

 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 or call 1-800-768-4375 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$1,000 individual / \$2,000 family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> , <u>primary care</u> , and <u>urgent care</u> are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$3,000 individual / \$6,000 family for medical \$3,850 individual / \$7,700 family for pharmacy	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , penalties, <u>balance-billing</u> charges and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.paisc.com or call 1-800-768-4375 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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	<u>Primary care</u> visit to treat an injury or illness	\$0 <u>copay</u> /visit for ProActive MD; \$100 <u>copay</u> /visit other primary providers; <u>deductible</u> does not apply	\$100 <u>copay</u> /visit; <u>deductible</u> does not apply	OB/GYN, Pediatrician and mental/behavioral health and substance abuse services take a \$25 <u>copay</u> . Non-network providers may balance bill.
	<u>Specialist</u> visit	\$40 <u>copay</u> /visit; <u>deductible</u> does not apply	\$40 <u>copay</u> /visit; <u>deductible</u> does not apply	Non-network providers may balance bill.
	<u>Preventive care/screening/immunization</u>	No charge <u>deductible</u> does not apply	No charge <u>deductible</u> does not apply	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for. Routine colonoscopies are subject to ACA age guidelines. Non-network providers may balance bill.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	\$40 <u>copay</u> /visit; <u>deductible</u> does not apply	\$40 <u>copay</u> /visit; <u>deductible</u> does not apply	If billed as outpatient; 30% <u>coinsurance</u> . Non-network providers may balance bill.
	Imaging (CT/PET scans, MRIs)	\$40 <u>copay</u> /visit; <u>deductible</u> does not apply	\$40 <u>copay</u> /visit; <u>deductible</u> does not apply	If billed as outpatient; 30% <u>coinsurance</u> . 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 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 <u>copay</u> /prescription (retail); \$6 <u>copay</u> /prescription (mail order); <u>deductible</u> does not apply to <u>prescription drugs</u>	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 <u>copay</u> /prescription (retail); \$110 <u>copay</u> /prescription (mail order); <u>deductible</u> does not apply to <u>prescription drugs</u>	Reduced coverage; call Pharmacy Provider for details.	
	Non-preferred brand drugs	\$80 <u>copay</u> /prescription (retail); \$160 <u>copay</u> /prescription (mail order); <u>deductible</u> does not apply to <u>prescription drugs</u>	Reduced coverage; call Pharmacy Provider for details.	
	<u>Specialty drugs</u>	\$250 <u>copay</u> /prescription or \$40 <u>copay</u> /prescription depending on if preferred or non-preferred drug.	Reduced coverage; call Pharmacy Provider for details.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <u>coinsurance</u>	30% <u>coinsurance</u>	Non-network providers may balance bill.
	Physician/surgeon fees	30% <u>coinsurance</u>	30% <u>coinsurance</u>	Non-network providers may balance bill.
If you need immediate medical attention	<u>Emergency room care</u>	\$150 <u>copay</u> /visit; 30% <u>coinsurance</u>	\$150 <u>copay</u> /visit; 30% <u>coinsurance</u>	\$150 <u>copay</u> waived is admitted.
	<u>Emergency medical transportation</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	None.
	<u>Urgent care</u>	\$75 <u>copay</u> /visit; <u>deductible</u> does not apply	\$75 <u>copay</u> /visit; <u>deductible</u> does not apply	Non-network providers may balance bill.

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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 have a hospital stay	Facility fee (e.g., hospital room)	30% <u>coinsurance</u> , after <u>deductible</u>	30% <u>coinsurance</u> , after <u>deductible</u>	<u>Preauthorization</u> is required. If you do not get <u>preauthorization</u> for a <u>network provider</u> , room and board charges will be denied. If you do not get <u>preauthorization</u> for an <u>out-of-network provider</u> , a penalty may apply. Non-network providers may balance bill.
	Physician/surgeon fees	30% <u>coinsurance</u>	30% <u>coinsurance</u>	Non-network providers may balance bill.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% <u>coinsurance</u>	30% <u>coinsurance</u>	Non-network providers may balance bill.
	Inpatient services	30% <u>coinsurance</u> , after <u>deductible</u>	30% <u>coinsurance</u> , after <u>deductible</u>	<u>Preauthorization</u> is required. If you do not get <u>preauthorization</u> for a <u>network provider</u> , room and board charges will be denied. If you do not get <u>preauthorization</u> for an <u>out-of-network provider</u> , a penalty may apply. Non-network providers may balance bill.
If you are pregnant	Office visits	\$25 <u>copay</u> for first visit/ <u>deductible</u> does not apply	\$25 <u>copay</u> for first visit/ <u>deductible</u> does not apply	<u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Depending on the type of services, <u>copayment</u> 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% <u>coinsurance</u> , after <u>deductible</u>	30% <u>coinsurance</u> , after <u>deductible</u>	
	Childbirth/delivery facility services	30% <u>coinsurance</u> , after <u>deductible</u>	30% <u>coinsurance</u> , after <u>deductible</u>	<u>Preauthorization</u> is required. If you do not get <u>preauthorization</u> for a <u>network provider</u> , room and board charges will be denied. If you do not get <u>preauthorization</u> for an <u>out-of-network provider</u> , a penalty may 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 need help recovering or have other special health needs	<u>Home health care</u>	30% <u>coinsurance</u> , after <u>deductible</u>	30% <u>coinsurance</u> , after <u>deductible</u>	Limited to 60 visits per benefit year. Non-network providers may balance bill.
	<u>Rehabilitation services</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> is required. If you do not get <u>preauthorization</u> for a <u>network provider</u> , room and board charges will be denied. If you do not get <u>preauthorization</u> for an <u>out-of-network provider</u> , a penalty may apply. Non-network providers may balance bill.
	<u>Habilitation services</u>	30% <u>coinsurance</u> , after <u>deductible</u>	30% <u>coinsurance</u> , after <u>deductible</u>	<u>Preauthorization</u> is required. If you do not get <u>preauthorization</u> for a <u>network provider</u> , room and board charges will be denied. If you do not get <u>preauthorization</u> for an <u>out-of-network provider</u> , a penalty may apply. Non-network providers may balance bill.
	<u>Skilled nursing care</u>	30% <u>coinsurance</u> , after <u>deductible</u>	30% <u>coinsurance</u> , after <u>deductible</u>	<u>Preauthorization</u> is required. If you do not get <u>preauthorization</u> for a <u>network provider</u> , room and board charges will be denied. If you do not get <u>preauthorization</u> for an <u>out-of-network provider</u> , a penalty may apply. Limited to 60 days per year. Non-network providers may balance bill.
	<u>Durable medical equipment</u>	30% <u>coinsurance</u> , after <u>deductible</u>	30% <u>coinsurance</u> , after <u>deductible</u>	<u>Preauthorization</u> is required for supplies over \$2,000. If you do not get <u>preauthorization</u> for a penalty may apply. Non-network providers may balance bill.
	<u>Hospice services</u>	30% <u>coinsurance</u> , after <u>deductible</u>	30% <u>coinsurance</u> , after <u>deductible</u>	<u>Preauthorization</u> is required. If you do not get <u>preauthorization</u> 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

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

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- 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

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, kwijijigo holne' 1-800-768-4375.

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 <u>plan's overall deductible</u>	\$1000
■ <u>Specialist copayment</u>	\$40
■ Hospital (facility) <u>coinsurance</u>	30%
■ Other <u>coinsurance</u>	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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$1000
<u>Copayments</u>	\$600
<u>Coinsurance</u>	\$1,4000
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,060

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's overall deductible</u>	\$1000
■ <u>Specialist copayment</u>	\$40
■ Hospital (facility) <u>coinsurance</u>	30%
■ Other <u>coinsurance</u>	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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$2,200
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$2,220

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's overall deductible</u>	\$1000
■ <u>Specialist copayment</u>	\$40
■ Hospital (facility) <u>coinsurance</u>	30%
■ Other <u>coinsurance</u>	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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$700
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,100