

 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> ?	\$600 individual / \$1,200 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>prescription drugs</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	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>prescription drugs</u> , <u>balance-billing charges</u> 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	<u>Primary care</u> visit to treat an injury or illness	\$30 <u>copay</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u>	Includes <u>primary care</u> visits for mental/behavioral health and substance abuse services.
	<u>Specialist</u> visit	\$30 <u>copay</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No charge; <u>deductible</u> does not apply.	40% <u>coinsurance</u>	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 gynecological exams and prostate exams are limited to one per coverage period. 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 subject to ACA age guidelines. This <u>plan's</u> benefit year/coverage period runs from 10/01 – 9/30.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	\$30 <u>copay</u> /test; <u>deductible</u> does not apply	40% <u>coinsurance</u>	Tests associated with an office visit but billed separately: 30% <u>coinsurance</u> after <u>deductible</u> for <u>network providers</u> and 40% <u>coinsurance</u> after <u>deductible</u> for <u>out-of-network providers</u> .
	Imaging (CT/PET scans, MRIs)	30% <u>coinsurance</u>	40% <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 prescription drug coverage is available at www.paisc.com .	Generic drugs	\$10 <u>copay</u> /prescription (retail); \$20 <u>copay</u> /prescription (mail order); <u>deductible</u> does not apply to <u>prescription drugs</u>	Not Covered	Covers up to a 34 day supply (retail prescription); 90 day supply (mail order prescription). There is a separate annual <u>out-of-pocket limit</u> for <u>prescription drugs</u> of \$4,000 individual / \$8,000 family. Once member meets their <u>out-of-pocket limit</u> , member pays zero cost for <u>prescription drugs</u> . For questions regarding <u>specialty drug</u> cost, please contact BrioVaRx at 1-877-259-9428.
	Preferred brand drugs	\$35 <u>copay</u> /prescription (retail); \$70 <u>copay</u> /prescription (mail order); <u>deductible</u> does not apply to <u>prescription drugs</u>	Not Covered	
	Non-preferred brand drugs	\$70 <u>copay</u> /prescription (retail); \$140 <u>copay</u> /prescription (mail order); <u>deductible</u> does not apply to <u>prescription drugs</u>	Not Covered	
	<u>Specialty drugs</u>	\$100 <u>copay</u> /prescription (retail); \$200 <u>copay</u> /prescription (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)	30% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Physician/surgeon fees	30% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<u>Emergency medical transportation</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<u>Urgent care</u>	\$30 <u>copay</u> /visit; <u>deductible</u> does not apply	40% <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)	30% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> is required. If you do not get <u>preauthorization</u> room and board charges will be denied.
	Physician/surgeon fees	30% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> is required.
	Inpatient services	30% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> is required. If you do not get <u>preauthorization</u> room and board charges will be denied.
If you are pregnant	Office visits	30% <u>coinsurance</u>	40% <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	30% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	30% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> is required. If you do not get <u>preauthorization</u> room and board charges will be denied.

* 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>	40% <u>coinsurance</u>	Limited to 100 visits per coverage period.
	<u>Rehabilitation services</u>	30% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> is required for Inpatient services. If you do not get <u>preauthorization</u> , you will be responsible for the first \$500.
	<u>Habilitation services</u>	30% <u>coinsurance</u>	40% <u>coinsurance</u>	
	<u>Skilled nursing care</u>	30% <u>coinsurance</u>	40% <u>coinsurance</u>	Within 7 days of a 5-day stay; limited to 60 days per coverage period. <u>Preauthorization</u> is required. If you do not get <u>preauthorization</u> , room and board charges will be denied.
	<u>Durable medical equipment</u>	30% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Preauthorization</u> required if charges are \$500 or more. If you do not get <u>preauthorization</u> , you will be responsible for the first \$500.
	<u>Hospice services</u>	30% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 30 days for inpatient services and 40 visits for outpatient services per coverage period.
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Limited to \$300 per coverage period for each employee and \$200 per coverage period for each covered dependent. This includes exams/lenses/frames combined.
	Children's glasses	No charge	No charge	
	Children's dental check-up	Not applicable	Not applicable	Covered under Delta Dental policy.

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.)

<ul style="list-style-type: none"> • Acupuncture • Bariatric surgery • Cosmetic surgery 	<ul style="list-style-type: none"> • Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> • Routine foot care • Weight loss programs
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

<ul style="list-style-type: none"> • Chiropractic care (\$500/year) • Dental care (Adult) under Delta Dental Policy 	<ul style="list-style-type: none"> • Hearing aids 	<ul style="list-style-type: none"> • Private-duty nursing • Routine eye care (Adult)
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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 1-803-255-8484.

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)

■ <u>The plan's overall deductible</u>	\$600
■ <u>Specialist copayment</u>	\$30
■ <u>Hospital (facility) coinsurance</u>	30%
■ <u>Other 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	\$12,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$600
Copayments	\$40
Coinsurance	\$2,400
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,100

Managing Joe's type 2 Diabetes

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

■ <u>The plan's overall deductible</u>	\$600
■ <u>Specialist copayment</u>	\$30
■ <u>Hospital (facility) coinsurance</u>	30%
■ <u>Other 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	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$94
Copayments	\$2,255
Coinsurance	\$40
<i>What isn't covered</i>	
Limits or exclusions	\$55
The total Joe would pay is	\$2,444

Mia's Simple Fracture

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

■ <u>The plan's overall deductible</u>	\$600
■ <u>Specialist copayment</u>	\$30
■ <u>Hospital (facility) coinsurance</u>	30%
■ <u>Other 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	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$600
Copayments	\$90
Coinsurance	\$490
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,180