

<b>Plan facts</b>	Member services	(888) 901-4636 Annual enrollment information: (888) 901-4636		
	Member services hours	Mon-Fri: 8:00 AM-6:00 PM; Sat: 9:00 AM-2:00 PM PT		
	Web address	www.ghc.org		
	Product name	Group Health Cooperative		
<b>Your medical expenses</b>	Office visits	\$15 (PCP) or \$30 (specialist) copay per visit		
	Maternity care prenatal office visits	\$15 copay per visit		
	Inpatient hospitalization	\$500 copay per admission		
	Outpatient surgical care	\$100 copay for hospital care. Office visit copay applies in physician's office		
	Outpatient lab and X-ray	Covered at 100%		
	Emergency room care Urgent care facility	\$75 copay/visit. Out-of-area: \$125 copay/visit (waived if admitted) \$15 copay/visit		
<b>Your prescription drug expenses</b>	Retail	\$10 copay (generic), \$20 copay (preferred brand) per prescription up to 30-day supply. Non-preferred brand drugs not covered		
	Mail order	\$30 copay (generic), \$60 copay (preferred brand) per prescription up to 90-day supply. Non-preferred brand drugs not covered		
<b>Preventive care</b>	Routine physical and GYN exam	Physical: \$15 copay per visit. Limits subject to well adult schedule. GYN: \$15 copay per visit		
	Routine vision exam	\$15 copay per visit. Limit 1 visit every 12 months		
	Well-child care and immunizations	Well Child Care: \$15 copay per visit. Immunizations: Covered at 100% (limits subject to well child care schedule)		
	Routine mammography	\$15 copay per visit		
<b>Mental health</b>	Inpatient	\$500 copay per admission. Limit 30 days per calendar year		
	Outpatient	\$15 copay per visit. Limit 20 visits per calendar year		
<b>Substance abuse</b>	Inpatient detoxification	\$500 copay per admission. Unlimited days		
	Inpatient rehabilitation	\$500 copay per admission. Limit \$14,000 maximum benefit per 24-month period combined with outpatient rehabilitation*		
	Outpatient detoxification	\$15 copay per visit. Unlimited visits		
	Outpatient rehabilitation	\$15 copay per visit. Limit \$14,000 maximum benefit per 24-month period combined with inpatient rehabilitation*		
<b>Other professional care</b>	Outpatient physical/speech/occupational therapy	\$15 copay per visit. Limit 60 visits per calendar year		
	Chiropractic care	\$15 copay per visit. Limit 10 visits per year		
<b>Out-of-network coverage</b>	Out-of-network non-emergency care	Not covered		
<b>Key facts</b>	NCQA status:	Excellent	Domestic partner coverage available:	Yes
	PCP referral required for specialist:	Yes	Domestic partner children coverage avail.:	Yes
	Lifetime Maximum Benefit:	NA		
	Provider Network:	See website for details		

\* Indicates a benefit change

The information contained in this summary is for comparative purposes and does not include all benefits, limitations, and exclusions.