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	$7,350 per Individual $14,700 per Family	
Preventive Care Provisions	No Deductible, No Copay	No Deductible, No Copay
Professional Outpatient Office Visits • Primary Care • Specialist • Mental Health & Substance Abuse	 $20 Copay per visit $40 Copay per visit $40 Copay per visit	 $20 Copay then Covered at 90% $40 Copay then Covered at 90% $40 Copay then Covered at 90%
Outpatient Diagnostic Tests, Lab & X-Ray	$60 Copay per visit	$60 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	$250 Copay per visit	$250 Copay per visit
• Urgent Care Visits • Ambulance	$60 Copay per visit $100 Copay	$60 Copay then Covered at 90% $100 Copay then Covered at 90%
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 • Serum	 $40 Copay per visit $100 Copay	 $40 Copay then Covered at 90% $100 Copay then Covered at 90%

PRESCRIPTION DRUGS	PPO PROVIDERS	NON-PPO PROVIDERS
• $0 Deductible • Generic/Preferred Brand Name/Non-Preferred Brand Name/Specialty Copays	$0/$30/$60/$250	Not Covered

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.

HEALTH PLAN OPTIONS

SERVICES	DESCRIPTION
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 do not include charges for diagnostic, surgical or medical procedures.
• Urgent Care Visits • Ambulance	
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	

*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.

**Please refer to the Network Provider information on the front page of this summary of 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.

ON YOUR TEAM.