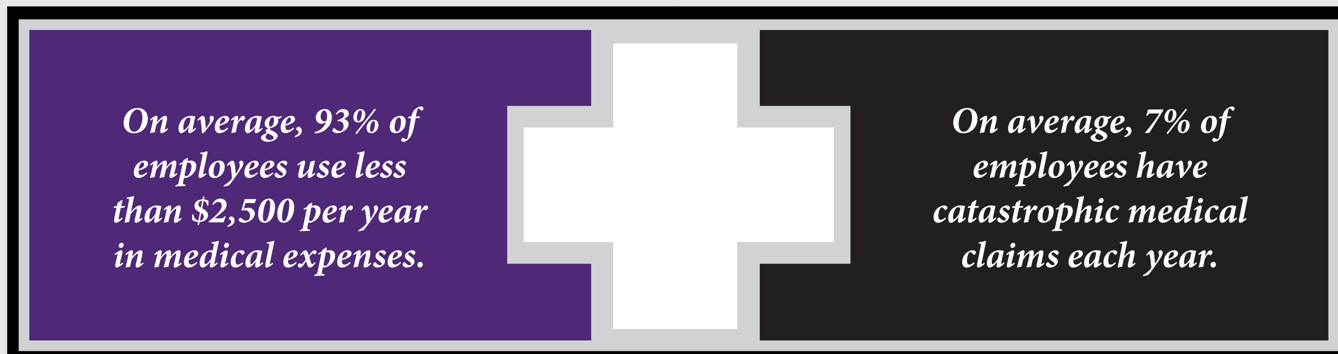
GBS
HealthyAdvantage

What is Self-Funding?

As the cost of healthcare continues to escalate more and more, employers are looking for alternative solutions. Self-funding offers employers a powerful, practical alternative to traditional insurance. It allows employers to directly fund their actual claim costs while limiting their risk with the purchase of stop-loss insurance. With a traditional fully insured plan, the insurance carrier pays for most of the benefits and offers members small out of pocket expenses in the form of deductibles, copays and coinsurance. In a self-funded plan, the employer pays the cost of benefits up to a higher deductible, but purchases stop-loss insurance to reimburse the plan if claim expenses exceed the deductible.

Stop-loss insurance protects the plan against individual catastrophic claims (specific stop-loss) or their total claim expenses (aggregate stop-loss) exceeding their annual budget. Employers hire a Third Party Administrator (TPA) such as GBS to process and pay the claims, provide professional customer serive and manage the plan on behalf of the employer.



Why Should You Consider It?

Self-Funding offers you several KEY ADVANTAGES over a traditional health plan.

When you choose GBS HealthyAdvantage Health Plans, you benefit from:

- **Lower Fixed Costs:** Most business realize immediate monthly savings.
- **Lower Claims Costs:** If claims are lower than expected, you would enjoy even greater savings.
- **Limited Risk:** Stop-loss insurance protects you against individual or total claims exceeding your annual budget.
- **Flexible Plan Options:** Wide variety of customized benefit designs including tax-favored HSA, HRA, and FSA plans.
- **Wellness Plan Designs:** Participant engagement and personal health coaching are critical to bending the curve of rising healthcare costs.
- **Reporting:** We will provide useful claim reports that will show you exactly where your benefit dollars are being spent and illustrate how your plan is performing financially.

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** **Healthy*Solutions*** - Earn up to $2,000 in deductible credits through wellness and health management activities.

Pre-Certification Penalty: Certain procedures or medical care require pre-certification in order to qualify for full benefits. Failure to pre-certify will result in a $250 penalty per service, procedure or confinement. Please refer to the Pre-Certification section in your SPD for details.

This brochure is intended as a brief overview of the actual plan. Please refer to your Summary Plan Description (SPD) for the actual benefits, limitations and exclusions. If there is any inconsistency between this brochure and the SPD, the SPD shall govern. For further information, please refer to the Summary Plan Description. You may request an SPD from your consultant or sales representative or via the web at www.gbshealthcare.net.

GBS *Healthy* Advantage Health Plan

PPO 0/50

Services	PPO Providers	Non-PPO Providers
Plan Year Deductible	$0 per Individual $0 per Family	
Coinsurance	Plan Pays 50%	Plan Pays 40%
Out-of-Pocket Maximum	$6,850 per Individual $13,700 per Family	
Preventive Care Provisions	No Deductible, No Copay	No Deductible, No Copay
Professional Outpatient Office Visits		
Primary Care	Covered at 50%	Covered at 40%
Specialist	Covered at 50%	Covered at 40%
Mental Health & Substance Abuse	Covered at 50%	Covered at 40%
Outpatient Diagnostic Tests, Lab & X-Ray	Covered at 50%	Covered at 40%
Inpatient Hospital Services Medical Services and Facility Anesthesiologiest & Surgeon Fees Mental Health & Substance Abuse	Covered at 50%	Covered at 40%
Outpatient Surgical, Diagnostic & Therapies Medical Services Facility Charges	Covered at 50%	Covered at 40%
Emergency Services		
Hospital Emergency Room	Covered at 50%	Covered at 50%
Urgent Care Visits	Covered at 50%	Covered at 40%
Ambulance	Covered at 50%	Covered at 40%
Prescription Drugs	Covered at 50%	Not Covered
Short Term Rehabilitation Services	Covered at 50%	Covered at 40%
Home Health, Skilled Nursing & Hospice	Covered at 50%	Covered at 40%
Durable Medical Equipment	Covered at 50%	Covered at 40%
Vision - Annual Eye Exam	Covered at 50%	Covered at 40%
Allergy Treatment		
Testing and Injections	Covered at 50%	Covered at 40%
Serum	Covered at 50%	Covered at 40%

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HEALTH PLAN OPTIONS

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Plan Year Deductible	*An individual within family coverage will only be required to meet the individual deductible amount before the coinsurance begins. Deductible does not apply to Preventive Care Provisions.*
Coinsurance	*Coinsurance is the share of the costs of a covered service, calculated as a percent of the allowed amount of the service.*
Out-of-Pocket Maximum	*All allowed deductibles, coinsurance, copayments and pre-certification penalties apply to the Out-of-Pocket Maximum. An individual within family coverage will only be required to meet the individual out-of-pocket maximum.*
Preventive Care Provisions	*Charges for preventive care services coverage at no cost sharing. Cost sharing may apply if a specific service is for non-preventive care (even if billed in conjunction with preventive care services).*
Professional Outpatient Office Visits Primary Care Specialist Mental Health & Substance Abuse	*These charges are billed by the physician for time spent with the patient. Office visits do not include charges for diagnostic, surgical, or medical procedures performed by the physician or for diagnostic services billed separately.* *Mental Health and Substance Abuse coverage excludes counseling for behavioral disorders.*
Outpatient Diagnostic Tests, Lab & X-Ray	*Includes diagnostic tests performed in a physician's office and billed by such physician or a free-standing non-hospital billed facility only.*
Inpatient Hospital Services Medical Services and Facility Anesthesiologiest & Surgeon Fees Mental Health & Substance Abuse	
Outpatient Surgical, Diagnostic & Therapies Medical Services Facility Charges	*Includes outpatient services, miscellaneous medical procedures & supplies, diagnostic & therapeutic procedures and surgery at a physician's office, freestanding surgery center, or hospital (when approved).*
Emergency Services Hospital Emergency Room Urgent Care Visits Ambulance	*Urgent care visits do not include charges for diagnostic, surgical or medical procedures.*
Prescription Drugs	*If Generics are available and a brand name is purchased, then the covered person must pay the copay PLUS the difference in the cost between the generic and the brand name drug. In the case of the integrated drug plan, the plan will reimburse only up to the cost of the generic equivalent.*
Short Term Rehabilitation Services	*Physical, chiropractic, speech, and occupational therapy. (Includes therapies performed in provider's office or non-hospital based facility only)*
Home Health, Skilled Nursing & Hospice	
Durable Medical Equipment	
Vision - Annual Eye Exam	*Any optometrist; member must submit a claim for reimbursement. Copay waived for children under 5 years of age.*
Allergy Treatment Testing and Injections Serum	

GBS *Healthy* Advantage Health Plan

PPO 250/100

Services	PPO Providers	Non-PPO Providers
Plan Year Deductible	$250 per Individual $500 per Family	
Coinsurance	Plan Pays 100%	Plan Pays 90%
Out-of-Pocket Maximum	$1,000 per Individual $2,000 per Family	
Preventive Care Provisions	No Deductible, No Copay	No Deductible, No Copay
Professional Outpatient Office Visits		
Primary Care	$20 Copay per visit	$20 Copay then Covered at 90%
Specialist	$40 Copay per visit	$40 Copay then Covered at 90%
Mental Health & Substance Abuse	$40 Copay per visit	$40 Copay then Covered at 90%
Outpatient Diagnostic Tests, Lab & X-Ray	$35 Copay per visit	$35 Copay then Covered at 90%
Inpatient Hospital Services Medical Services and Facility Anesthesiologist & Surgeon Fees Mental Health & Substance Abuse	100% after Deductible	90% after Deductible
Outpatient Surgical, Diagnostic & Therapies Medical Services Facility Charges	100% after Deductible	90% after Deductible
Emergency Services		
Hospital Emergency Room	$100 Copay per visit	$100 Copay per visit
Urgent Care Visits	$40 Copay per visit	$40 Copay then Covered at 90%
Ambulance	$100 Copay	$100 Copay then Covered at 90%
Prescription Drugs	$0/$30/$60	Not Covered
Short Term Rehabilitation Services	$40 Copay per visit	$40 Copay then Covered at 90%
Home Health, Skilled Nursing & Hospice	100% after Deductible	90% after Deductible
Durable Medical Equipment	100% after Deductible	90% after Deductible
Vision - Annual Eye Exam	$40 Copay per visit	$40 Copay then Covered at 90%
Allergy Treatment		
Testing and Injections	$20 Copay per visit	$20 Copay then Covered at 90%
Serum	$100 Copay	$100 Copay then Covered at 90%

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HEALTH PLAN OPTIONS

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Plan Year Deductible	*An individual within family coverage will only be required to meet the individual deductible amount before the coinsurance begins. Deductible does not apply to Preventive Care Provisions.*
Coinsurance	*Coinsurance is the share of the costs of a covered service, calculated as a percent of the allowed amount of the service.*
Out-of-Pocket Maximum	*All allowed deductibles, coinsurance, copayments and pre-certification penalties apply to the Out-of-Pocket Maximum. An individual within family coverage will only be required to meet the individual out-of-pocket maximum.*
Preventive Care Provisions	*Charges for preventive care services coverage at no cost sharing. Cost sharing may apply if a specific service is for non-preventive care (even if billed in conjunction with preventive care services).*
Professional Outpatient Office Visits Primary Care Specialist Mental Health & Substance Abuse	*These charges are billed by the physician for time spent with the patient. Office visits do not include charges for diagnostic, surgical, or medical procedures performed by the physician or for diagnostic services billed separately.* *Mental Health and Substance Abuse coverage excludes counseling for behavioral disorders.*
Outpatient Diagnostic Tests, Lab & X-Ray	*Includes diagnostic tests performed in a physician's office and billed by such physician or a free-standing non-hospital billed facility only.*
Inpatient Hospital Services Medical Services and Facility Anesthesiologiest & Surgeon Fees Mental Health & Substance Abuse	
Outpatient Surgical, Diagnostic & Therapies Medical Services Facility Charges	*Includes outpatient services, miscellaneous medical procedures & supplies, diagnostic & therapeutic procedures and surgery at a physician's office, freestanding surgery center, or hospital (when approved).*
Emergency Services Hospital Emergency Room Urgent Care Visits Ambulance	*Urgent care visits do not include charges for diagnostic, surgical or medical procedures.*
Prescription Drugs	*If Generics are available and a brand name is purchased, then the covered person must pay the copay PLUS the difference in the cost between the generic and the brand name drug. In the case of the integrated drug plan, the plan will reimburse only up to the cost of the generic equivalent.*
Short Term Rehabilitation Services	*Physical, chiropractic, speech, and occupational therapy. (Includes therapies performed in provider's office or non-hospital based facility only)*
Home Health, Skilled Nursing & Hospice	
Durable Medical Equipment	
Vision - Annual Eye Exam	*Any optometrist; member must submit a claim for reimbursement. Copay waived for children under 5 years of age.*
Allergy Treatment Testing and Injections Serum	

GBS *Healthy* Advantage Health Plan
PPO 500/80

Services	PPO Providers	Non-PPO Providers
Plan Year Deductible	$500 per Individual $1,000 per Family	
Coinsurance	Plan Pays 80%	Plan Pays 70%
Out-of-Pocket Maximum	$3,000 per Individual $6,000 per Family	
Preventive Care Provisions	No Deductible, No Copay	No Deductible, No Copay
Professional Outpatient Office Visits		
Primary Care	$20 Copay per visit	$20 Copay then Covered at 70%
Specialist	$40 Copay per visit	$40 Copay then Covered at 70%
Mental Health & Substance Abuse	$40 Copay per visit	$40 Copay then Covered at 70%
Outpatient Diagnostic Tests, Lab & X-Ray	$35 Copay per visit	$35 Copay then Covered at 70%
Inpatient Hospital Services Medical Services and Facility Anesthesiologiest & Surgeon Fees Mental Health & Substance Abuse	80% after Deductible	70% after Deductible
Outpatient Surgical, Diagnostic & Therapies Medical Services Facility Charges	80% after Deductible	70% after Deductible
Emergency Services		
Hospital Emergency Room	$100 Copay per visit	$100 Copay per visit
Urgent Care Visits	$40 Copay per visit	$40 Copay then Covered at 70%
Ambulance	$100 Copay	$100 Copay then Covered at 70%
Prescription Drugs	$0/$30/$60	Not Covered
Short Term Rehabilitation Services	$40 Copay per visit	$40 Copay then Covered at 70%
Home Health, Skilled Nursing & Hospice	80% after Deductible	70% after Deductible
Durable Medical Equipment	80% after Deductible	70% after Deductible
Vision - Annual Eye Exam	$40 Copay per visit	$40 Copay then Covered at 70%
Allergy Treatment		
Testing and Injections	$20 Copay per visit	$20 Copay then Covered at 70%
Serum	$100 Copay	$100 Copay then Covered at 70%

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Plan Year Deductible	*An individual within family coverage will only be required to meet the individual deductible amount before the coinsurance begins. Deductible does not apply to Preventive Care Provisions.*
Coinsurance	*Coinsurance is the share of the costs of a covered service, calculated as a percent of the allowed amount of the service.*
Out-of-Pocket Maximum	*All allowed deductibles, coinsurance, copayments and pre-certification penalties apply to the Out-of-Pocket Maximum. An individual within family coverage will only be required to meet the individual out-of-pocket maximum.*
Preventive Care Provisions	*Charges for preventive care services coverage at no cost sharing. Cost sharing may apply if a specific service is for non-preventive care (even if billed in conjunction with preventive care services).*
Professional Outpatient Office Visits Primary Care Specialist Mental Health & Substance Abuse	*These charges are billed by the physician for time spent with the patient. Office visits do not include charges for diagnostic, surgical, or medical procedures performed by the physician or for diagnostic services billed separately.* *Mental Health and Substance Abuse coverage excludes counseling for behavioral disorders.*
Outpatient Diagnostic Tests, Lab & X-Ray	*Includes diagnostic tests performed in a physician's office and billed by such physician or a free-standing non-hospital billed facility only.*
Inpatient Hospital Services Medical Services and Facility Anesthesiologiest & Surgeon Fees Mental Health & Substance Abuse	
Outpatient Surgical, Diagnostic & Therapies Medical Services Facility Charges	*Includes outpatient services, miscellaneous medical procedures & supplies, diagnostic & therapeutic procedures and surgery at a physician's office, freestanding surgery center, or hospital (when approved).*
Emergency Services Hospital Emergency Room Urgent Care Visits Ambulance	*Urgent care visits do not include charges for diagnostic, surgical or medical procedures.*
Prescription Drugs	*If Generics are available and a brand name is purchased, then the covered person must pay the copay PLUS the difference in the cost between the generic and the brand name drug. In the case of the integrated drug plan, the plan will reimburse only up to the cost of the generic equivalent.*
Short Term Rehabilitation Services	*Physical, chiropractic, speech, and occupational therapy. (Includes therapies performed in provider's office or non-hospital based facility only)*
Home Health, Skilled Nursing & Hospice	
Durable Medical Equipment	
Vision - Annual Eye Exam	*Any optometrist; member must submit a claim for reimbursement. Copay waived for children under 5 years of age.*
Allergy Treatment Testing and Injections Serum	

GBS *Healthy* Advantage Health Plan

PPO 1000/70

Services	PPO Providers	Non-PPO Providers
Plan Year Deductible	$1,000 per Individual $2,000 per Family	
Coinsurance	Plan Pays 70%	Plan Pays 60%
Out-of-Pocket Maximum	$4,000 per Individual $8,000 per Family	
Preventive Care Provisions	No Deductible, No Copay	No Deductible, No Copay
Professional Outpatient Office Visits		
Primary Care	$20 Copay per visit	$20 Copay then Covered at 60%
Specialist	$40 Copay per visit	$40 Copay then Covered at 60%
Mental Health & Substance Abuse	$40 Copay per visit	$40 Copay then Covered at 60%
Outpatient Diagnostic Tests, Lab & X-Ray	$35 Copay per visit	$35 Copay then Covered at 60%
Inpatient Hospital Services Medical Services and Facility Anesthesiologiest & Surgeon Fees Mental Health & Substance Abuse	70% after Deductible	60% after Deductible
Outpatient Surgical, Diagnostic & Therapies Medical Services Facility Charges	70% after Deductible	60% after Deductible
Emergency Services		
Hospital Emergency Room	$100 Copay per visit	$100 Copay per visit
Urgent Care Visits	$40 Copay per visit	$40 Copay then Covered at 60%
Ambulance	$100 Copay	$100 Copay then Covered at 60%
Prescription Drugs	$0/$30/$60	Not Covered
Short Term Rehabilitation Services	$40 Copay per visit	$40 Copay then Covered at 60%
Home Health, Skilled Nursing & Hospice	70% after Deductible	60% after Deductible
Durable Medical Equipment	70% after Deductible	60% after Deductible
Vision - Annual Eye Exam	$40 Copay per visit	$40 Copay then Covered at 60%
Allergy Treatment		
Testing and Injections	$20 Copay per visit	$20 Copay then Covered at 60%
Serum	$100 Copay	$100 Copay then Covered at 60%

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Coinsurance	*Coinsurance is the share of the costs of a covered service, calculated as a percent of the allowed amount of the service.*
Out-of-Pocket Maximum	*All allowed deductibles, coinsurance, copayments and pre-certification penalties apply to the Out-of-Pocket Maximum. An individual within family coverage will only be required to meet the individual out-of-pocket maximum.*
Preventive Care Provisions	*Charges for preventive care services coverage at no cost sharing. Cost sharing may apply if a specific service is for non-preventive care (even if billed in conjunction with preventive care services).*
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Short Term Rehabilitation Services	*Physical, chiropractic, speech, and occupational therapy. (Includes therapies performed in provider's office or non-hospital based facility only)*
Home Health, Skilled Nursing & Hospice	
Durable Medical Equipment	
Vision - Annual Eye Exam	*Any optometrist; member must submit a claim for reimbursement. Copay waived for children under 5 years of age.*
Allergy Treatment Testing and Injections Serum	

GBS *Healthy* Advantage Health Plan

Services	PPO Providers	Non-PPO Providers
Plan Year Deductible	$2,500 per Individual $5,000 per Family	
Coinsurance	Plan Pays 100%	Plan Pays 90%
Out-of-Pocket Maximum	$4,000 per Individual $8,000 per Family	
Preventive Care Provisions	No Deductible, No Copay	No Deductible, No Copay
Professional Outpatient Office Visits		
Primary Care	$20 Copay per visit	$20 Copay then Covered at 90%
Specialist	$40 Copay per visit	$40 Copay then Covered at 90%
Mental Health & Substance Abuse	$40 Copay per visit	$40 Copay then Covered at 90%
Outpatient Diagnostic Tests, Lab & X-Ray	$35 Copay per visit	$35 Copay then Covered at 90%
Inpatient Hospital Services Medical Services and Facility Anesthesiologiest & Surgeon Fees Mental Health & Substance Abuse	100% after Deductible	90% after Deductible
Outpatient Surgical, Diagnostic & Therapies Medical Services Facility Charges	100% after Deductible	90% after Deductible
Emergency Services		
Hospital Emergency Room	$100 Copay per visit	$100 Copay per visit
Urgent Care Visits	$40 Copay per visit	$40 Copay then Covered at 90%
Ambulance	$100 Copay	$100 Copay then Covered at 90%
Prescription Drugs	$0/$30/$60	Not Covered
Short Term Rehabilitation Services	$40 Copay per visit	$40 Copay then Covered at 90%
Home Health, Skilled Nursing & Hospice	100% after Deductible	90% after Deductible
Durable Medical Equipment	100% after Deductible	90% after Deductible
Vision - Annual Eye Exam	$40 Copay per visit	$40 Copay then Covered at 90%
Allergy Treatment		
Testing and Injections	$20 Copay per visit	$20 Copay then Covered at 90%
Serum	$100 Copay	$100 Copay then Covered at 90%

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Home Health, Skilled Nursing & Hospice	
Durable Medical Equipment	
Vision - Annual Eye Exam	*Any optometrist; member must submit a claim for reimbursement. Copay waived for children under 5 years of age.*
Allergy Treatment Testing and Injections Serum	

GBS *Healthy* Advantage Health Plan
PPO 2000/100

Services	PPO Providers	Non-PPO Providers
Plan Year Deductible	$2,000 per Individual $4,000 per Family	
Coinsurance	Plan Pays 100%	Plan Pays 90%
Out-of-Pocket Maximum	$4,000 per Individual $8,000 per Family	
Preventive Care Provisions	No Deductible, No Copay	No Deductible, No Copay
Professional Outpatient Office Visits		
Primary Care	$20 Copay per visit	$20 Copay then Covered at 90%
Specialist	$40 Copay per visit	$40 Copay then Covered at 90%
Mental Health & Substance Abuse	$40 Copay per visit	$40 Copay then Covered at 90%
Outpatient Diagnostic Tests, Lab & X-Ray	$35 Copay per visit	$35 Copay then Covered at 90%
Inpatient Hospital Services Medical Services and Facility Anesthesiologiest & Surgeon Fees Mental Health & Substance Abuse	100% after Deductible	90% after Deductible
Outpatient Surgical, Diagnostic & Therapies Medical Services Facility Charges	100% after Deductible	90% after Deductible
Emergency Services		
Hospital Emergency Room	$100 Copay per visit	$100 Copay per visit
Urgent Care Visits	$40 Copay per visit	$40 Copay then Covered at 90%
Ambulance	$100 Copay	$100 Copay then Covered at 90%
Prescription Drugs	$0/$30/$60	Not Covered
Short Term Rehabilitation Services	$40 Copay per visit	$40 Copay then Covered at 90%
Home Health, Skilled Nursing & Hospice	100% after Deductible	90% after Deductible
Durable Medical Equipment	100% after Deductible	90% after Deductible
Vision - Annual Eye Exam	$40 Copay per visit	$40 Copay then Covered at 90%
Allergy Treatment		
Testing and Injections	$20 Copay per visit	$20 Copay then Covered at 90%
Serum	$100 Copay	$100 Copay then Covered at 90%

***Network Providers have agreed to accept the Maximum Allowable Charge (MAC) as payment in full.** However, when you receive services from Non-Network providers, you are responsible for any amounts over Medicare-based reimbursement levels. Non-Network providers may charge considerably higher amounts. Therefore, if the billed amount exceeds the Medicare-based allowable charge, your provider may bill you for the difference. It is best to utilize network providers whenever possible. These amounts over the Allowed Charges, while the responsibility of the Covered Person, do not apply toward deductible or out-of-pocket maximums. Please refer to your Summary Plan Description (SPD) for details. **The SPD is the final determination of all benefits.**

Pre-Certification Penalty: Certain procedures or medical care require pre-certification in order to qualify for full benefits.
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HEALTH PLAN OPTIONS

PLEASE REFER TO THE NETWORK PROVIDER* INFORMATION ON THE FRONT PAGE OF THIS SUMMARY OF BENEFITS.

Plan Year Deductible	*An individual within family coverage will only be required to meet the individual deductible amount before the coinsurance begins. Deductible does not apply to Preventive Care Provisions.*
Coinsurance	*Coinsurance is the share of the costs of a covered service, calculated as a percent of the allowed amount of the service.*
Out-of-Pocket Maximum	*All allowed deductibles, coinsurance, copayments and pre-certification penalties apply to the Out-of-Pocket Maximum. An individual within family coverage will only be required to meet the individual out-of-pocket maximum.*
Preventive Care Provisions	*Charges for preventive care services coverage at no cost sharing. Cost sharing may apply if a specific service is for non-preventive care (even if billed in conjunction with preventive care services).*
Professional Outpatient Office Visits Primary Care Specialist Mental Health & Substance Abuse	*These charges are billed by the physician for time spent with the patient. Office visits do not include charges for diagnostic, surgical, or medical procedures performed by the physician or for diagnostic services billed separately.* *Mental Health and Substance Abuse coverage excludes counseling for behavioral disorders.*
Outpatient Diagnostic Tests, Lab & X-Ray	*Includes diagnostic tests performed in a physician's office and billed by such physician or a free-standing non-hospital billed facility only.*
Inpatient Hospital Services Medical Services and Facility Anesthesiologiest & Surgeon Fees Mental Health & Substance Abuse	
Outpatient Surgical, Diagnostic & Therapies Medical Services Facility Charges	*Includes outpatient services, miscellaneous medical procedures & supplies, diagnostic & therapeutic procedures and surgery at a physician's office, freestanding surgery center, or hospital (when approved).*
Emergency Services Hospital Emergency Room Urgent Care Visits Ambulance	*Urgent care visits do not include charges for diagnostic, surgical or medical procedures.*
Prescription Drugs	*If Generics are available and a brand name is purchased, then the covered person must pay the copay PLUS the difference in the cost between the generic and the brand name drug. In the case of the integrated drug plan, the plan will reimburse only up to the cost of the generic equivalent.*
Short Term Rehabilitation Services	*Physical, chiropractic, speech, and occupational therapy. (Includes therapies performed in provider's office or non-hospital based facility only)*
Home Health, Skilled Nursing & Hospice	
Durable Medical Equipment	
Vision - Annual Eye Exam	*Any optometrist; member must submit a claim for reimbursement. Copay waived for children under 5 years of age.*
Allergy Treatment Testing and Injections Serum	

GBS *Healthy* Advantage Health Plan
PPO 2500/80

Services	PPO Providers	Non-PPO Providers
Plan Year Deductible	$2,500 per Individual $5,000 per Family	
Coinsurance	Plan Pays 80%	Plan Pays 70%
Out-of-Pocket Maximum	$4,000 per Individual $8,000 per Family	
Preventive Care Provisions	No Deductible, No Copay	No Deductible, No Copay
Professional Outpatient Office Visits		
Primary Care	$20 Copay per visit	$20 Copay then Covered at 70%
Specialist	$40 Copay per visit	$40 Copay then Covered at 70%
Mental Health & Substance Abuse	$40 Copay per visit	$40 Copay then Covered at 70%
Outpatient Diagnostic Tests, Lab & X-Ray	$35 Copay per visit	$35 Copay then Covered at 70%
Inpatient Hospital Services Medical Services and Facility Anesthesiologist & Surgeon Fees Mental Health & Substance Abuse	80% after Deductible	70% after Deductible
Outpatient Surgical, Diagnostic & Therapies Medical Services Facility Charges	80% after Deductible	70% after Deductible
Emergency Services		
Hospital Emergency Room	$100 Copay per visit	$100 Copay per visit
Urgent Care Visits	$40 Copay per visit	$40 Copay then Covered at 70%
Ambulance	$100 Copay	$100 Copay then Covered at 70%
Prescription Drugs	$0/$30/$60	Not Covered
Short Term Rehabilitation Services	$40 Copay per visit	$40 Copay then Covered at 70%
Home Health, Skilled Nursing & Hospice	80% after Deductible	70% after Deductible
Durable Medical Equipment	80% after Deductible	70% after Deductible
Vision - Annual Eye Exam	$40 Copay per visit	$40 Copay then Covered at 70%
Allergy Treatment		
Testing and Injections	$20 Copay per visit	$20 Copay then Covered at 70%
Serum	$100 Copay	$100 Copay then Covered at 70%

***Network Providers have agreed to accept the Maximum Allowable Charge (MAC) as payment in full.** However, when you receive services from Non-Network providers, you are responsible for any amounts over Medicare-based reimbursement levels. Non-Network providers may charge considerably higher amounts. Therefore, if the billed amount exceeds the Medicare-based allowable charge, your provider may bill you for the difference. It is best to utilize network providers whenever possible. These amounts over the Allowed Charges, while the responsibility of the Covered Person, do not apply toward deductible or out-of-pocket maximums. Please refer to your Summary Plan Description (SPD) for details. **The SPD is the final determination of all benefits.**

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HEALTH PLAN OPTIONS

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Plan Year Deductible	*An individual within family coverage will only be required to meet the individual deductible amount before the coinsurance begins. Deductible does not apply to Preventive Care Provisions.*
Coinsurance	*Coinsurance is the share of the costs of a covered service, calculated as a percent of the allowed amount of the service.*
Out-of-Pocket Maximum	*All allowed deductibles, coinsurance, copayments and pre-certification penalties apply to the Out-of-Pocket Maximum. An individual within family coverage will only be required to meet the individual out-of-pocket maximum.*
Preventive Care Provisions	*Charges for preventive care services coverage at no cost sharing. Cost sharing may apply if a specific service is for non-preventive care (even if billed in conjunction with preventive care services).*
Professional Outpatient Office Visits Primary Care Specialist Mental Health & Substance Abuse	*These charges are billed by the physician for time spent with the patient. Office visits do not include charges for diagnostic, surgical, or medical procedures performed by the physician or for diagnostic services billed separately.* *Mental Health and Substance Abuse coverage excludes counseling for behavioral disorders.*
Outpatient Diagnostic Tests, Lab & X-Ray	*Includes diagnostic tests performed in a physician's office and billed by such physician or a free-standing non-hospital billed facility only.*
Inpatient Hospital Services Medical Services and Facility Anesthesiologiest & Surgeon Fees Mental Health & Substance Abuse	
Outpatient Surgical, Diagnostic & Therapies Medical Services Facility Charges	*Includes outpatient services, miscellaneous medical procedures & supplies, diagnostic & therapeutic procedures and surgery at a physician's office, freestanding surgery center, or hospital (when approved).*
Emergency Services Hospital Emergency Room Urgent Care Visits Ambulance	*Urgent care visits do not include charges for diagnostic, surgical or medical procedures.*
Prescription Drugs	*If Generics are available and a brand name is purchased, then the covered person must pay the copay PLUS the difference in the cost between the generic and the brand name drug. In the case of the integrated drug plan, the plan will reimburse only up to the cost of the generic equivalent.*
Short Term Rehabilitation Services	*Physical, chiropractic, speech, and occupational therapy. (Includes therapies performed in provider's office or non-hospital based facility only)*
Home Health, Skilled Nursing & Hospice	
Durable Medical Equipment	
Vision - Annual Eye Exam	*Any optometrist; member must submit a claim for reimbursement. Copay waived for children under 5 years of age.*
Allergy Treatment Testing and Injections Serum	

GBS *Healthy* Advantage Health Plan

PPO 3000/100 - *Healthy* Solutions

Services	PPO Providers	Non-PPO Providers
Plan Year Deductible	$3,000 per Individual $6,000 per Family	
Coinsurance	Plan Pays 100%	Plan Pays 90%
Out-of-Pocket Maximum	$4,000 per Individual $8,000 per Family	
Preventive Care Provisions	No Deductible, No Copay	No Deductible, No Copay
Professional Outpatient Office Visits		
Primary Care	$25 Copay per visit	$25 Copay then Covered at 90%
Specialist	$40 Copay per visit	$40 Copay then Covered at 90%
Mental Health & Substance Abuse	$40 Copay per visit	$40 Copay then Covered at 90%
Outpatient Diagnostic Tests, Lab & X-Ray	$30 Copay per visit	$30 Copay then Covered at 90%
Inpatient Hospital Services Medical Services and Facility Anesthesiologist & Surgeon Fees Mental Health & Substance Abuse	100% after Deductible	90% after Deductible
Outpatient Surgical, Diagnostic & Therapies Medical Services Facility Charges	100% after Deductible	90% after Deductible
Emergency Services		
Hospital Emergency Room	$40 Copay per visit	$40 Copay per visit
Urgent Care Visits	$20 Copay per visit	$20 Copay then Covered at 90%
Ambulance	$40 Copay	$40 Copay then Covered at 90%
Prescription Drugs	$0/$30/$60	Not Covered
Short Term Rehabilitation Services	$45 Copay per visit	$45 Copay then Covered at 90%
Home Health, Skilled Nursing & Hospice	100% after Deductible	90% after Deductible
Durable Medical Equipment	100% after Deductible	90% after Deductible
Vision - Annual Eye Exam	$40 Copay per visit	$40 Copay then Covered at 90%
Allergy Treatment		
Testing and Injections	$25 Copay per visit	$25 Copay then Covered at 90%
Serum	$100 Copay	$100 Copay then Covered at 90%

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HEALTH PLAN OPTIONS

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Plan Year Deductible	*An individual within family coverage will only be required to meet the individual deductible amount before the coinsurance begins. Deductible does not apply to Preventive Care Provisions.*
Coinsurance	*Coinsurance is the share of the costs of a covered service, calculated as a percent of the allowed amount of the service.*
Out-of-Pocket Maximum	*All allowed deductibles, coinsurance, copayments and pre-certification penalties apply to the Out-of-Pocket Maximum. An individual within family coverage will only be required to meet the individual out-of-pocket maximum.*
Preventive Care Provisions	*Charges for preventive care services coverage at no cost sharing. Cost sharing may apply if a specific service is for non-preventive care (even if billed in conjunction with preventive care services).*
Professional Outpatient Office Visits Primary Care Specialist Mental Health & Substance Abuse	*These charges are billed by the physician for time spent with the patient. Office visits do not include charges for diagnostic, surgical, or medical procedures performed by the physician or for diagnostic services billed separately.* *Mental Health and Substance Abuse coverage excludes counseling for behavioral disorders.*
Outpatient Diagnostic Tests, Lab & X-Ray	*Includes diagnostic tests performed in a physician's office and billed by such physician or a free-standing non-hospital billed facility only.*
Inpatient Hospital Services Medical Services and Facility Anesthesiologiest & Surgeon Fees Mental Health & Substance Abuse	
Outpatient Surgical, Diagnostic & Therapies Medical Services Facility Charges	*Includes outpatient services, miscellaneous medical procedures & supplies, diagnostic & therapeutic procedures and surgery at a physician's office, freestanding surgery center, or hospital (when approved).*
Emergency Services Hospital Emergency Room Urgent Care Visits Ambulance	*Urgent care visits do not include charges for diagnostic, surgical or medical procedures.*
Prescription Drugs	*If Generics are available and a brand name is purchased, then the covered person must pay the copay PLUS the difference in the cost between the generic and the brand name drug. In the case of the integrated drug plan, the plan will reimburse only up to the cost of the generic equivalent.*
Short Term Rehabilitation Services	*Physical, chiropractic, speech, and occupational therapy. (Includes therapies performed in provider's office or non-hospital based facility only)*
Home Health, Skilled Nursing & Hospice	
Durable Medical Equipment	
Vision - Annual Eye Exam	*Any optometrist; member must submit a claim for reimbursement. Copay waived for children under 5 years of age.*
Allergy Treatment Testing and Injections Serum	

GBS *Healthy* Advantage Health Plan

PPO 3500/100

Services	PPO Providers	Non-PPO Providers
Plan Year Deductible	$3,500 per Individual $7,000 per Family	
Coinsurance	Plan Pays 100%	Plan Pays 90%
Out-of-Pocket Maximum	$5,000 per Individual $10,000 per Family	
Preventive Care Provisions	No Deductible, No Copay	No Deductible, No Copay
Professional Outpatient Office Visits		
Primary Care	$20 Copay per visit	$20 Copay then Covered at 90%
Specialist	$40 Copay per visit	$40 Copay then Covered at 90%
Mental Health & Substance Abuse	$40 Copay per visit	$40 Copay then Covered at 90%
Outpatient Diagnostic Tests, Lab & X-Ray	$35 Copay per visit	$35 Copay then Covered at 90%
Inpatient Hospital Services Medical Services and Facility Anesthesiologiest & Surgeon Fees Mental Health & Substance Abuse	100% after Deductible	90% after Deductible
Outpatient Surgical, Diagnostic & Therapies Medical Services Facility Charges	100% after Deductible	90% after Deductible
Emergency Services		
Hospital Emergency Room	$100 Copay per visit	$100 Copay per visit
Urgent Care Visits	$40 Copay per visit	$40 Copay then Covered at 90%
Ambulance	$100 Copay	$100 Copay then Covered at 90%
Prescription Drugs	$0/$30/$60	Not Covered
Short Term Rehabilitation Services	$40 Copay per visit	$40 Copay then Covered at 90%
Home Health, Skilled Nursing & Hospice	100% after Deductible	90% after Deductible
Durable Medical Equipment	100% after Deductible	90% after Deductible
Vision - Annual Eye Exam	$40 Copay per visit	$40 Copay then Covered at 90%
Allergy Treatment		
Testing and Injections	$20 Copay per visit	$20 Copay then Covered at 90%
Serum	$100 Copay	$100 Copay then Covered at 90%

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HEALTH PLAN OPTIONS

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Coinsurance	*Coinsurance is the share of the costs of a covered service, calculated as a percent of the allowed amount of the service.*
Out-of-Pocket Maximum	*All allowed deductibles, coinsurance, copayments and pre-certification penalties apply to the Out-of-Pocket Maximum. An individual within family coverage will only be required to meet the individual out-of-pocket maximum.*
Preventive Care Provisions	*Charges for preventive care services coverage at no cost sharing. Cost sharing may apply if a specific service is for non-preventive care (even if billed in conjunction with preventive care services).*
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Emergency Services Hospital Emergency Room Urgent Care Visits Ambulance	*Urgent care visits do not include charges for diagnostic, surgical or medical procedures.*
Prescription Drugs	*If Generics are available and a brand name is purchased, then the covered person must pay the copay PLUS the difference in the cost between the generic and the brand name drug. In the case of the integrated drug plan, the plan will reimburse only up to the cost of the generic equivalent.*
Short Term Rehabilitation Services	*Physical, chiropractic, speech, and occupational therapy. (Includes therapies performed in provider's office or non-hospital based facility only)*
Home Health, Skilled Nursing & Hospice	
Durable Medical Equipment	
Vision - Annual Eye Exam	*Any optometrist; member must submit a claim for reimbursement. Copay waived for children under 5 years of age.*
Allergy Treatment Testing and Injections Serum	

GBS *Healthy* Advantage Health Plan

PPO 3500/80

Services	PPO Providers	Non-PPO Providers
Plan Year Deductible	$3,500 per Individual $7,000 per Family	
Coinsurance	Plan Pays 80%	Plan Pays 70%
Out-of-Pocket Maximum	$5,000 per Individual $10,000 per Family	
Preventive Care Provisions	No Deductible, No Copay	No Deductible, No Copay
Professional Outpatient Office Visits		
Primary Care	$20 Copay per visit	$20 Copay then Covered at 70%
Specialist	$40 Copay per visit	$40 Copay then Covered at 70%
Mental Health & Substance Abuse	$40 Copay per visit	$40 Copay then Covered at 70%
Outpatient Diagnostic Tests, Lab & X-Ray	$35 Copay per visit	$35 Copay then Covered at 70%
Inpatient Hospital Services Medical Services and Facility Anesthesiologiest & Surgeon Fees Mental Health & Substance Abuse	80% after Deductible	70% after Deductible
Outpatient Surgical, Diagnostic & Therapies Medical Services Facility Charges	80% after Deductible	70% after Deductible
Emergency Services		
Hospital Emergency Room	$100 Copay per visit	$100 Copay per visit
Urgent Care Visits	$40 Copay per visit	$40 Copay then Covered at 70%
Ambulance	$100 Copay	$100 Copay then Covered at 70%
Prescription Drugs	$0/$30/$60	Not Covered
Short Term Rehabilitation Services	$40 Copay per visit	$40 Copay then Covered at 70%
Home Health, Skilled Nursing & Hospice	80% after Deductible	70% after Deductible
Durable Medical Equipment	80% after Deductible	70% after Deductible
Vision - Annual Eye Exam	$40 Copay per visit	$40 Copay then Covered at 70%
Allergy Treatment		
Testing and Injections	$20 Copay per visit	$20 Copay then Covered at 70%
Serum	$100 Copay	$100 Copay then Covered at 70%

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HEALTH PLAN OPTIONS

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Coinsurance	*Coinsurance is the share of the costs of a covered service, calculated as a percent of the allowed amount of the service.*
Out-of-Pocket Maximum	*All allowed deductibles, coinsurance, copayments and pre-certification penalties apply to the Out-of-Pocket Maximum. An individual within family coverage will only be required to meet the individual out-of-pocket maximum.*
Preventive Care Provisions	*Charges for preventive care services coverage at no cost sharing. Cost sharing may apply if a specific service is for non-preventive care (even if billed in conjunction with preventive care services).*
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Outpatient Surgical, Diagnostic & Therapies Medical Services Facility Charges	*Includes outpatient services, miscellaneous medical procedures & supplies, diagnostic & therapeutic procedures and surgery at a physician's office, freestanding surgery center, or hospital (when approved).*
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Short Term Rehabilitation Services	*Physical, chiropractic, speech, and occupational therapy. (Includes therapies performed in provider's office or non-hospital based facility only)*
Home Health, Skilled Nursing & Hospice	
Durable Medical Equipment	
Vision - Annual Eye Exam	*Any optometrist; member must submit a claim for reimbursement. Copay waived for children under 5 years of age.*
Allergy Treatment Testing and Injections Serum	

GBS *Healthy* Advantage Health Plan

PPO 4000/100

Services	PPO Providers	Non-PPO Providers
Plan Year Deductible	$4,000 per Individual $8,000 per Family	
Coinsurance	Plan Pays 100%	Plan Pays 90%
Out-of-Pocket Maximum	$5,000 per Individual $10,000 per Family	
Preventive Care Provisions	No Deductible, No Copay	No Deductible, No Copay
Professional Outpatient Office Visits		
Primary Care	$20 Copay per visit	$20 Copay then Covered at 90%
Specialist	$40 Copay per visit	$40 Copay then Covered at 90%
Mental Health & Substance Abuse	$40 Copay per visit	$40 Copay then Covered at 90%
Outpatient Diagnostic Tests, Lab & X-Ray	$35 Copay per visit	$35 Copay then Covered at 90%
Inpatient Hospital Services Medical Services and Facility Anesthesiologiest & Surgeon Fees Mental Health & Substance Abuse	100% after Deductible	90% after Deductible
Outpatient Surgical, Diagnostic & Therapies Medical Services Facility Charges	100% after Deductible	90% after Deductible
Emergency Services		
Hospital Emergency Room	$100 Copay per visit	$100 Copay per visit
Urgent Care Visits	$40 Copay per visit	$40 Copay then Covered at 90%
Ambulance	$100 Copay	$100 Copay then Covered at 90%
Prescription Drugs	$0/$30/$60	Not Covered
Short Term Rehabilitation Services	$40 Copay per visit	$40 Copay then Covered at 90%
Home Health, Skilled Nursing & Hospice	100% after Deductible	90% after Deductible
Durable Medical Equipment	100% after Deductible	90% after Deductible
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Allergy Treatment		
Testing and Injections	$20 Copay per visit	$20 Copay then Covered at 90%
Serum	$100 Copay	$100 Copay then Covered at 90%

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Coinsurance	*Coinsurance is the share of the costs of a covered service, calculated as a percent of the allowed amount of the service.*
Out-of-Pocket Maximum	*All allowed deductibles, coinsurance, copayments and pre-certification penalties apply to the Out-of-Pocket Maximum. An individual within family coverage will only be required to meet the individual out-of-pocket maximum.*
Preventive Care Provisions	*Charges for preventive care services coverage at no cost sharing. Cost sharing may apply if a specific service is for non-preventive care (even if billed in conjunction with preventive care services).*
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Short Term Rehabilitation Services	*Physical, chiropractic, speech, and occupational therapy. (Includes therapies performed in provider's office or non-hospital based facility only)*
Home Health, Skilled Nursing & Hospice	
Durable Medical Equipment	
Vision - Annual Eye Exam	*Any optometrist; member must submit a claim for reimbursement. Copay waived for children under 5 years of age.*
Allergy Treatment Testing and Injections Serum	

GBS *Healthy* Advantage Health Plan

PPO 5000/100

Services	PPO Providers	Non-PPO Providers
Plan Year Deductible	$5,000 per Individual $10,000 per Family	
Coinsurance	Plan Pays 100%	Plan Pays 90%
Out-of-Pocket Maximum	$6,850 per Individual $13,700 per Family	
Preventive Care Provisions	No Deductible, No Copay	No Deductible, No Copay
Professional Outpatient Office Visits		
Primary Care	$20 Copay per visit	$20 Copay then Covered at 90%
Specialist	$40 Copay per visit	$40 Copay then Covered at 90%
Mental Health & Substance Abuse	$40 Copay per visit	$40 Copay then Covered at 90%
Outpatient Diagnostic Tests, Lab & X-Ray	$35 Copay per visit	$35 Copay then Covered at 90%
Inpatient Hospital Services Medical Services and Facility Anesthesiologiest & Surgeon Fees Mental Health & Substance Abuse	100% after Deductible	90% after Deductible
Outpatient Surgical, Diagnostic & Therapies Medical Services Facility Charges	100% after Deductible	90% after Deductible
Emergency Services		
Hospital Emergency Room	$100 Copay per visit	$100 Copay per visit
Urgent Care Visits	$40 Copay per visit	$40 Copay then Covered at 90%
Ambulance	$100 Copay	$100 Copay then Covered at 90%
Prescription Drugs	$0/$30/$60	Not Covered
Short Term Rehabilitation Services	$40 Copay per visit	$40 Copay then Covered at 90%
Home Health, Skilled Nursing & Hospice	100% after Deductible	90% after Deductible
Durable Medical Equipment	100% after Deductible	90% after Deductible
Vision - Annual Eye Exam	$40 Copay per visit	$40 Copay then Covered at 90%
Allergy Treatment		
Testing and Injections	$20 Copay per visit	$20 Copay then Covered at 90%
Serum	$100 Copay	$100 Copay then Covered at 90%

***Network Providers have agreed to accept the Maximum Allowable Charge (MAC) as payment in full.** However, when you receive services from Non-Network providers, you are responsible for any amounts over Medicare-based reimbursement levels. Non-Network providers may charge considerably higher amounts. Therefore, if the billed amount exceeds the Medicare-based allowable charge, your provider may bill you for the difference. It is best to utilize network providers whenever possible. These amounts over the Allowed Charges, while the responsibility of the Covered Person, do not apply toward deductible or out-of-pocket maximums. Please refer to your Summary Plan Description (SPD) for details. **The SPD is the final determination of all benefits.**

Pre-Certification Penalty: Certain procedures or medical care require pre-certification in order to qualify for full benefits.
Failure to pre-certify will result in a $250 penalty per service, procedure or confinement. Please refer to the Pre-Certification section in your SPD for details.
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HEALTH PLAN OPTIONS

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Plan Year Deductible	*An individual within family coverage will only be required to meet the individual deductible amount before the coinsurance begins. Deductible does not apply to Preventive Care Provisions.*
Coinsurance	*Coinsurance is the share of the costs of a covered service, calculated as a percent of the allowed amount of the service.*
Out-of-Pocket Maximum	*All allowed deductibles, coinsurance, copayments and pre-certification penalties apply to the Out-of-Pocket Maximum. An individual within family coverage will only be required to meet the individual out-of-pocket maximum.*
Preventive Care Provisions	*Charges for preventive care services coverage at no cost sharing. Cost sharing may apply if a specific service is for non-preventive care (even if billed in conjunction with preventive care services).*
Professional Outpatient Office Visits Primary Care Specialist Mental Health & Substance Abuse	*These charges are billed by the physician for time spent with the patient. Office visits do not include charges for diagnostic, surgical, or medical procedures performed by the physician or for diagnostic services billed separately.* *Mental Health and Substance Abuse coverage excludes counseling for behavioral disorders.*
Outpatient Diagnostic Tests, Lab & X-Ray	*Includes diagnostic tests performed in a physician's office and billed by such physician or a free-standing non-hospital billed facility only.*
Inpatient Hospital Services Medical Services and Facility Anesthesiologiest & Surgeon Fees Mental Health & Substance Abuse	
Outpatient Surgical, Diagnostic & Therapies Medical Services Facility Charges	*Includes outpatient services, miscellaneous medical procedures & supplies, diagnostic & therapeutic procedures and surgery at a physician's office, freestanding surgery center, or hospital (when approved).*
Emergency Services Hospital Emergency Room Urgent Care Visits Ambulance	*Urgent care visits do not include charges for diagnostic, surgical or medical procedures.*
Prescription Drugs	*If Generics are available and a brand name is purchased, then the covered person must pay the copay PLUS the difference in the cost between the generic and the brand name drug. In the case of the integrated drug plan, the plan will reimburse only up to the cost of the generic equivalent.*
Short Term Rehabilitation Services	*Physical, chiropractic, speech, and occupational therapy. (Includes therapies performed in provider's office or non-hospital based facility only)*
Home Health, Skilled Nursing & Hospice	
Durable Medical Equipment	
Vision - Annual Eye Exam	*Any optometrist; member must submit a claim for reimbursement. Copay waived for children under 5 years of age.*
Allergy Treatment Testing and Injections Serum	

GBS *Healthy* Advantage Health Plan

PPO 6350/100

Services	PPO Providers	Non-PPO Providers
Plan Year Deductible	$6,350 per Individual $12,700 per Family	
Coinsurance	Plan Pays 100%	Plan Pays 60%
Out-of-Pocket Maximum	$6,850 per Individual $13,700 per Family	
Preventive Care Provisions	No Deductible, No Copay	No Deductible, No Copay
Professional Outpatient Office Visits		
Primary Care	$30 Copay per visit	$30 Copay then Covered at 60%
Specialist	$60 Copay per visit	$60 Copay then Covered at 60%
Mental Health & Substance Abuse	$60 Copay per visit	$60 Copay then Covered at 60%
Outpatient Diagnostic Tests, Lab & X-Ray	$35 Copay per visit	$35 Copay then Covered at 60%
Inpatient Hospital Services Medical Services and Facility Anesthesiologiest & Surgeon Fees Mental Health & Substance Abuse	100% after Deductible	60% after Deductible
Outpatient Surgical, Diagnostic & Therapies Medical Services Facility Charges	100% after Deductible	60% after Deductible
Emergency Services		
Hospital Emergency Room	$300 Copay per visit	$300 Copay per visit
Urgent Care Visits	$60 Copay per visit	$60 Copay then Covered at 60%
Ambulance	$300 Copay	$300 Copay then Covered at 60%
Prescription Drugs	$0/$40/$70	Not Covered
Short Term Rehabilitation Services	$60 Copay per visit	$60 Copay then Covered at 60%
Home Health, Skilled Nursing & Hospice	100% after Deductible	60% after Deductible
Durable Medical Equipment	100% after Deductible	60% after Deductible
Vision - Annual Eye Exam	$30 Copay per visit	$30 Copay then Covered at 60%
Allergy Treatment		
Testing and Injections	$30 Copay per visit	$30 Copay then Covered at 60%
Serum	$100 Copay	$100 Copay then Covered at 60%

***Network Providers have agreed to accept the Maximum Allowable Charge (MAC) as payment in full.** However, when you receive services from Non-Network providers, you are responsible for any amounts over Medicare-based reimbursement levels. Non-Network providers may charge considerably higher amounts. Therefore, if the billed amount exceeds the Medicare-based allowable charge, your provider may bill you for the difference. It is best to utilize network providers whenever possible. These amounts over the Allowed Charges, while the responsibility of the Covered Person, do not apply toward deductible or out-of-pocket maximums. Please refer to your Summary Plan Description (SPD) for details. **The SPD is the final determination of all benefits.**

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HEALTH PLAN OPTIONS

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Plan Year Deductible	*An individual within family coverage will only be required to meet the individual deductible amount before the coinsurance begins. Deductible does not apply to Preventive Care Provisions.*
Coinsurance	*Coinsurance is the share of the costs of a covered service, calculated as a percent of the allowed amount of the service.*
Out-of-Pocket Maximum	*All allowed deductibles, coinsurance, copayments and pre-certification penalties apply to the Out-of-Pocket Maximum. An individual within family coverage will only be required to meet the individual out-of-pocket maximum.*
Preventive Care Provisions	*Charges for preventive care services coverage at no cost sharing. Cost sharing may apply if a specific service is for non-preventive care (even if billed in conjunction with preventive care services).*
Professional Outpatient Office Visits Primary Care Specialist Mental Health & Substance Abuse	*These charges are billed by the physician for time spent with the patient. Office visits do not include charges for diagnostic, surgical, or medical procedures performed by the physician or for diagnostic services billed separately.* *Mental Health and Substance Abuse coverage excludes counseling for behavioral disorders.*
Outpatient Diagnostic Tests, Lab & X-Ray	*Includes diagnostic tests performed in a physician's office and billed by such physician or a free-standing non-hospital billed facility only.*
Inpatient Hospital Services Medical Services and Facility Anesthesiologiest & Surgeon Fees Mental Health & Substance Abuse	
Outpatient Surgical, Diagnostic & Therapies Medical Services Facility Charges	*Includes outpatient services, miscellaneous medical procedures & supplies, diagnostic & therapeutic procedures and surgery at a physician's office, freestanding surgery center, or hospital (when approved).*
Emergency Services Hospital Emergency Room Urgent Care Visits Ambulance	*Urgent care visits do not include charges for diagnostic, surgical or medical procedures.*
Prescription Drugs	*If Generics are available and a brand name is purchased, then the covered person must pay the copay PLUS the difference in the cost between the generic and the brand name drug. In the case of the integrated drug plan, the plan will reimburse only up to the cost of the generic equivalent.*
Short Term Rehabilitation Services	*Physical, chiropractic, speech, and occupational therapy. (Includes therapies performed in provider's office or non-hospital based facility only)*
Home Health, Skilled Nursing & Hospice	
Durable Medical Equipment	
Vision - Annual Eye Exam	*Any optometrist; member must submit a claim for reimbursement. Copay waived for children under 5 years of age.*
Allergy Treatment Testing and Injections Serum	

GBS *Healthy* Advantage Health Plan

QHDHP 1500/100

Services	PPO Providers	Non-PPO Providers
Plan Year Deductible	$1,500 per Individual $3,000 per Family	
Coinsurance	Plan Pays 100%	Plan Pays 90%
Out-of-Pocket Maximum	$3,600 per Individual $7,200 per Family	
Preventive Care Provisions	No Deductible, No Copay	No Deductible, No Copay
Professional Outpatient Office Visits	**Deductible then;**	**Deductible then;**
Primary Care	$20 Copay then 100%	$20 Copay then 90%
Specialist	$40 Copay then 100%	$40 Copay then 90%
Mental Health & Substance Abuse	$40 Copay then 100%	$40 Copay then 90%
Outpatient Diagnostic Tests, Lab & X-Ray	Deductible then $20 Copay	Deductible, $20 Copay then 90%
Inpatient Hospital Services	**Deductible then;**	**Deductible then;**
Medical Services and Facility	$250 Copay then 100%	$250 Copay then 90%
Anesthesiologist & Surgeon Fees	$40 Copay then 100%	$40 Copay then 90%
Mental Health & Substance Abuse	$250 Copay then 100%	$250 Copay then 90%
Outpatient Surgical, Diagnostic & Therapies	**Deductible then;**	**Deductible then;**
Medical Services	$40 Copay then 100%	$40 Copay then 90%
Facility Charges	$40 Copay then 100%	$40 Copay then 90%
Emergency Services	**Deductible then;**	**Deductible then;**
Hospital Emergency Room	$250 Copay then 100%	$250 Copay then 100%
Urgent Care Visits	$20 Copay then 100%	$20 Copay then 90%
Ambulance	$40 Copay then 100%	$40 Copay then 90%
Prescription Drugs	Deductible then $0/$30/$60	Not Covered
Short Term Rehabilitation Services	Deductible then $40 Copay	Deductible, $40 Copay then 90%
Home Health, Skilled Nursing & Hospice	Deductible then $40 Copay	Deductible, $40 Copay then 90%
Durable Medical Equipment	Deductible then 100%	Deductible then 90%
Vision - Annual Eye Exam	Deductible then $40 Copay	Deductible, $40 Copay then 90%
Allergy Treatment	**Deductible then;**	**Deductible then;**
Testing and Injections	$20 Copay then 100%	$20 Copay then 90%
Serum	$100 Copay then 100%	$100 Copay then 90%

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HEALTH PLAN OPTIONS

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Plan Year Deductible	*An individual within family coverage will be required to meet the family deductible amount before the coinsurance begins. Deductible does not apply to Preventive Care Provisions.*
Coinsurance	*Coinsurance is the share of the costs of a covered service, calculated as a percent of the allowed amount of the service.*
Out-of-Pocket Maximum	*All allowed deductibles, coinsurance, copayments and pre-certification penalties apply to the Out-of-Pocket Maximum. An individual within family coverage will be required to meet the family out-of-pocket maximum.*
Preventive Care Provisions	*Charges for preventive care services coverage at no cost sharing. Cost sharing may apply if a specific service is for non-preventive care (even if billed in conjunction with preventive care services).*
Professional Outpatient Office Visits Primary Care Specialist Mental Health & Substance Abuse	*These charges are billed by the physician for time spent with the patient. Office visits do not include charges for diagnostic, surgical, or medical procedures performed by the physician or for diagnostic services billed separately.* *Mental Health and Substance Abuse coverage excludes counseling for behavioral disorders.*
Outpatient Diagnostic Tests, Lab & X-Ray	*Includes diagnostic tests performed in a physician's office and billed by such physician or a free-standing non-hospital billed facility only.*
Inpatient Hospital Services Medical Services and Facility Anesthesiologiest & Surgeon Fees Mental Health & Substance Abuse	
Outpatient Surgical, Diagnostic & Therapies Medical Services Facility Charges	*Includes outpatient services, miscellaneous medical procedures & supplies, diagnostic & therapeutic procedures and surgery at a physician's office, freestanding surgery center, or hospital (when approved).*
Emergency Services Hospital Emergency Room Urgent Care Visits Ambulance	*Urgent care visits do not include charges for diagnostic, surgical or medical procedures.*
Prescription Drugs	*If Generics are available and a brand name is purchased, then the covered person must pay the copay PLUS the difference in the cost between the generic and the brand name drug. In the case of the integrated drug plan, the plan will reimburse only up to the cost of the generic equivalent.*
Short Term Rehabilitation Services	*Physical, chiropractic, speech, and occupational therapy. (Includes therapies performed in provider's office or non-hospital based facility only)*
Home Health, Skilled Nursing & Hospice	
Durable Medical Equipment	
Vision - Annual Eye Exam	*Any optometrist; member must submit a claim for reimbursement. Copay waived for children under 5 years of age.*
Allergy Treatment Testing and Injections Serum	

GBS *Healthy* Advantage Health Plan
QHDHP 2600/100

Services	PPO Providers	Non-PPO Providers
Plan Year Deductible	$2,600 per Individual $5,200 per Family	
Coinsurance	Plan Pays 100%	Plan Pays 90%
Out-of-Pocket Maximum	$3,600 per Individual $6,200 per Family	
Preventive Care Provisions	No Deductible, No Copay	No Deductible, No Copay
Professional Outpatient Office Visits Primary Care Specialist Mental Health & Substance Abuse	100% after Deductible	90% after Deductible
Outpatient Diagnostic Tests, Lab & X-Ray	100% after Deductible	90% after Deductible
Inpatient Hospital Services Medical Services and Facility Anesthesiologiest & Surgeon Fees Mental Health & Substance Abuse	100% after Deductible	90% after Deductible
Outpatient Surgical, Diagnostic & Therapies Medical Services Facility Charges	100% after Deductible	90% after Deductible
Emergency Services Hospital Emergency Room Urgent Care Visits Ambulance	 100% after Deductible 100% after Deductible 100% after Deductible	 100% after Deductible 90% after Deductible 90% after Deductible
Prescription Drugs	100% after Deductible	Not Covered
Short Term Rehabilitation Services	100% after Deductible	90% after Deductible
Home Health, Skilled Nursing & Hospice	100% after Deductible	90% after Deductible
Durable Medical Equipment	100% after Deductible	90% after Deductible
Vision - Annual Eye Exam	100% after Deductible	90% after Deductible
Allergy Treatment Testing and Injections Serum	100% after Deductible	90% after Deductible

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HEALTH PLAN OPTIONS

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Plan Year Deductible	*An individual within family coverage will only be required to meet the individual deductible amount before the coinsurance begins. Deductible does not apply to Preventive Care Provisions.*
Coinsurance	*Coinsurance is the share of the costs of a covered service, calculated as a percent of the allowed amount of the service.*
Out-of-Pocket Maximum	*All allowed deductibles, coinsurance, copayments and pre-certification penalties apply to the Out-of-Pocket Maximum. An individual within family coverage will only be required to meet the individual out-of-pocket maximum.*
Preventive Care Provisions	*Charges for preventive care services coverage at no cost sharing. Cost sharing may apply if a specific service is for non-preventive care (even if billed in conjunction with preventive care services).*
Professional Outpatient Office Visits Primary Care Specialist Mental Health & Substance Abuse	*These charges are billed by the physician for time spent with the patient. Office visits do not include charges for diagnostic, surgical, or medical procedures performed by the physician or for diagnostic services billed separately.* *Mental Health and Substance Abuse coverage excludes counseling for behavioral disorders.*
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Inpatient Hospital Services Medical Services and Facility Anesthesiologiest & Surgeon Fees Mental Health & Substance Abuse	
Outpatient Surgical, Diagnostic & Therapies Medical Services Facility Charges	*Includes outpatient services, miscellaneous medical procedures & supplies, diagnostic & therapeutic procedures and surgery at a physician's office, freestanding surgery center, or hospital (when approved).*
Emergency Services Hospital Emergency Room Urgent Care Visits Ambulance	*Urgent care visits do not include charges for diagnostic, surgical or medical procedures.*
Prescription Drugs	*If Generics are available and a brand name is purchased, then the covered person must pay the copay PLUS the difference in the cost between the generic and the brand name drug. In the case of the integrated drug plan, the plan will reimburse only up to the cost of the generic equivalent.*
Short Term Rehabilitation Services	*Physical, chiropractic, speech, and occupational therapy. (Includes therapies performed in provider's office or non-hospital based facility only)*
Home Health, Skilled Nursing & Hospice	
Durable Medical Equipment	
Vision - Annual Eye Exam	*Any optometrist; member must submit a claim for reimbursement. Copay waived for children under 5 years of age.*
Allergy Treatment Testing and Injections Serum	

GBS *Healthy* Advantage Health Plan

QHDHP 2600/80

Services	PPO Providers	Non-PPO Providers
Plan Year Deductible	$2,600 per Individual $5,200 per Family	
Coinsurance	Plan Pays 80%	Plan Pays 70%
Out-of-Pocket Maximum	$5,000 per Individual $10,000 per Family	
Preventive Care Provisions	No Deductible, No Copay	No Deductible, No Copay
Professional Outpatient Office Visits Primary Care Specialist Mental Health & Substance Abuse	80% after Deductible	70% after Deductible
Outpatient Diagnostic Tests, Lab & X-Ray	80% after Deductible	70% after Deductible
Inpatient Hospital Services Medical Services and Facility Anesthesiologiest & Surgeon Fees Mental Health & Substance Abuse	80% after Deductible	70% after Deductible
Outpatient Surgical, Diagnostic & Therapies Medical Services Facility Charges	80% after Deductible	70% after Deductible
Emergency Services		
Hospital Emergency Room	80% after Deductible	80% after Deductible
Urgent Care Visits	80% after Deductible	70% after Deductible
Ambulance	80% after Deductible	70% after Deductible
Prescription Drugs	80% after Deductible	Not Covered
Short Term Rehabilitation Services	80% after Deductible	70% after Deductible
Home Health, Skilled Nursing & Hospice	80% after Deductible	70% after Deductible
Durable Medical Equipment	80% after Deductible	70% after Deductible
Vision - Annual Eye Exam	80% after Deductible	70% after Deductible
Allergy Treatment Testing and Injections Serum	80% after Deductible	70% after Deductible

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Coinsurance	*Coinsurance is the share of the costs of a covered service, calculated as a percent of the allowed amount of the service.*
Out-of-Pocket Maximum	*All allowed deductibles, coinsurance, copayments and pre-certification penalties apply to the Out-of-Pocket Maximum. An individual within family coverage will only be required to meet the individual out-of-pocket maximum.*
Preventive Care Provisions	*Charges for preventive care services coverage at no cost sharing. Cost sharing may apply if a specific service is for non-preventive care (even if billed in conjunction with preventive care services).*
Professional Outpatient Office Visits Primary Care Specialist Mental Health & Substance Abuse	*These charges are billed by the physician for time spent with the patient. Office visits do not include charges for diagnostic, surgical, or medical procedures performed by the physician or for diagnostic services billed separately.* *Mental Health and Substance Abuse coverage excludes counseling for behavioral disorders.*
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Home Health, Skilled Nursing & Hospice	
Durable Medical Equipment	
Vision - Annual Eye Exam	*Any optometrist; member must submit a claim for reimbursement. Copay waived for children under 5 years of age.*
Allergy Treatment Testing and Injections Serum	

GBS *Healthy* Advantage Health Plan

QHDHP 3500/100

Services	PPO Providers	Non-PPO Providers
Plan Year Deductible	$3,500 per Individual $7,000 per Family	
Coinsurance	Plan Pays 100%	Plan Pays 90%
Out-of-Pocket Maximum	$4,500 per Individual $8,000 per Family	
Preventive Care Provisions	No Deductible, No Copay	No Deductible, No Copay
Professional Outpatient Office Visits Primary Care Specialist Mental Health & Substance Abuse	100% after Deductible	90% after Deductible
Outpatient Diagnostic Tests, Lab & X-Ray	100% after Deductible	90% after Deductible
Inpatient Hospital Services Medical Services and Facility Anesthesiologiest & Surgeon Fees Mental Health & Substance Abuse	100% after Deductible	90% after Deductible
Outpatient Surgical, Diagnostic & Therapies Medical Services Facility Charges	100% after Deductible	90% after Deductible
Emergency Services Hospital Emergency Room Urgent Care Visits Ambulance	 100% after Deductible 100% after Deductible 100% after Deductible	 100% after Deductible 90% after Deductible 90% after Deductible
Prescription Drugs	100% after Deductible	Not Covered
Short Term Rehabilitation Services	100% after Deductible	90% after Deductible
Home Health, Skilled Nursing & Hospice	100% after Deductible	90% after Deductible
Durable Medical Equipment	100% after Deductible	90% after Deductible
Vision - Annual Eye Exam	100% after Deductible	90% after Deductible
Allergy Treatment Testing and Injections Serum	100% after Deductible	90% after Deductible

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HEALTH PLAN OPTIONS

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Coinsurance	*Coinsurance is the share of the costs of a covered service, calculated as a percent of the allowed amount of the service.*
Out-of-Pocket Maximum	*All allowed deductibles, coinsurance, copayments and pre-certification penalties apply to the Out-of-Pocket Maximum. An individual within family coverage will only be required to meet the individual out-of-pocket maximum.*
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Outpatient Diagnostic Tests, Lab & X-Ray	*Includes diagnostic tests performed in a physician's office and billed by such physician or a free-standing non-hospital billed facility only.*
Inpatient Hospital Services Medical Services and Facility Anesthesiologiest & Surgeon Fees Mental Health & Substance Abuse	
Outpatient Surgical, Diagnostic & Therapies Medical Services Facility Charges	*Includes outpatient services, miscellaneous medical procedures & supplies, diagnostic & therapeutic procedures and surgery at a physician's office, freestanding surgery center, or hospital (when approved).*
Emergency Services Hospital Emergency Room Urgent Care Visits Ambulance	*Urgent care visits do not include charges for diagnostic, surgical or medical procedures.*
Prescription Drugs	*If Generics are available and a brand name is purchased, then the covered person must pay the copay PLUS the difference in the cost between the generic and the brand name drug. In the case of the integrated drug plan, the plan will reimburse only up to the cost of the generic equivalent.*
Short Term Rehabilitation Services	*Physical, chiropractic, speech, and occupational therapy. (Includes therapies performed in provider's office or non-hospital based facility only)*
Home Health, Skilled Nursing & Hospice	
Durable Medical Equipment	
Vision - Annual Eye Exam	*Any optometrist; member must submit a claim for reimbursement. Copay waived for children under 5 years of age.*
Allergy Treatment Testing and Injections Serum	

GBS *Healthy* Advantage Health Plan

QHDHP 4000/70

Services	PPO Providers	Non-PPO Providers
Plan Year Deductible	$4,000 per Individual $8,000 per Family	
Coinsurance	Plan Pays 70%	Plan Pays 60%
Out-of-Pocket Maximum	$6,550 per Individual $13,100 per Family	
Preventive Care Provisions	No Deductible, No Copay	No Deductible, No Copay
Professional Outpatient Office Visits Primary Care Specialist Mental Health & Substance Abuse	70% after Deductible	60% after Deductible
Outpatient Diagnostic Tests, Lab & X-Ray	70% after Deductible	60% after Deductible
Inpatient Hospital Services Medical Services and Facility Anesthesiologiest & Surgeon Fees Mental Health & Substance Abuse	70% after Deductible	60% after Deductible
Outpatient Surgical, Diagnostic & Therapies Medical Services Facility Charges	70% after Deductible	60% after Deductible
Emergency Services		
Hospital Emergency Room	70% after Deductible	70% after Deductible
Urgent Care Visits	70% after Deductible	60% after Deductible
Ambulance	70% after Deductible	60% after Deductible
Prescription Drugs	70% after Deductible	Not Covered
Short Term Rehabilitation Services	70% after Deductible	60% after Deductible
Home Health, Skilled Nursing & Hospice	70% after Deductible	60% after Deductible
Durable Medical Equipment	70% after Deductible	60% after Deductible
Vision - Annual Eye Exam	70% after Deductible	60% after Deductible
Allergy Treatment Testing and Injections Serum	70% after Deductible	60% after Deductible

***Network Providers have agreed to accept the Maximum Allowable Charge (MAC) as payment in full.** However, when you receive services from Non-Network providers, you are responsible for any amounts over Medicare-based reimbursement levels. Non-Network providers may charge considerably higher amounts. Therefore, if the billed amount exceeds the Medicare-based allowable charge, your provider may bill you for the difference. It is best to utilize network providers whenever possible. These amounts over the Allowed Charges, while the responsibility of the Covered Person, do not apply toward deductible or out-of-pocket maximums. Please refer to your Summary Plan Description (SPD) for details. **The SPD is the final determination of all benefits.**

Pre-Certification Penalty: Certain procedures or medical care require pre-certification in order to qualify for full benefits.
Failure to pre-certify will result in a $250 penalty per service, procedure or confinement. Please refer to the Pre-Certification section in your SPD for details.
Please Note: This schedule applies as indicated in the Summary Plan Description.
This schedule must be read in conjunction with the entire Summary Plan Description and has no full meaning by itself.

HEALTH PLAN OPTIONS

PLEASE REFER TO THE NETWORK PROVIDER* INFORMATION ON THE FRONT PAGE OF THIS SUMMARY OF BENEFITS.

Plan Year Deductible	*An individual within family coverage will only be required to meet the individual deductible amount before the coinsurance begins. Deductible does not apply to Preventive Care Provisions.*
Coinsurance	*Coinsurance is the share of the costs of a covered service, calculated as a percent of the allowed amount of the service.*
Out-of-Pocket Maximum	*All allowed deductibles, coinsurance, copayments and pre-certification penalties apply to the Out-of-Pocket Maximum. An individual within family coverage will only be required to meet the individual out-of-pocket maximum.*
Preventive Care Provisions	*Charges for preventive care services coverage at no cost sharing. Cost sharing may apply if a specific service is for non-preventive care (even if billed in conjunction with preventive care services).*
Professional Outpatient Office Visits Primary Care Specialist Mental Health & Substance Abuse	*These charges are billed by the physician for time spent with the patient. Office visits do not include charges for diagnostic, surgical, or medical procedures performed by the physician or for diagnostic services billed separately.* *Mental Health and Substance Abuse coverage excludes counseling for behavioral disorders.*
Outpatient Diagnostic Tests, Lab & X-Ray	*Includes diagnostic tests performed in a physician's office and billed by such physician or a free-standing non-hospital billed facility only.*
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Allergy Treatment Testing and Injections Serum	

GBS *Healthy* Advantage Health Plan

QHDHP 5000/100

Services	PPO Providers	Non-PPO Providers
Plan Year Deductible	$5,000 per Individual $10,000 per Family	
Coinsurance	Plan Pays 100%	Plan Pays 90%
Out-of-Pocket Maximum	$6,000 per Individual $11,000 per Family	
Preventive Care Provisions	No Deductible, No Copay	No Deductible, No Copay
Professional Outpatient Office Visits Primary Care Specialist Mental Health & Substance Abuse	100% after Deductible	90% after Deductible
Outpatient Diagnostic Tests, Lab & X-Ray	100% after Deductible	90% after Deductible
Inpatient Hospital Services Medical Services and Facility Anesthesiologiest & Surgeon Fees Mental Health & Substance Abuse	100% after Deductible	90% after Deductible
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Durable Medical Equipment	100% after Deductible	90% after Deductible
Vision - Annual Eye Exam	100% after Deductible	90% after Deductible
Allergy Treatment Testing and Injections Serum	100% after Deductible	90% after Deductible

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This plan is designed and administered by Group Benefit Services, Inc. (GBS) to provide the most sophisticated protection available in the small and large group self-funded market. This benefit brochure describes the innovative plan design available for groups with 5 or more employees. Please see your underwriting guidelines or sales representative for details on participation and minimum group size. GBS works with underwriting partners and stop-loss carriers to package the most competitive and conservative plans possible for your group. Please see your final proposal for carrier specifics and plan details. **NOTICE: Never, under any circumstances, should you terminate your employee benefit coverage with one carrier before receiving written notice of approval with the next.** In the case of HealthySolutions, you should not cancel prior coverage until you receive a signed written acceptance of coverage along with final rates from an authorized officer of GBS. **This brochure and your proposal are intended as a brief overview of the actual plan. Please refer to your Summary Plan Description (SPD) for the actual benefits, limitations and exclusions. If there is any inconsistency between this brochure or any other document and the SPD, the SPD shall govern.**

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