

 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> ?	For <u>network providers</u> \$750 individual / \$2,250 family For <u>out-of-network providers</u> \$1,250 individual / \$3,750 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> , <u>urgent care</u> , hospice, and home health care 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> ?	For <u>network providers</u> \$3,750 individual / \$9,000 family For <u>out-of-network providers</u> \$4,250 individual / \$10,500 family	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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$30 <u>copay</u> /visit; <u>deductible</u> does not apply	50% <u>coinsurance</u>	Includes Primary Care Visits for Mental/Behavioral Health and Substance Use Disorder.
	<u>Specialist</u> visit	\$50 <u>copay</u> /visit; <u>deductible</u> does not apply	50% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No charge	Not Covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	\$30 <u>copay</u> /test when associated with an office visit; <u>deductible</u> does not apply	50% <u>coinsurance</u>	Tests associated with an office visit but billed separately: 20% <u>coinsurance</u> after <u>deductible</u> for <u>network providers</u> and 50% <u>coinsurance</u> after <u>deductible</u> for <u>out-of-network providers</u> .
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None

* 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 <u>prescription drug coverage</u> is available at www.paisc.com .	Generic drugs	20% <u>coinsurance</u> (retail) \$10 <u>copay</u> (mail order); <u>deductible</u> does not apply to <u>prescription drugs</u>	Not Covered	Retail: 34 day supply maximum per prescription. Mail order: 90 day supply maximum per prescription.
	Brand drugs	40% <u>coinsurance</u> (retail) \$35 <u>copay</u> (mail order); <u>deductible</u> does not apply to <u>prescription drugs</u>	Not Covered	
	<u>Specialty drugs</u>	40% <u>coinsurance</u> (retail) \$35 <u>copay</u> (mail order); <u>deductible</u> does not apply to <u>prescription drugs</u>	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Urgent care</u>	\$50 <u>copay/visit</u> ; <u>deductible</u> does not apply	50% <u>coinsurance</u>	None

* 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)	20% <u>coinsurance</u>	50% <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> you will be responsible for a penalty of \$50.
	Physician/surgeon fees	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> is required.
	Inpatient services	20% <u>coinsurance</u>	50% <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> you will be responsible for a penalty of \$50.
If you are pregnant	Office visits	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<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).
	Childbirth/delivery professional services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	

* 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>	No charge	No charge	Limited to 100 visits per coverage period.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	50% <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> you will be responsible for a penalty of \$50.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> is required. Limited to 100 days per coverage period.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Hospice services</u>	No charge	No charge	None
If your child needs dental or eye care	Children's eye exam	\$15 <u>copay</u> /visit	\$15 <u>copay</u> /visit	Vision screening covered for child at no charge under ACA.
	Children's glasses	Not covered	Not covered	Not Applicable
	Children's dental check-up	No charge	Not covered	Pediatric Oral Exam covered at no charge per ACA guidelines.

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.)

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|--|---|--|
| <ul style="list-style-type: none"> • Acupuncture • Bariatric surgery • Cosmetic surgery | <ul style="list-style-type: none"> • Dental care (Adult) • Hearing aids • Long-Term Care | <ul style="list-style-type: none"> • Non-emergency care when traveling outside the U.S. • Private-duty nursing |
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

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| <ul style="list-style-type: none"> • Chiropractic Care • Infertility treatment | <ul style="list-style-type: none"> • Routine eye care (Adult) • Routine foot care |
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* For more information about limitations and exceptions, see the plan or policy document at www.paisc.com.

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 1-863-597-4230.

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:

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, kwijigo 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 plan's overall deductible \$750
- Specialist [*cost sharing*] \$50
- Hospital (facility) [*cost sharing*] 20%
- Other [*cost sharing*] 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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$750
Copayments	\$60
Coinsurance	\$2,487
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,357

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

- The plan's overall deductible \$750
- Specialist [*cost sharing*] \$50
- Hospital (facility) [*cost sharing*] 20%
- Other [*cost sharing*] 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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$107
Copayments	\$340
Coinsurance	\$2,286
<i>What isn't covered</i>	
Limits or exclusions	\$55
The total Joe would pay is	\$2,788

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

- The plan's overall deductible \$750
- Specialist [*cost sharing*] \$50
- Hospital (facility) [*cost sharing*] 20%
- Other [*cost sharing*] 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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$750
Copayments	\$150
Coinsurance	\$326
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,226