Does not apply to in-network preventive care, prescription drugs, ambulance, in-network durable medical equipment.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
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, for in-network **$1,150** individual/**$2,300** family $2,875 individual out-of-network/$5,750 family out-of-network	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, office/hospital copayments, benefit-specific coinsurances, prescription drug copayments, 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 6. 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 in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	30% coinsurance	_____none_____
	Specialist visit	20% coinsurance	30% coinsurance	_____none_____
	Other practitioner office visit	20% coinsurance for manipulative therapy, acupuncture and naturopathy	30% coinsurance for manipulative therapy, acupuncture and naturopathy	Manipulative therapy limited to 20 visits per calendar year combined in and out-of-network, acupuncture limited to 8 visits per medical diagnosis per calendar year in-network, additional visits are covered with Preauthorization (no limit out-of-network), and naturopathy limited to 3 visits per medical diagnosis per calendar year in-network, additional visits are covered with Preauthorization or will not be covered (no limit out-of-network).
	Preventive care/screening/immunization	No charge	30% coinsurance	Deductible does not apply in-network Services must be in accordance with the Group Health well-care schedule.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	30% coinsurance	_____none_____
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance	High end radiology imaging services such as CT, MRI and PET require preauthorization or will not be covered.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.ghc.org.	Preferred generic drugs	$20 copayment	$25 copayment	Deductible does not apply Covers up to a 30-day supply
	Preferred brand drugs	$40 copayment	$45 copayment	Deductible does not apply Covers up to a 30-day supply
	Non-preferred generic/brand drugs	$60 copayment	$65 copayment	Deductible does not apply. Covers up to a 30-day supply
	Mail-order drugs	Member pays two times the prescription drug cost share	Available when dispensed through the Group Health designated mail order service	Deductible does not apply Covers up to a 90-day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance	_____none_____
	Physician/surgeon fees	20% coinsurance	30% coinsurance	_____none_____
If you need immediate medical attention	Emergency room services	$125 copayment + 20% coinsurance	$125 copayment + 20% coinsurance	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	Deductible does not apply
	Urgent care	20% coinsurance	30% coinsurance	_____none_____
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance	Non-emergency inpatient services require preauthorization or will not be covered.
	Physician/surgeon fee	20% coinsurance	30% coinsurance	Non-emergency inpatient services require preauthorization or will not be covered.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance	30% coinsurance	_____none_____
	Mental/Behavioral health inpatient services	20% coinsurance	30% coinsurance	Non-emergency inpatient services require preauthorization or will not be covered.
	Substance use disorder outpatient services	20% coinsurance	30% coinsurance	_____none_____
	Substance use disorder inpatient services	20% coinsurance	30% coinsurance	Non-emergency inpatient services require preauthorization or will not be covered.
If you are pregnant	Prenatal and postnatal care	20% coinsurance	30% coinsurance	Preventive services related to prenatal and preconception care are covered as preventive care. Routine prenatal and postnatal care is not subject to the co-pay.
	Delivery and all inpatient services	20% coinsurance	30% coinsurance	Notify Group Health within 24 hours of admission, or as soon thereafter as medically possible. Newborn services cost shares are separate from that of the mother.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No charge	30% coinsurance	Deductible does not apply in-network Requires preauthorization or will not be covered.
	Rehabilitation services	20% coinsurance / outpatient 20% coinsurance / inpatient	30% coinsurance / outpatient 30% coinsurance / inpatient	Limited to 60 visits per condition per calendar year/outpatient. Limited to 60 days per condition per calendar year/inpatient. (combined limit with Habilitation services) Limits combined in and out-of-network. Requires preauthorization or will not be covered.
	Habilitation services	20% coinsurance / outpatient 20% coinsurance / inpatient	30% coinsurance / outpatient 30% coinsurance / inpatient	Limited to 60 visits per condition per calendar year/outpatient. Limited to 60 days per condition per calendar year/inpatient. (combined limit with Rehabilitation services) Limits combined in and out-of-network. Requires preauthorization or will not be covered.
	Skilled nursing care	20% coinsurance	30% coinsurance	Limited to 60 days per calendar year combined in and out-of-network. Requires preauthorization or will not be covered.
	Durable medical equipment	20% benefit-specific coinsurance	20% benefit-specific coinsurance	Deductible does not apply in-network. Requires preauthorization or will not be covered.
	Hospice service	No charge	30% coinsurance	Deductible does not apply in-network Requires preauthorization or will not be covered.
If your child needs dental or eye care	Eye exam	No charge	30% coinsurance	Deductible does not apply in-network Limited to one exam every 12 months
	Glasses	No charge	Shared with in-network	Deductible does not apply. Members age 19 and over limited to $165 every 24 months, Members under age 19 limited to 1 pair of frames and lenses per year
	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) • 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)	• Glasses • Hearing Aids	• Infertility treatment • 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** $5,620
- **Patient pays** $1,920

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	$300
Copays	$20
Coinsurance	$1,400
Limits or exclusions	$200
Total	**$1,920**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,820
- **Patient pays** $1,580

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	$200
Copays	$1,100
Coinsurance	$200
Limits or exclusions	$80
Total	**$1,580**

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.