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 GPA at 1-800-827-7223. 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 www.cciio.cms.gov or call 903-575-0300 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$3,000** person/**$6,000** family Level I & Level II PPO **$6,000** person/**$12,000** family Level II Non-PPO	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible?	**Yes.** Copayments, prescriptions & PPO preventive services do not apply towards the 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 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?	**Yes**, **$2,500** person/**$5,000** family for services performed at Titus Regional Medical Center & **$100** person/**$300** family for Prescriptions	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	**$6,350** person/**$12,700** family Level I & Level II PPO **$12,700** person/**$25,400** family Level II Non-PPO	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Premiums; balance-billed charges; charges in excess of UCR (Usual, Customary & Reasonable); any noncompliance penalties; 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 Level II Providers. See page 2 for an explanation of Level I & Level II Providers. Visit www.multiplan.com or call 1-888-611-7427 for a list of participating PHCS physicians.	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). 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.
Do you need a referral to see a specialist?	**No.**	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.
Level I Providers include but are not limited to: Hospitals (Inpatient and Outpatient treatment); Inpatient Facilities (such as Rehabilitation Facilities, Skilled Nursing Facilities and Hospice); Inpatient and Outpatient Facilities of Mental Disorders, Chemical Dependency, Drug and Substance Abuse; Ambulatory Surgery Centers and Dialysis Clinics
Level II Providers are Physicians and all other Providers of service not defined as a Level I Provider.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Level I Provider	Level II PPO Provider	Level II Non-PPO Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	N/A	$40 copay/visit; 0% coinsurance; deductible waived	40% coinsurance; deductible applies	Family/General Practitioners, Pediatricians, Internists & Obstetricians/Gynecologists are considered Primary Care Physicians (PCP). PCP copay applies to mental/behavioral/ substance abuse office visits, psychological testing & group therapy. There is no charge for PPO office surgery, all PPO FDA approved contraceptive methods & PPO allergy testing/serum/injections. $45 consultation fee applies to Teladoc Telephone Consultations. Non-PPO charges are subject to Usual, Customary & Reasonable fees.
	Specialist visit	N/A	$75 copay/visit; 0% coinsurance; deductible waived	40% coinsurance; deductible applies	
	Preventive care/screening/ immunization	No Charge	No Charge	40% coinsurance; deductible applies	See your plan document for additional benefit information & limitations. Level I charges based on Allowable Claims Limits. Non-PPO charges are subject to Usual, Customary & Reasonable fees.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	No Charge	40% coinsurance; deductible applies	PPO deductible & 0% coinsurance applies to MRIs, CTs & PET Scans billed by One Call Medical. Level I charges based on Allowable Claims Limits. Non-PPO charges are subject to Usual, Customary & Reasonable fees.
	Imaging (CT/PET scans, MRIs)	0% coinsurance; deductible applies	0% coinsurance; deductible applies	40% coinsurance; deductible applies	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com	Generic drugs	Tier 1 Copays: Retail $5/Mail Order $10			Covers a 30-day supply for Retail/90-day supply for Mail Order/30-day supply for Specialty. See your plan document for information about drugs that require prior authorization and drugs that are excluded.
	Preferred brand drugs	Tier 2 Copays: Retail $30/Mail Order $60			
	Non-preferred brand drugs	Tier 3 Copays: Retail $50/Mail Order $100			
	Specialty drugs	20% copay up to a maximum of $500 per rx			

[* For more information about limitations and exceptions, see the plan or policy document at www.gpatpa.com.]

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Level I Provider	Level II PPO Provider	Level II Non-PPO Provider	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance; deductible applies	N/A	N/A	UR notification required or $250 non-compliance penalty applies. Level I charges based on Allowable Claims Limits. Non-PPO charges are subject to Usual, Customary & Reasonable fees.
	Physician/surgeon fees	N/A	0% coinsurance; deductible applies	40% coinsurance; deductible applies	
If you need immediate medical attention	Emergency room care	$300 copay/visit; 0% coinsurance; deductible waived	No Charge	No Charge	Applicable deductible & coinsurance applies to treatment of a non-medical emergency. UR notification required if admitted inpatient or $250 non-compliance penalty applies. Level I charges based on Allowable Claims Limits. Non-PPO charges are subject to Usual, Customary & Reasonable fees.
	Emergency medical transportation	0% coinsurance; deductible applies	0% coinsurance; deductible applies	0% coinsurance; PPO deductible applies	Level I charges based on Allowable Claims Limits. Non-PPO charges are subject to Usual, Customary & Reasonable fees.
	Urgent care	$75 copay/visit; 0% coinsurance; deductible waived	$75 copay/visit; 0% coinsurance; deductible waived	40% coinsurance; deductible applies	Level I charges based on Allowable Claims Limits. Non-PPO charges are subject to Usual, Customary & Reasonable fees.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance; deductible applies	N/A	N/A	UR notification required or $250 non-compliance penalty applies. Level I charges based on Allowable Claims Limits. Non-PPO charges are subject to Usual, Customary & Reasonable fees.
	Physician/surgeon fees	N/A	0% coinsurance; deductible applies	40% coinsurance; deductible applies	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance; deductible applies	0% coinsurance; deductible applies	40% coinsurance; deductible applies	See '**If you visit a health care provider's office or clinic**' for the office visit benefit. UR notification required for inpatient admissions and day treatment or $250 non-compliance penalty applies. Level I charges based on Allowable Claims Limits. Non-PPO charges are subject to Usual, Customary & Reasonable fees.
	Inpatient services	0% coinsurance; deductible applies	0% coinsurance; deductible applies	40% coinsurance; deductible applies	
If you are pregnant	Office visits	N/A	0% coinsurance; deductible applies	40% coinsurance; deductible applies	Contact UR for coordination of prenatal care. UR notification required or $250 non-compliance penalty applies. Level I charges based on Allowable Claims Limits. Non-PPO

[* For more information about limitations and exceptions, see the plan or policy document at www.gpatpa.com.]

Common Medical Event	Services You May Need	What You Will Pay Level I Provider	What You Will Pay Level II PPO Provider	What You Will Pay Level II Non-PPO Provider	Limitations, Exceptions, & Other Important Information
	Childbirth/delivery professional services	N/A	0% coinsurance; deductible applies	40% coinsurance; deductible applies	charges are subject to Usual, Customary & Reasonable fees.
	Childbirth/delivery facility services	0% coinsurance; deductible applies	N/A	N/A	
If you need help recovering or have other special health needs	Home health care	0% coinsurance; deductible applies	0% coinsurance; deductible applies	40% coinsurance; deductible applies	Services are limited per calendar year to 60 visits for Home Health, 60 combined visits for Physical/Speech/Occupational Therapy & 90 days each for Skilled Nursing/Rehabilitation Facilities. Chiropractic is limited to $1,000 per calendar year & Hospice limited to $10,000 per lifetime. Treatment of developmental delays may not be covered. See your plan document for additional information. Contact UR for coordination of care for Home Health & Outpatient Hospice. UR notification required for inpatient admission or $250 non-compliance penalty applies. Level I charges based on Allowable Claims Limits. Non-PPO charges are subject to Usual, Customary & Reasonable fees.
	Rehabilitation services	No Charge	No Charge	40% coinsurance; deductible applies	
	Habilitation services	0% coinsurance; deductible applies	0% coinsurance; deductible applies	40% coinsurance; deductible applies	
	Skilled nursing care	No Charge	No Charge	40% coinsurance; deductible applies	
	Durable medical equipment	0% coinsurance; deductible applies	0% coinsurance; deductible applies	40% coinsurance; deductible applies	
	Hospice services	No Charge	No Charge	40% coinsurance; deductible applies	
If your child needs dental or eye care	Children's eye exam	No Charge	No Charge	40% coinsurance; deductible applies	Benefit applies up to age 19 only. Non-PPO charges are subject to Usual, Customary & Reasonable fees.
	Children's glasses	Not Covered			Not Covered
	Children's dental check-up	Not Covered			Not Covered

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
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Routine eye care (Adult)
- Routine foot care
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
• Chiropractic Care	• Hearing Aids (**only** for initial purchase if hearing loss is due to illness, accidental injury, congenital anomaly or surgical procedure)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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: 800-827-7223 or the Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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.

Language Access Services:

Español: Para obtener asistencia en Español, llame al 800-827-7223.

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

[* For more information about limitations and exceptions, see the plan or policy document at www.gpatpa.com.]

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	$3000
Specialist copayment	$75
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	$40
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,100**

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

The plan's overall deductible	$3000
Specialist copayment	$75
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,700
Copayments	$840
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,600**

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

The plan's overall deductible	$3000
Specialist copayment	$75
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$990
Copayments	$160
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,150**

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