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?	For network providers **$500** individual / **$1,500** family For out-of-network providers **$1,000** individual / **$3,000** 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, urgent care and prescription drugs 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?	For network providers **$4,000** individual / **$8,000** family For out-of-network providers **$7,500** individual / **$15,000** family	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, prescription drugs, 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 control number: 1210 0147/Expiration date: 5/31/2022)
(HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)

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	$25 copay/visit; deductible does not apply	40% coinsurance	Primary Care Visits for Mental/Behavioral Health and Substance Use Disorder: No cost to member at a network provider and 40% coinsurance after deductible at an out-of-network provider
	Specialist visit	$25 copay/visit; deductible does not apply	40% coinsurance	None
	Preventive care/screening/ immunization	No charge; deductible does not apply.	Not Covered	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 mammograms are limited to one mammogram between the ages of 35 and 39 and each year for women 40 and over. Routine colonoscopies are limited to age 45+. Preventive care covered at no cost is based on ACA guidelines. Visit www.healthcare.gov for more information. Copay applies to preventive care outside of ACA guidelines:
If you have a test	Diagnostic test (x-ray, blood work)	$25 copay/visit; deductible does not apply	40% coinsurance	Tests associated with an office visit but billed separately: 20% coinsurance after deductible at a network provider and 40% coinsurance after deductible at an out-of-network provider. Preauthorization is required for Imaging (CT/PET scans, MRI's, MRA's). If you do not get preauthorization, benefits may be denied.
	Imaging (CT/PET scans, MRIs)	$25 copay/visit; deductible does not apply	40% coinsurance	

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.paisc.com.	Generic drugs	$3 copay/prescription (retail) $6 copay/prescription (mail order); deductible does not apply to prescription drugs	$3 copay/prescription (retail) $6 copay/prescription (mail order); deductible does not apply to prescription drugs	Covers up to a 30 day supply (retail); 90 day supply (mail order). 90 day supply of maintenance drugs are available at all network pharmacies. Brand drugs: Members pay coinsurance cost up to a maximum of $250/prescription. Diabetic Medications: $50 copay/prescription for 30 day supply. $100 copay/prescription for 60-90 day supply. Diabetic Supplies: $6 copay/prescription for 30 day supply. $12 copay/prescription for 60-90 day supply. All Specialty drugs require prior authorization and are limited to 30 day supply retail/mail order. Prescription drugs may be subject to Prior Authorization. Call 1-800-424-0472 to determine if any of your medications require prior authorization. Prescription drug costs count towards a separate out-of-pocket limit of $4,150 individual / $8,300 family.
	Brand drugs	30% coinsurance /prescription (retail); 20% coinsurance/prescription (mail order); deductible does not apply to prescription drugs	30% coinsurance /prescription (retail); 20% coinsurance/prescription (mail order); deductible does not apply to prescription drugs	
	Specialty drugs	30% coinsurance /prescription (retail); 20% coinsurance/prescription (mail order); deductible does not apply to prescription drugs	30% coinsurance /prescription (retail); 20% coinsurance/prescription (mail order); deductible does not apply to prescription drugs	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Outpatient services may require preauthorization.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	$250 copay/visit 20% coinsurance	$250 copay/visit 20% coinsurance	Copay waived if admitted to hospital.
	Emergency medical transportation	20% coinsurance; deductible does not apply	20% coinsurance; deductible does not apply	Preauthorization is required (when reasonable under the circumstance). If you do not get preauthorization, benefits may be denied.
	Urgent care	$25 copay/visit; deductible does not apply	40% coinsurance	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)	$250 copay/visit 20% coinsurance	$500 copay/visit 40% 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, you will be responsible for the first $1,000.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	Facility-based outpatient services (partial hospitalization/intensive outpatient programs/residential treatment centers) require preauthorization. If you do not get preauthorization, benefits may be denied.
	Inpatient services	$250 copay/visit 20% coinsurance	$500 copay/visit 40% 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, you will be responsible for the first $1,000.
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Depending on the type of services, copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	$250 copay/visit 20% coinsurance	$500 copay/visit 40% 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, you will be responsible for the first $1,000.

* 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	Home health care	20% coinsurance	40% coinsurance	Preauthorization is required. If you do not get preauthorization, benefits may be denied.
	Rehabilitation services	$250 copay/visit 20% coinsurance	$500 copay/visit 40% 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, you will be responsible for the first $1,000.
	Habilitation services	$250 copay/visit 20% coinsurance	$500 copay/visit 40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	Limited to 100 days per coverage period. Per admission copay does not apply. 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, you will be responsible for the first $1,000.
	Durable medical equipment	20% coinsurance	40% coinsurance	Preauthorization is required if charges are $500 or more. If you do not get preauthorization, benefits may be denied. Preauthorization is required for orthotic devices.
	Hospice services	20% coinsurance	40% coinsurance	Preauthorization is required. If you do not get preauthorization, benefits may be denied. Bereavement Counseling is limited to 3 visits within 12 months of death.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Covered under Eyemed policy. For more information, please call 1-866-723-0513
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	Covered under Delta Dental policy. For more information, please call 1- 800-335-8266

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.
- 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.)

- Private-duty nursing (medically necessary only)
- Chiropractic Care (24 visits/year)

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 1-864-364-5219.

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 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.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 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	$500
■ Specialist copayment	$25
■ 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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$260
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,220**

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

■ The plan's overall deductible	$500
■ Specialist copayment	$25
■ 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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$100
Copayments	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,220**

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

■ The plan's overall deductible	$500
■ Specialist copayment	$25
■ 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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$400
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,200**

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