**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, contact PAI at 1-800-768-4375 or visit www.paisc.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 www.paisc.com.com or call 1-800-768-4375 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | **$1,000** individual / **$2,000** family | 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. Preventive care, primary care, and urgent care 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 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. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | **$3,000** individual / **$6,000** family for medical<br>**$3,850** individual / **$7,700** family for pharmacy | 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, penalties, 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. See www.paisc.com or call 1-800-768-4375 for a list of network 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. |



(DT - OMB control number: 1545-0047/Expiration Date: 12/31/2019)(DOL - OMB

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 | $0 copay/visit for ProActive MD; $100 copay/visit other primary providers; deductible does not apply | $100 copay/visit; deductible does not apply | OB/GYN, Pediatrician and mental/behavioral health and substance abuse services take a $25 copay. Non-network providers may balance bill. |
| | Specialist visit | $40 copay/visit; deductible does not apply | $40 copay/visit; deductible does not apply | Non-network providers may balance bill. |
| | Preventive care/screening/ immunization | No charge deductible does not apply | No charge deductible does not apply | You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. Routine colonoscopies are subject to ACA age guidelines. Non-network providers may balance bill. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | $40 copay/visit; deductible does not apply | $40 copay/visit; deductible does not apply | If billed as outpatient; 30% coinsurance. Non-network providers may balance bill. |
| | Imaging (CT/PET scans, MRIs) | $40 copay/visit; deductible does not apply | $40 copay/visit; deductible does not apply | If billed as outpatient; 30% coinsurance. Non-network providers may balance bill. |

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 need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.scriptcare.com or 1-800-880-9988. | Generic drugs | $3 copay/prescription (retail); $6 copay/prescription (mail order); deductible does not apply to prescription drugs | Reduced coverage; call Pharmacy Provider for details. | Covers up to a 31 day supply (retail prescription); Mail order prescriptions cover up to a 90 day supply. Specialty is limited to a 31-day supply.<br><br>Alternative Therapeutic (Nexium) $125 co-pay (retail); $250 co-pay (mail order) |
| | Preferred brand drugs | $55 copay/prescription (retail); $110 copay/prescription (mail order); deductible does not apply to prescription drugs | Reduced coverage; call Pharmacy Provider for details. | |
| | Non-preferred brand drugs | $80 copay/prescription (retail); $160 copay/prescription (mail order); deductible does not apply to prescription drugs | Reduced coverage; call Pharmacy Provider for details. | |
| | Specialty drugs | $250 copay/prescription | Reduced coverage; call Pharmacy Provider for details. | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 30% coinsurance | 30% coinsurance | Non-network providers may balance bill. |
| | Physician/surgeon fees | 30% coinsurance | 30% coinsurance | Non-network providers may balance bill. |
| **If you need immediate medical attention** | Emergency room care | $150 copay/visit; 30% coinsurance | $150 copay/visit; 30% coinsurance | $150 copay waived is admitted. |
| | Emergency medical transportation | 0% coinsurance | 0% coinsurance | None. |
| | Urgent care | $75 copay/visit; deductible does not apply | $75 copay/visit; deductible does not apply | Non-network providers may balance bill. |

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

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 have a hospital stay** | Facility fee (e.g., hospital room) | 30% coinsurance, after deductible | 30% coinsurance, after deductible | Preauthorization is required. If you do not get preauthorization for a network provider, room and board charges will be denied. If you do not get preauthorization for an out-of-network provider, a penalty may apply. Non-network providers may balance bill. |
| | Physician/surgeon fees | 30% coinsurance | 30% coinsurance | Non-network providers may balance bill. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | 30% coinsurance | 30% coinsurance | Non-network providers may balance bill. |
| | Inpatient services | 30% coinsurance, after deductible | 30% coinsurance, after deductible | Preauthorization is required. If you do not get preauthorization for a network provider, room and board charges will be denied. If you do not get preauthorization for an out-of-network provider, a penalty may apply. Non-network providers may balance bill. |
| **If you are pregnant** | Office visits | $25 copay for first visit/deductible does not apply | $25 copay for first visit/deductible does not apply | Cost sharing does not apply to certain preventive services. Depending on the type of services, copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Non-network providers may balance bill. |
| | Childbirth/delivery professional services | 30% coinsurance, after deductible | 30% coinsurance, after deductible | |
| | Childbirth/delivery facility services | 30% coinsurance, after deductible | 30% coinsurance, after deductible | Preauthorization is required. If you do not get preauthorization for a network provider, room and board charges will be denied. If you do not get preauthorization for an out-of-network provider, a penalty may apply. Non-network providers may balance bill. |

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 need help recovering or have other special health needs** | Home health care | 30% coinsurance, after deductible | 30% coinsurance, after deductible | Limited to 60 visits per benefit year. Non-network providers may balance bill. |
| | Rehabilitation services | 30% coinsurance | 30% coinsurance | Preauthorization is required. If you do not get preauthorization for a network provider, room and board charges will be denied. If you do not get preauthorization for an out-of-network provider, a penalty may apply. Non-network providers may balance bill. |
| | Habilitation services | 30% coinsurance, after deductible | 30% coinsurance, after deductible | |
| | Skilled nursing care | 30% coinsurance, after deductible | 30% coinsurance, after deductible | Preauthorization is required. If you do not get preauthorization for a network provider, room and board charges will be denied. If you do not get preauthorization for an out-of-network provider, a penalty may apply. Limited to 60 days per year. Non-network providers may balance bill. |
| | Durable medical equipment | 30% coinsurance, after deductible | 30% coinsurance, after deductible | Preauthorization is required for supplies over $2,000. If you do not get preauthorization for a penalty may apply. Non-network providers may balance bill. |
| | Hospice services | 30% coinsurance, after deductible | 30% coinsurance, after deductible | Preauthorization is required. If you do not get preauthorization for a penalty may apply. Non-network providers may balance bill. |
| **If your child needs dental or eye care** | Children's eye exam | Not Covered | Not covered | Refer to Vision Plan |
| | Children's glasses | Not covered | Not covered | Refer to Vision Plan |
| | Children's dental check-up | Not covered | Not covered | Refer to Dental Plan |

**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 | • Hearing aids | • Private-duty nursing |
| • Bariatric surgery | • Infertility treatment | • Routine eye care (Adult) |
| • Cosmetic surgery | • Long-term care | • Routine foot care |
| • Dental care (Adult) | • Non-emergency care when traveling outside the U.S. | • 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 |

**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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform / Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323x61565 or www.cciio.cms.gov / Planned Administrators Inc. at 1-800-768-4375 or visit www.paisc.com. 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 the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform/ Planned Administrators Inc. at 1-800-768-4375 or visit www.paisc.com or you can contact your employer's human resources department at 1-843-740-2596.

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

**Language Access Services:**
Spanish (Español): Para obtener asistencia en Español, llame al 1-800-768-4375.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-768-4375.
Chinese (中文): 如果需要中文的帮助， 请拨打这个号码 1-800-768-4375.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-768-4375.

*To see examples of how this plan might cover*

* For more information about limitations and exceptions, see the plan or policy document at www.paisc.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

### Peg is Having a

- **The plan's overall deductible** **$1000**
- **Specialist copayment** **$40**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **30%**

**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 | $1000 |
| Copayments | $600 |
| Coinsurance | $1,400 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$3,060** |

### Managing Joe's

- **The plan's overall deductible** **$1000**
- **Specialist copayment** **$40**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **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 | $0 |
| Copayments | $2,200 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$2,220** |

### Mia's Simple

- **The plan's overall deductible** **$1000**
- **Specialist copayment** **$40**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **30%**

**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 | $700 |
| Copayments | $400 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,100** |

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

# Non-Discrimination Statement and Foreign Language Access

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in our health plans, when we enroll members or provide benefits.

If you or someone you're assisting is disabled and needs interpretation assistance, help is available at the contact number posted on our website or listed in the materials included with this notice (TDD: 711).

Free language interpretation support is available for those who cannot read or speak English by calling one of the appropriate numbers listed below.

If you think we have not provided these services or have discriminated in any way, you can file a grievance by emailing contact@hcrcompliance.com or by calling our Compliance area at 1-800-832-9686 or the U.S. Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019 or 1-800-537-7697 (TDD).

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de este plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-396-0183. (Spanish)

如果您，或是您正在協助的對象，有關於本健康計畫方面的問題，您有權利免費以您的母語得到幫助和訊 息。洽詢一位翻譯員，請撥 1-844-396-0188。(Chinese)

Nếu quý vị, hoặc là người mà quý vị đang giúp đỡ, có những câu hỏi quan tâm về chương trình sức khỏe này, quý vị sẽ được giúp đở với các thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-389-4838 (Vietnamese)

이 건강보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187로 연락해 주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. (Korean)

Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa planong pangkalusugang ito, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-389-4839. (Tagalog)

Если у Вас или лица, которому вы помогаете, имеются вопросы по поводу Вашего плана медицинского обслуживания, то Вы имеете право на бесплатное получение помощи и информации на русском языке. Для разговора с переводчиком позвоните по телефону 1-844-389-4840. (Russian)

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص خطة الصحة هذه، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة.للتحدث مع مترجم اتصل ب 1-844-396-0189 (Arabic)

Si ou menm oswa yon moun w ap ede gen kesyon konsènan plan sante sa a, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-844-398-6232. (French/Haitian Creole)

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Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions à propos de ce plan médical, vous avez le droit d'obtenir gratuitement de l'aide et des informations dans votre langue. Pour parler à un interprète, appelez le 1-844-396-0190. (French)

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Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie planu ubezpieczenia zdrowotnego, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-396-0186. (Polish)

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Se você, ou alguém a quem você está ajudando, tem perguntas sobre este plano de saúde, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-396-0182. (Portuguese)

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Se tu o qualcuno che stai aiutando avete domande su questo piano sanitario, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-844-396-0184. (Italian)

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あなた、またはあなたがお世話をされている方が、この健康保険 についてご質問がございましたら、ご 希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳 とお話される場合、1-844-396-0185 までお電話ください。 (Japanese)

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Falls Sie oder jemand, dem Sie helfen, Fragen zu diesem Krankenversicherungsplan haben bzw. hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-396-0191 an. (German)

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اگر شما یا فردی که به او کمک می کنید سؤالاتی در باره‌ی این برنامه‌ی بهداشتی داشته باشید، حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت کنید. برای صحبت کردن با مترجم، لطفاً با شماره‌ی 1-844-398-6233 تماس حاصل نمایید. (Persian-Farsi)

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Ni da doodago t'áá háída bíká'aná nílwo'ígíí díí Béeso Ách'ą́ąh naa'nilígi háá'ída yí na' į́díł kidgo, nihá'áḩóót'i' nihí ká'a'doo wołgo kwii ha'át'íshį́į́ bí na'ídołkidígi doo bik'é'azláagóó. Ata' halne'é ła' bich'į' ha desdzih nínízingo, kojį' béésh bee hólne' 1-844-516-6328. (Navajo)

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Vann du adda ebbah es du am helfa bisht, ennichi questions hend veyyich *deah health plan*, hend diah's recht fa hilf un information greeya in eiyah aykni shprohch unni kosht. Fa shvetza mitt en interpreter, roof deah nummah oh 1-833-584-1829. (Pennsylvania Dutch)