GBS *Healthy*Advantage Health Plan

PPO 0/50

Copay/Coinsurance: **Not Subject to the Deductible***	50% In Network 40% Out of Network	*Out of network charges are subject to the Maximum Allowable Charge (MAC).*
Preventive Care Provisions	No Deductible, No Copay	*Charges for preventive care services covered 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	50%	*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	50%	*Includes diagnostic tests performed in a physician's office and billed by such physician or a free standing non-hospital billed facility only.*
Vision Annual Eye Exam	50%	*Any optometrist; member must submit claim for reimbursement. Copay waived for children under 5 years of age.*
Short Term Rehabilitation Services	50%	*Physical, chiropractic, speech and occupational therapy. (Includes therapies performed in provider's office or non-hospital based facility only)*
Emergency Services Hospital Emergency Room Urgent Care/Physician Ambulance	50%	*Urgent Care visits do not include charges for diagnostic, surgical or medical procedures.*
Allergy Treatment Testing and Injections Serum	50%	

ITEMS ABOVE THIS BAR ARE NOT SUBJECT TO THE DEDUCTIBLE.

Coinsurance after the Deductible*	50% In Network 40% Out of Network	*Coinsurance is the plan's share of the costs of a covered service, calculated as a percent of the allowed amount of the service.*
Plan Year Deductible	$0 per Individual $0 per Family	*An individual within family coverage will only be required to meet the individual deductible amount before coinsurance begins.*
Out-of-Pocket Maximum	$6,600 per Individual $13,200 per Family	*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.*
Inpatient Hospital Services Medical Services and Facility Anesthesiologist and Surgeon Fees Mental Health & Substance Abuse	50%	
Outpatient Surgical, Diagnostic & Therapies Medical Services Facility Charges	50%	*Includes outpatient services, miscellaneous medical procedures & supplies, diagnostic & therapeutic procedures and surgery at a physician's office, freestanding surgery center, or hospital (when approved).*
Home Health, Skilled Nursing, Hospice	50%	
Durable Medical Equipment	50%	
Prescription Drug Options	50%	*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.*

*** 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.

GBS HealthyAdvantage

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