**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.glhealthplan.org or by calling 1-800-897-1923.

| 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. Medical: **$500** person/**$1,000** family. Prescription drug Level 1 and 2: **$410** person/**$820** family Formulary specialty drugs: **$1,000** person/**$2,000** 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?** | Emergency room and pharmacy copayments and coinsurance. | Even though you pay these expenses, they don't count toward the **out–of–pocket limit**. |
| **Is there an overall annual limit on what the plan pays?** | No | The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits. |
| **Does this plan use a network of providers?** | Yes. For a list of **preferred providers**, see www.glhealthplan.com or call 1-800-897-1923. | 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?** | No. | You can see the **specialist** you choose without permission from this plan. |
| **Are there services this plan doesn't cover?** | Yes. | Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**. |

**Questions:** Call 1-800-897-1923 or visit us at www.glhealthplan.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.glhealthplan.org or call 1-800-897-1923 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 **participating 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 | 10% Coinsurance | Not Covered | ----------none---------- |
| | Specialist visit | 10% Coinsurance | Not Covered | No referral needed within the network. |
| | Other practitioner office visit | 10% Coinsurance | Not Covered | ----------none---------- |
| | Preventive care/screening/immunization | 0% Coinsurance | Not Covered | Full coverage if required by federal law. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 10% Coinsurance | Not Covered | ----------none---------- |
| | Imaging (CT/PET scans, MRIs) | 10% Coinsurance | Not Covered | ----------none---------- |

| 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**<br><br>More information about **prescription drug coverage** is available at www.navitus.com. | Level 1 Formulary generic drugs and certain low cost brand name drugs | $5/prescription to **out-of-pocket limit**. (2 copays apply to certain 90-day supply mail order.) | Not Covered | In-network covers most up to a 30-day supply (90-day for certain prescriptions) retail and mail order. Out-of-network emergency or urgent care allowed but if your ID card is not used, you may have to pay more than the copay. |
| | Level 2 Formulary brand name drugs and certain high cost generic drugs | $15/prescription to **out-of-pocket limit**. (2 copays apply to certain 90-day supply mail order.) | Not Covered | In-network covers most up to a 30-day supply (90-day for certain prescriptions) retail and mail order. Out-of-network emergency or urgent care allowed but if your ID card is not used, you may have to pay more than the copay. |
| | Level 3 Non-formulary prescription drugs | $35/prescription | Not Covered | No out-of-pocket limit. Out-of-network emergency or urgent care allowed but if your ID card is not used, you may have to pay more than the copay. |
| | Specialty drugs | $15 Formulary drugs to **out-of-pocket limit**; $50 non-formulary no **out-of-pocket limit** | $50 formulary drugs to **out-of-pocket limit**; $50 non-formulary no **out-of-pocket limit** | Out-of-network emergency or urgent care allowed but if your ID card is not used, you may have to pay more than the copay. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 10% Coinsurance | Not Covered | ----------none---------- |
| | Physician/surgeon fees | 10% Coinsurance | Not Covered | ----------none---------- |
| **If you need immediate medical attention** | Emergency room services | $75 Copayment then 10% Coinsurance | Not Covered | Waived if admitted directly from the emergency room or for observation for 24 hours or longer. |
| | Emergency medical transportation | 10% Coinsurance | Not Covered | ----------none---------- |
| | Urgent care | 10% Coinsurance | Not Covered | ----------none---------- |

| 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 a hospital stay** | Facility fee (e.g., hospital room) | 10% Coinsurance | Not Covered | ----------none---------- |
| | Physician/surgeon fee | 10% Coinsurance | Not Covered | ----------none---------- |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | 10% Coinsurance | Not Covered | ----------none---------- |
| | Mental/Behavioral health inpatient services | 10% Coinsurance | Not Covered | ----------none---------- |
| | Substance use disorder outpatient services | 10% Coinsurance | Not Covered | ----------none---------- |
| | Substance use disorder inpatient services | 10% Coinsurance | Not Covered | ----------none---------- |
| **If you are pregnant** | Prenatal and postnatal care | 10% Coinsurance | Not Covered | ----------none---------- |
| | Delivery and all inpatient services | 10% Coinsurance | Not Covered | ----------none---------- |
| **If you need help recovering or have other special health needs** | Home health care | 10% Coinsurance | Not Covered | Limited to 50 visits per calendar year. |
| | Rehabilitation services | 10% Coinsurance | Not Covered | Limited to 50 visits per calendar year. |
| | Habilitation services | 10% Coinsurance | Not Covered | ----------none---------- |
| | Skilled nursing care | 10% Coinsurance | Not Covered | Limited to 120 days per benefit period. |
| | Durable medical equipment | 20% Coinsurance | Not Covered | ----------none---------- |
| | Hospice service | 10% Coinsurance | Not Covered | ----------none---------- |
| **If your child needs dental or eye care** | Eye exam | 10% Coinsurance | Not Covered | Full coverage if required by federal law. Limited to one per person per year. Contact lens fittings not covered. |
| | 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.)**

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Infertility Treatment
- Long-term Care
- Non-emergency care when traveling outside the USA
- 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.)**

- Chiropractic Care
- Hearing Aids
- Most coverage provided outside the USA (Emergency/Urgent care only)
- 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 1-800-897-1923. 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: 1-800-897-1923.

*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** $6,950
- **Patient pays** $590

**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 | $0 |
| Coinsurance | $590 |
| Limits or exclusions | $0 |
| **Total** | **$590** |

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,740
- **Patient pays** $660

**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 | $410 |
| Coinsurance | $250 |
| Limits or exclusions | $0 |
| **Total** | **$660** |

## 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.