The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, Call 1-888-301-0747 or visit us at www.groupplansolutions.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-888-301-0747 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For Network Providers (Preferred Providers): **$750/Individual, $2,250/ family.** For Out- of-Network Providers (Non-Preferred Providers): **$1,500/Individual**, **$4,500/family.** No one person will be responsible for more than the individual deductible amount.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay for covered services you use. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there services covered before you meet your deductible?	Yes. Preventative Care**,** prescription drugs, office visits/ manipulative therapy and services billed at these visits are covered before you meet your deductible**.**	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services at a network provider without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No, there are no other specific deductibles.	You don't have to meet other specific deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	For Network Providers (Preferred Providers): **$4,000/ Individual $8,000/ family.** For Out- of-Network Providers Non-Preferred Providers): **$8,000/ Individual, $16,000/family.** No one person will be responsible for more than the individual deductible amount.	The out-of-pocket limit is the most you could pay in a year for your share of the cost of covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. This limit helps you plan for health care expenses.

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What is not included in the out-of-pocket limit?	Penalties for failure to preauthorize services, premiums, balance-billing charges, and health care this plan doesn't cover	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. For a list of participating providers, see www.groupplansolutions.com. Click "Member", then "Find a Provider." See your Plan ID card to choose the correct Network; call 888-301-0747.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing).Plans use the term in-network, preferred, or participating for providers in their network.. Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do you need a referral to see a specialist?	No. You don't need a referral to see a specialist.	This plan will pay some or all of the costs to see a specialist for covered services. You can see the specialist you choose without a referral from this plan.

 All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 Copay/visit	40% Coinsurance	In-Network Telemedicine provider or Virtual Care visit - $25 Copay (copay waived for COVID testing and related office or virtual care visit). Chiropractic, Osteopathic & Naprapathy visits - $25 Copay, limited to 20 visits per calendar year. Deductible waived - 20% coinsurance applies to additional services.
	Specialist visit	$40 Copay/visit	40% Coinsurance	
	Preventive care/screening/ Immunization	No Charge	Not Covered	For a list of covered preventive services, go to www.healthcare.gov
If you have a test	Diagnostic test (x-ray, blood work)	20% Coinsurance	40% Coinsurance	————————none————————
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	40% Coinsurance	————————none————————

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com	Generic drugs	$10 retail copay(30 day) $30 mail order copay	Not Covered	90 day supply retail or mail order AFTER 30 day supply is filled. Retail -1 copay 1 to 30 day supply; 2 copays 31-60 day supply; 3 copays 61 to 90 day supply. Difference between brand and equivalent generic is not covered. Early drug refills can be allowed to ensure participants have a one-month supply,
	Preferred brand drugs	$30 retail copay(30 day) $90 mail order copay		
	Non-preferred brand drugs	$50 retail copay(30 day) $150 mail order copay		
	Specialty drugs	$100 copay; $100 mail order copay; 30 Day supply per fill limit (Retail or Mail order).	Not Covered	30 Day supply per fill limit (Retail or Mail order) on Specialty drugs. Specialty drugs and injectable medications purchased with the drug card require Case Management **preauthorization** as required by the Pharmacy Benefit Manager Call **1-844-265-1771.**
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	40% Coinsurance	————none————
	Physician/surgeon fees	20% Coinsurance	40% Coinsurance	————none————
If you need immediate medical attention	Emergency room care	$75 Access Fee and 20% Coinsurance	$75 Access Fee and 20% Coinsurance	Access Fee waived if admitted. Non-Emergent Emergency Room Services are not covered.
	Emergency medical transportation	20% Coinsurance	20% Coinsurance	To the nearest hospital. The Plan will cover limited, Medically Necessary, non-emergency ambulance transportation relating to COVID-19 Diagnosis or treatment.
	Urgent care	20% Coinsurance	20% Coinsurance for Emergency Services 40% Coinsurance for Non-Emergent Services	————none————

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	40% Coinsurance	**Precertification** is required or the first $500 of covered expense will not be covered. **For Precertification Call 1-888-641-5304.** A private room can be covered if a participant with COVID-19 needs to be quarantined in a private room to avoid infecting others.
	Physician/surgeon fees	20% Coinsurance	40% Coinsurance	————————none————————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/office visit and 20% Coinsurance for outpatient services.	40% Coinsurance	Day treatment and intensive outpatient and partial hospitalization services **Precertification** is recommended**. Call 1-888-641-5304.**
	Inpatient services	20% Coinsurance	40% Coinsurance	**Precertification** is required or the first $500 of covered expense will not be covered. **For Precertification Call 1-888-641-5304.**
If you are pregnant	Office visits	$25 Copay	40% Coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% Coinsurance	40% Coinsurance	
	Childbirth/delivery facility services	20% Coinsurance	40% Coinsurance	**Precertification** is required if inpatient stay exceeds 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery, or the first $500 of covered expense will not be covered. **For Precertification Call 1-888-641-5304.**
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	40% Coinsurance	Home Health Care Services limited to 90 visits per calendar year. **Case Management Prior Authorization is required Call 888-641-5304.**
	Rehabilitation services	20% Coinsurance	40% Coinsurance	Cardiac rehabilitation services limited to 36 outpatient sessions within a 6 month period. Speech Therapy is limited to 20 visits/cal. yr**.** Outpatient Occupational and Physical Therapy is limited to 20 visits/ cal. yr., for each type of therapy**. Preapproval is required for**
	Habilitation services			

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				additional visits. Call 888-301-0747ext.3390.
	Durable medical equipment	20% Coinsurance	40% Coinsurance	**Preapproval required Call 888-301-0747 ext. 3390.**
	Skilled nursing care	20% Coinsurance	40% Coinsurance	Short term non-custodial care limited to 90 days per calendar year. **Case Management Prior Authorization is required Call 1-888-641-5304.**
	Hospice services			
If your child needs dental or eye care	Children's eye exam	Covered age 6 months to 5 years	Not Covered	————————none————————
	Children's glasses	Not Covered	Not Covered	————————none————————
	Children's dental check-up	Covered to age 5	Not Covered	————————none————————

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Costmetic surgery
- Non-emergency care when traveling outside the U.S
- Hearing aids
- Long-term care
- Weigh Loss Programs
- Routine foot care
- Routine eye care
- Custodial Care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- In-Network telemedicine Virtual Care visits
- Infertility treatment
- Chiropractic Care (20 visits calendar year limit)
- TMJ ($2,500 Lifetime Limit)
- Bariatric Surgery (when guidelines are met)
- Routine foot care (for diabetics)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. You can contact the plan at 1-888-301-0747 or the contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: GPS Claim Committee at Group Plan Solutions, 2505 Court Street and Pekin, IL 61558 or call us at 888-301-0747 or you may also contact the Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes**

* For more information about limitations and exceptions call 1-888-301-0747 or visit us at www.groupplansolutions.com.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$750
Specialist copayment	$40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$750
Copayments	$80
Coinsurance	$2,310
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$3,140**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$750
Specialist *copayment (PCP $25)*	$40
Hospital (facility) & Other coinsurance	20%
Prescription copay for Pref. Brand drug	$30

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$750
Copayments	$660
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,510**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$750
Specialist copayment	$40
Hospital (facility) & Other coinsurance	20%
Other - Emergency Room Access Fee	$75

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$750
Copayments/Access Fee	$75
Coinsurance	$410
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,235**

The plan would be responsible for the other costs of these EXAMPLE covered services.