<table>
<thead>
<tr>
<th>Type of Plan</th>
<th>PPO/Indemnity</th>
<th>HMO</th>
<th>POS</th>
<th>EPO</th>
<th>GATED EPO</th>
<th>HMO</th>
<th>OAP-OPEN ACCESS PLAN</th>
<th>HMO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly Cost</td>
<td>Basic Only</td>
<td>Basic Only</td>
<td>Basic Only</td>
<td>Basic Only</td>
<td>Basic Only</td>
<td>Basic Only</td>
<td>Basic Only</td>
<td>Basic Only</td>
</tr>
<tr>
<td>(Premium) 7/1</td>
<td>Individual $1,199.81</td>
<td>Individual $1,199.81</td>
<td>Individual $1,199.81</td>
<td>Individual $1,199.81</td>
<td>Individual $1,199.81</td>
<td>Individual $1,199.81</td>
<td>Individual $1,199.81</td>
<td>Individual $1,199.81</td>
</tr>
<tr>
<td>(Premium) 7/1</td>
<td>Family $4,172.71</td>
<td>Family $4,172.71</td>
<td>Family $4,172.71</td>
<td>Family $4,172.71</td>
<td>Family $4,172.71</td>
<td>Family $4,172.71</td>
<td>Family $4,172.71</td>
<td>Family $4,172.71</td>
</tr>
<tr>
<td>Deductible</td>
<td>Individual $1,199.81</td>
<td>Individual $1,199.81</td>
<td>Individual $1,199.81</td>
<td>Individual $1,199.81</td>
<td>Individual $1,199.81</td>
<td>Individual $1,199.81</td>
<td>Individual $1,199.81</td>
<td>Individual $1,199.81</td>
</tr>
<tr>
<td>Limits</td>
<td>Individual $14,199.81</td>
<td>Individual $14,199.81</td>
<td>Individual $14,199.81</td>
<td>Individual $14,199.81</td>
<td>Individual $14,199.81</td>
<td>Individual $14,199.81</td>
<td>Individual $14,199.81</td>
<td>Individual $14,199.81</td>
</tr>
</tbody>
</table>

**Medical/Surgical Services - In Network Providers**: All providers listed in the Table of Participating Offi ce Network (TON) maintain minimum professional liability insurance and are covered under the GHI Program. Consideration has been given to the quality of care furnished by the participating providers, including their reputation, experience, and the facilities available to the providers. *Non-preferred PCP $10 co-pay. 90 visits. Non-preferred PCP $10 co-pay. 90 visits. Non-preferred PCP $10 co-pay. 90 visits. Non-preferred PCP $10 co-pay. 90 visits. Non-preferred PCP $10 co-pay. 90 visits. Non-preferred PCP $10 co-pay. 90 visits. Non-preferred PCP $10 co-pay. 90 visits.*

**Preventive Care (Including Well Child Care & Immunizations)**: Treatment or care to prevent an illness, injury, or disease. Preventive care such as annual physical examinations and immunizations are covered at 100% instead of 20/80 as described above.

**Laboratory Test**: Required to establish the diagnosis of a condition. Pre-admission screening such as tests performed at the time of admission to a hospital or other inpatient hospital service.

**Ambulance Service**: A specially equipped vehicle designed and operated for the emergency transport of sick or injured persons.

**Emergency Services**: Treatment rendered in an emergency room including radiology and cardiology services rendered in the emergency room.

**Dental Services**: Partially covered, except in some instances where more complete coverage is provided through rider.


**Postpartum Care**: Covered anytime, anywhere in the world, 24 hours a day, 7 days a week.

**Mental Health Services**: Covered in full.

**Podiatry**: Covered in full.

**Chiropractic**: Covered in full.

**Travel Protection**: Covered in full.

**Catastrophic Coverage**: Covered in full.

**Dialysis, Home**: Covered in full.

**Medications**: Covered in full.

**Out-of-Area Care**: Covered in full.

**Psychiatric Care**: Covered in full.

**Ophthalmology**: Covered in full.

**Dermatology**: Covered in full.

**Endoscopy**: Covered in full.

**Respiratory**: Covered in full.

**Oncology**: Covered in full.

**Transplant**: Covered in full.

**Plastic Surgery**: Covered in full.

**Urology**: Covered in full.

**Orthopedics**: Covered in full.

**Anesthesiology**: Covered in full.

**Emergency Services Only**: Covered in full.

**Inpatient Care**: Covered in full.

**Ambulatory Surgery Center**: Covered in full.

**Outpatient Surgery Center**: Covered in full.

**Inpatient Hospital**: Covered in full.

**Outpatient Hospital**: Covered in full.

**Inpatient Rehabilitation**: Covered in full.

**Outpatient Rehabilitation**: Covered in full.

**Emergency Care Only**: Covered in full.

**Hospitalization**: Covered in full.

**Other Health Services**: Covered in full.

**Hospital-Bound Services**: Covered in full. 110% of participating provider schedule of allowances. **Not Covered.**

**Case Management Services**: Covered in full. No charge. Covered in full when medically necessary.

**Physician Services**:

- Non-preferred PCP $10 co-pay.
- Non-preferred PCP $10 co-pay.
- Non-preferred PCP $10 co-pay.
- Non-preferred PCP $10 co-pay.
- Non-preferred PCP $10 co-pay.
- Non-preferred PCP $10 co-pay.
- Non-preferred PCP $10 co-pay.
- Non-preferred PCP $10 co-pay.

**Physician Services Related** to Mental Health:

- Non-preferred PCP $10 co-pay.
- Non-preferred PCP $10 co-pay.
- Non-preferred PCP $10 co-pay.
- Non-preferred PCP $10 co-pay.
- Non-preferred PCP $10 co-pay.
- Non-preferred PCP $10 co-pay.
- Non-preferred PCP $10 co-pay.
- Non-preferred PCP $10 co-pay.

**Non-Preferred PCP Services**:

- Non-preferred PCP $10 co-pay.
- Non-preferred PCP $10 co-pay.
- Non-preferred PCP $10 co-pay.
- Non-preferred PCP $10 co-pay.
- Non-preferred PCP $10 co-pay.
- Non-preferred PCP $10 co-pay.
- Non-preferred PCP $10 co-pay.
- Non-preferred PCP $10 co-pay.

**Preferred PCP Services**:

- Preferred PCP $15 co-pay.
- Preferred PCP $15 co-pay.
- Preferred PCP $15 co-pay.
- Preferred PCP $15 co-pay.
- Preferred PCP $15 co-pay.
- Preferred PCP $15 co-pay.
- Preferred PCP $15 co-pay.
- Preferred PCP $15 co-pay.

**Emergency Care**:

- Hospital emergency room, $50 co-pay.
- Hospital emergency room, $50 co-pay.
- Hospital emergency room, $50 co-pay.
- Hospital emergency room, $50 co-pay.
- Hospital emergency room, $50 co-pay.
- Hospital emergency room, $50 co-pay.
- Hospital emergency room, $50 co-pay.
- Hospital emergency room, $50 co-pay.

**Other Services**:

- X-rays: $15 co-pay.
- X-rays: $15 co-pay.
- X-rays: $15 co-pay.
- X-rays: $15 co-pay.
- X-rays: $15 co-pay.
- X-rays: $15 co-pay.
- X-rays: $15 co-pay.
- X-rays: $15 co-pay.

**Additional Information**:

- GHI pays a portion of covered charges as determined by GHI. The services to which the benefits apply are subject to approval by ValueOptions. Out of network: 80% of participating provider schedule of allowances after $250 deductible per person per calendar year.
- In-network: Covered in full. No charge. Covered in full when medically necessary.
- Covered in full. No charge. Covered in full when medically necessary.
- Covered in full. No charge. Covered in full when medically necessary.
- Covered in full. No charge. Covered in full when medically necessary.
- Covered in full. No charge. Covered in full when medically necessary.
- Covered in full. No charge. Covered in full when medically necessary.
- Covered in full. No charge. Covered in full when medically necessary.

Please note, at the time of printing, the July 1, 2021 rates have not yet been finalized. The rates will be published on the GHI website. The benefits in California and Arizona may differ. See City Summary Program Descriptions for complete details.