FirstGroup America, Inc. **PanaBridge Advantage** **Coverage for: Employee & Dependent | Plan Type: Wellness**

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, 1-800-999-5382. 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. http://www.dol.gov/ebsa/healthcare.com or call 1-800-999-5382 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Not Applicable; there are no deductibles under this Plan	You do not have to meet a deductible for services covered under this Plan.
Are there services covered before you meet your deductible?	Not Applicable; there are no deductibles under this Plan	You do not have to meet a deductible for services covered under this Plan.
Are there other deductibles for specific services?	Not Applicable; there are no deductibles under this Plan	You do not have to meet a deductible for services covered under this Plan.
What is the out-of-pocket limit for this plan?	Not Applicable; there are no out of pocket limits under this Plan	Out-of-Pocket expenses under this Plan include premium and preventive services not covered under this Plan. This includes all services other than in-network preventive services.
What is not included in the out-of-pocket limit?	Preventive services this plan does not cover.	This includes all services other than in-network preventive services
Will you pay less if you use a network provider?	Yes	If you use a network doctor or other health care provider, this Plan will pay 100% of the covered preventive services.
Do you need a referral to see a specialist?	No	You do not need a referral to see a specialist. Please note that this Plan will only pay for 100% of covered in-network preventive services.

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	Not Covered	Not covered	No coverage for primary care visits to treat an injury or illness.
	Specialist visit	Not Covered	Not covered	No coverage for a specialist visit except for covered in-network preventive services.
	Preventive care/screening/ immunization	$0	Not covered	Out of Network preventive services are not covered.
If you have a test	Diagnostic test (x-ray, blood work)	$0	Not covered	Coverage is only provided for covered in-network preventive services.
	Imaging (CT/PET scans, MRIs)	$0	Not covered	Coverage is only provided for covered in-network preventive services.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.[insert].com	Generic drugs	$0	Not covered	Coverage is only provided for covered in-network preventive services.
	Preferred brand drugs	$0	Not covered	Coverage is only provided for covered in-network preventive services.
	Non-preferred brand drugs	$0	Not covered	Coverage is only provided for covered in-network preventive services.
	Specialty drugs	Not covered	Not covered	Coverage is not provided for specialty drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered	Not covered	No coverage for facility fees.
	Physician/surgeon fees	Not covered	Not covered	No coverage for physician/surgeon fees.
If you need immediate medical attention	Emergency room care	Not covered	Not covered	No coverage for emergency room services.
	Emergency medical transportation	Not covered	Not covered	No coverage for emergency medical transportation.
	Urgent care	Not covered	Not covered	No coverage for urgent care.
If you have a hospital stay	Facility fee (e.g., hospital room)	Not covered	Not covered	No coverage for facility fees.
	Physician/surgeon fees	Not covered	Not covered	No coverage for physician/surgeon fees.
If you need mental health, behavioral	Outpatient services	Not covered	Not covered	No coverage for mental, behavioral health, or substance abuse outpatient services.

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)	
health, or substance abuse services	Inpatient services	Not covered	Not covered	No coverage for mental, behavioral health, or substance abuse inpatient services.
If you are pregnant	Office visits	Not covered	Not covered	Coverage is only provided for covered in-network preventive services.
	Childbirth/delivery professional services	Not covered	Not covered	No coverage for Childbirth/delivery professional services.
	Childbirth/delivery facility services	Not covered	Not covered	No coverage for Childbirth/delivery facility services.
If you need help recovering or have other special health needs	Home health care	Not covered	Not covered	No coverage for home health care.
	Rehabilitation services	Not covered	Not covered	No coverage for rehabilitation services.
	Habilitation services	Not covered	Not covered	No coverage for habilitation services.
	Skilled nursing care	Not covered	Not covered	No coverage for skilled nursing care.
	Durable medical equipment	Not covered	Not covered	No coverage for durable medical equipment.
	Hospice services	Not covered	Not covered	No coverage for hospice care.
If your child needs dental or eye care	Children's eye exam	No charge for child screening	Not covered	Coverage is only provided for covered in-network preventive services.
	Children's glasses	Not covered	Not covered	No coverage for glasses.
	Children's dental check-up	Not covered	Not covered	No coverage for dental check-up.

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.)

- Any service not covered under the preventive care benefit.
- Any service for an Injury or Illness
- Charges incurred in connection with routine vision exams (except as required under the wellness benefit)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Immunizations for Adults and Children
- Colorectal cancer screening (including CT colonography*, fecal occult blood testing, screening sigmoidoscopy, and screening colonoscopy)
- Cholesterol and lipid disorders
- Mammography screening (film and digital) for all adult women*
- Genetic screening and evaluation for the BRCA breast cancer gene
- Cervical cancer screening including Pap smears
- Newborn screening for hearing, thyroid disease, phenylketonuria and sickle cell anemia and standard metabolic screening panel for inherited enzyme deficiency diseases
- Counseling for fluoride use
- Major depressive disorders screening

* For more information about limitations and exceptions, see the plan or policy document at www.mypalic.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: The U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov, you can also contact your state insurance department. 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 on how 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: 1-800-999-5382.

Does this plan provide Minimum Essential Coverage? This plan or policy does provide minimal essential coverage.
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? This health coverage does not meet the minimum value standard for the benefits it provides.
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 1-800-999-5382

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-999-5382

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-999-5382

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-999-5382

*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	**$0**
Specialist *copayment*	**n/a**
Hospital (facility) *copayment*	**n/a**
Other *copayment*	**n/a**

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	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$12,663
The total Peg would pay is	**$12,663**

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

The plan's overall deductible	**$0**
Specialist *copayment*	**n/a**
Hospital (facility) *copayment*	**n/a**
Other *copayment*	**n/a**

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	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$5,450
The total Joe would pay is	**$5,450**

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

The plan's overall deductible	**$0**
Specialist *copayment*	**n/a**
Hospital (facility) copayment	**n/a**
Other *copayment*	**n/a**

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	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$2,800
The total Mia would pay is	**$2,800**

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