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 visit www.gunnisoncounty.org to view the 2020 Benefits Summary Guide.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$800** person/**$1,600** family PHCS, Direct Contract, and all other Providers	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. 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.
Are there services covered before you meet your deductible?	**Yes.** Copayments & 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**, **$100** deductible per person 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?	**$3,200** person/**$6,400** family PHCS, Direct Contract, and all other Providers **Note:** There is a separate **$3,000** person/**$6,000** family Pharmacy Out-of-Pocket	The out-of-pocket limit is the most you could pay in a year for 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.
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,** PHCS and Direct Contract Providers will not balance bill. See page 2 for an explanation of Providers. Visit www.multiplan.com or call 1-877-952-7427 for a list of participating PHCS providers.	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.
PHCS and Direct Contract 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
All Other Providers are Physicians and all other Providers of service not defined as a PHCS and Direct Contract Provider.

Common Medical Event	Services You May Need	Limitations, Exceptions, & Other Important Information		
		PHCS and Direct Contract Providers	All Other Providers	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$40 copay/visit; 0% coinsurance; deductible waived	$40 copay/visit; 0% coinsurance; deductible waived	$20 copay/visit; 0% coinsurance; deductible waived applies to Gunnison Valley Family Physicians. Family/General Practitioners, Pediatricians, Internists & Obstetrician/ Gynecologists are considered Primary Care Providers (PCP). PCP copay applies to mental/behavioral & substance abuse office visits. There is no charge for PPO female office sterilization & all PPO FDA approved contraceptive methods. All Other charges are subject to Usual, Customary & Reasonable fees.
	Specialist visit	$60 copay/visit; 0% coinsurance; deductible waived	$60 copay/visit; 0% coinsurance; deductible waived	
	Preventive care/screening/ immunization	No Charge	No Charge	See your plan document for additional benefit information & limitations. PHCS and Direct Contract charges are based on Allowable Claims Limits. All Other charges are subject to Usual, Customary & Reasonable fees. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance; deductible applies	20% coinsurance; deductible applies	PHCS and Direct Contract charges are based on Allowable Claims Limits. All Other charges are subject to Usual, Customary & Reasonable fees.

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

Common Medical Event	Services You May Need	Limitations, Exceptions, & Other Important Information		
		PHCS and Direct Contract Providers	All Other Providers	
	Imaging (CT/PET scans, MRIs)	20% coinsurance; deductible applies	20% coinsurance; deductible applies	PHCS and Direct Contract charges are based on Allowable Claims Limits. All Other charges are subject to Usual, Customary & Reasonable fees.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com.	Generic drugs	Covers a 30-day (90-day for Generic only) 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			
	Non-preferred brand drugs			
	Specialty drugs			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance; deductible applies	20% coinsurance; deductible applies	PHCS and Direct Contract charges are based on Allowable Claims Limits. All Other charges are subject to Usual, Customary & Reasonable fees.
	Physician/surgeon fees	20% coinsurance; deductible applies	20% coinsurance; deductible applies	
If you need immediate medical attention	Emergency room care	20% coinsurance; deductible applies	20% coinsurance; deductible applies	UR notification required if admitted inpatient. PHCS and Direct Contract charges are based on Allowable Claims Limits. All Other charges are subject to Usual, Customary & Reasonable fees.
	Emergency medical transportation	20% coinsurance; deductible applies	20% coinsurance; deductible applies	PHCS and Direct Contract charges are based on Allowable Claims Limits. All Other charges are subject to Usual, Customary & Reasonable fees.
	Urgent care	20% coinsurance; deductible applies	20% coinsurance; deductible applies	PHCS and Direct Contract charges are based on Allowable Claims Limits. All Other charges are subject to Usual, Customary & Reasonable fees.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance; deductible applies	20% coinsurance; deductible applies	UR notification required. PHCS and Direct Contract charges are based on Allowable Claims Limits. All Other charges are subject to Usual, Customary & Reasonable fees.
	Physician/surgeon fees	20% coinsurance; deductible applies	20% coinsurance; deductible applies	

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

Common Medical Event	Services You May Need	Limitations, Exceptions, & Other Important Information		
		PHCS and Direct Contract Providers	All Other Providers	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance; deductible applies	20% 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. PHCS and Direct Contract charges are based on Allowable Claims Limits. All Other charges are subject to Usual, Customary & Reasonable fees.
	Inpatient services	20% coinsurance; deductible applies	20% coinsurance; deductible applies	
If you are pregnant	Office visits	20% coinsurance; deductible applies	20% coinsurance; deductible applies	Office visit copayment applies to the initial visit only. Contact UR for coordination of prenatal care. PHCS and Direct Contract charges are based on Allowable Claims Limits. All Other charges are subject to Usual, Customary & Reasonable fees.
	Childbirth/delivery professional services	20% coinsurance; deductible applies	20% coinsurance; deductible applies	
	Childbirth/delivery facility services	20% coinsurance; deductible applies	20% coinsurance; deductible applies	
If you need help recovering or have other special health needs	Home health care	20% coinsurance; deductible applies	20% coinsurance; deductible applies	Services are limited per calendar year to 120 visits for Home Health, 60 visits each for Physical/Speech/Occupational Therapy & 120 combined days for Skilled Nursing Facilities. Treatment of developmental delays may not be covered. See your plan document for additional information. Contact UR for coordination of care for Outpatient Hospice. UR notification required for Home Health & Inpatient Admission. PHCS and Direct Contract charges are based on Allowable Claims Limits. All Other charges are subject to Usual, Customary & Reasonable fees.
	Rehabilitation services	20% coinsurance; deductible applies	20% coinsurance; deductible applies	
	Habilitation services	20% coinsurance; deductible applies	20% coinsurance; deductible applies	
	Skilled nursing care	20% coinsurance; deductible applies	20% coinsurance; deductible applies	
	Durable medical equipment	20% coinsurance; deductible applies	20% coinsurance; deductible applies	
	Hospice services	20% coinsurance; deductible applies	20% coinsurance; deductible applies	
If your child needs dental or eye care	Children's eye exam	No Charge	No Charge	Benefit applies to routine vision screenings for children. All Other charges are subject to Usual, Customary & Reasonable fees.
	Children's glasses	Benefits may be available through a separate vision plan.		
	Children's dental check-up	Not Covered		

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

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.)

- 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.)

- Acupuncture
- Bariatric Surgery
- Chiropractic Care
- Hearing Aids

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	$800
Specialist copayment	$60
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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$840
Copayments	$40
Coinsurance	$2320
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,260**

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

The plan's overall deductible	$800
Specialist copayment	$60
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$900
Copayments	$770
Coinsurance	$200
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,930**

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

The plan's overall deductible	$800
Specialist copayment	$60
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$800
Copayments	$180
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,080**

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