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 **$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.

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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. 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.