

## Limited Benefit Indemnity Plan Pays

BENEFIT DESCRIPTION	PLAN 1
<b>HOSPITAL ADMISSION INDEMNITY BENEFIT</b> <ul style="list-style-type: none"> <li>• Pays in addition to hospital indemnity</li> <li>• Once per admission, once per diagnosis</li> <li>• Benefit will not be payable for the same or related injury or illness.</li> </ul>	\$1,500 first day when admitted as an inpatient into a hospital room
<b>HOSPITAL INDEMNITY BENEFIT</b> <ul style="list-style-type: none"> <li>• Must be admitted as an inpatient into a hospital room</li> <li>• If hospital confinement falls into a category below a different maximum applies</li> </ul>	\$1,400 per day Overall calendar year max subject to 30 days total for any inpatient stay in a hospital
<b>Intensive Care</b> If the participant is confined in a hospital intensive care unit	\$2,800 per day Up to 30 days calendar year max (applied to overall calendar year max)
<b>Substance Abuse</b> Must be diagnosed and admitted as an inpatient in a substance abuse unit	\$1,400 per day Up to 30 days calendar year max (applied to overall calendar year max)
<b>Mental Illness</b> Must be diagnosed and admitted as an inpatient into a mental illness unit	\$700 per day Up to 30 days calendar year max (applied to overall calendar year max)
<b>Skilled Nursing Facility</b> Must be admitted in skilled nursing facility following a covered hospital stay of at least 3 days	\$700 per day Up to 27 days calendar year max (applied to overall calendar year max)
<b>DOCTOR'S OFFICE BENEFIT</b> Benefit pays one benefit per day if the patient is seen by a doctor for an illness or injury	\$70 per day 10 days per calendar year
<b>OUTPATIENT DIAGNOSTIC LABS</b> <ul style="list-style-type: none"> <li>• Includes glucose test, urinalysis, CBC, and others</li> <li>• When hospital confinement is not required and the test is ordered or performed by a doctor</li> </ul>	\$70 per day 3 days per calendar year
<b>OUTPATIENT DIAGNOSTIC RADIOLOGY</b> <ul style="list-style-type: none"> <li>• Includes chest, broken bones, and others</li> <li>• When hospital confinement is not required and the test is ordered or performed by a doctor</li> </ul>	\$70 per day 4 days per calendar year
<b>OUTPATIENT ADVANCED STUDIES</b> <ul style="list-style-type: none"> <li>• Includes CT Scan, MRI, and others</li> <li>• When hospital confinement is not required and the test is ordered or performed by a doctor</li> </ul>	\$200 per day 2 days per calendar year
<b>INPATIENT SURGICAL BENEFIT</b> <ul style="list-style-type: none"> <li>• Surgery must be performed due to an illness or injury as an inpatient stay in a hospital</li> <li>• Minor surgical procedures are excluded</li> </ul>	\$1,000 per day 2 days per calendar year
<b>INPATIENT ANESTHESIA BENEFIT</b> 30% of the amount paid under the inpatient surgical benefit	\$300 per day 2 days per calendar year
<b>OUTPATIENT SURGICAL BENEFIT</b> <ul style="list-style-type: none"> <li>• Surgery must be performed due to an illness or injury at an outpatient surgical facility center or hospital outpatient surgical facility</li> <li>• Minor surgical procedures are excluded</li> </ul>	\$1,000 per day 2 days per calendar year
<b>OUTPATIENT ANESTHESIA BENEFIT</b> 30% of the amount paid under the outpatient surgical benefit	\$300 per day 2 days per calendar year
<b>WELLNESS BENEFIT</b> <ul style="list-style-type: none"> <li>• Pays one benefit per day for routine wellness exams</li> <li>• Not for the treatment of an illness or injury</li> </ul>	\$150 per day 1 day per calendar year
<b>EMERGENCY ROOM SICKNESS BENEFIT</b> Pays one benefit per day for services received in an ER as a result of an illness	\$200 per day 4 days per calendar year

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<p><b>AMBULANCE SERVICES</b> Pays one benefit per day for emergency ground, air and water ambulance transportation</p>	<p>\$1,000 per day 4 days per calendar year</p>
<p><b>OUTPATIENT SURGICAL FACILITY</b> Pays one benefit per day for surgery performed at an outpatient surgical facility center or hospital outpatient surgical facility</p>	<p>\$300 per day 2 days per calendar year</p>
<p>THIS POLICY DOES NOT CONSTITUTE COMPREHENSIVE HEALTH INSURANCE COVERAGE (MAJOR MEDICAL COVERAGE) AND DOES NOT SATISFY THE REQUIREMENT OF MINIMUM ESSENTIAL COVERAGE UNDER THE AFFORDABLE CARE ACT</p>	

ADDITIONAL BENEFITS AND SERVICES	PLAN 1
<p><b>MEDICAL ACCIDENT WITH AD&amp;D</b> \$100 deductible per accident, per insured</p>	<p>\$2,500 per occurrence \$5,000 AD&amp;D Up to \$5,000 accidental dismemberment</p>
<p><b>PRESCRIPTION DRUG BENEFIT</b></p> <p><i>Prescription benefits are provided by PRAM Insurance Services, Inc. and processed through RxEDO, Inc. Pan-American Life is not affiliated with PRAM Insurance Services, Inc. or RxEDO, Inc.</i></p>	<p>Formulary Generics - \$10 copay Formulary Brand - \$20 co-pay Non-Formulary – N/A \$3,000 Annual Maximum Benefit per insured For questions or drug look-up call <b>1-888-879-7336</b> or visit <a href="http://www.rxedo.com">www.rxedo.com</a></p>
<p><b>PPO PROVIDER NETWORK*</b></p> <p><i>PPO Provider services are provided by Competitive Health, Inc. Pan-American Life and Competitive Health, Inc. are not affiliated.</i></p>	<p>First Health To locate in-network Physicians or Hospitals visit <a href="http://www.providerlocator.com/palichf">www.providerlocator.com/palichf</a> or call <b>1-888-561-5759</b></p>
<p><b>PROFESSIONAL HEALTH SERVICES*</b></p> <p><i>Professional health services are provided by Compass Professional Health Services. Pan-American Life and Compass Professional Health Services are not affiliated.</i></p>	<p>In addition to your insurance plan, Compass is here to serve as your personal healthcare advisor. Our mission is to help you understand and reap the full value from your healthcare benefits. Call or email Compass for help any step of the way:  For more information email <a href="mailto:pal@compassphs.com">pal@compassphs.com</a> or call <b>1-800-421-4742</b></p>
<p><b>EMPLOYEE ASSISTANCE PROGRAM*</b></p> <p><i>Employee Assistance Program benefit is provided by Competitive Health, Inc. Pan-American Life and Competitive Health, Inc. are not affiliated.</i></p>	<p>From relationship and family issues to legal problems to stress, anxiety and depression, the EAP helps members deal with life's daily challenges. SupportLinc's experienced team of licensed mental health clinicians and work-life specialists are available around-the-clock to provide support, advocacy and care. For more information visit <a href="http://www.supportlinc.com">www.supportlinc.com</a> or call <b>1-888-539-3327 Username: panamerican</b></p>
<p><b>MEMBER SERVICES AND MEMBER ADVOCACY</b></p>	<p>We make healthcare work for our members, no more hassle or frustration. Members have easy access to the Pan-American teams of Member Services and Advocacy Service Representatives. For timely answers to benefit questions, both teams are accessible via telephone: Monday through Friday, 7:30 AM – 6:00 PM, Central Time, <b>1-877-569-3075</b>. Bilingual (English – Spanish) services are available.</p>

\*Not an insurance product. Not a Pan-American Life product.

This summary has been designed to provide you with an overview of your benefits. Your plan documents and a complete benefit guide with comprehensive information about your benefits are available online at [www.mypalich.com](http://www.mypalich.com), or you may call our Member Services at **1-877-569-3075**.

Limited benefit indemnity plan and medical accident Insurance are issued by Pan-American Life Insurance Company on policy form number PAN-POL-13-T and SM-2003. There are no exclusions for pre-existing conditions. The plan will not pay benefits for any care provided prior to the coverage effective date or if the insured is confined in a hospital at the time the coverage is effective. Hospital does not include a nursing home, convalescent home or extended care facility. Accident benefit pays "Off the Job" accident medical benefits for covered expenses that result directly, and from no other cause, than from a covered accident. Coverage is not available in all states. Like most group benefit programs, our products have exclusions, limitations, waiting periods and terms for keeping them in force.

# Dental

(Included with Plan 1)

Our comprehensive dental plan provides members with the Preventive Care, Basic Care and Major Care Services they need.

To help minimize out-of-pocket dental expenses members have access to the DentalGuard Preferred Select Network, one of the industry's largest dental preferred provider networks with dentists in over 120,000 locations across the country. Members are free to visit any dentist or specialist they wish. However, by visiting a dentist within the DentalGuard Preferred Select Network, members can save money. How?

- DentalGuard Preferred Select Network dentists are up to 35% less than what most dentists usually charge<sup>1</sup>.
- By taking advantage of the lower fees offered by in-network providers, members can stretch their annual plan maximums further.

## Outline of Dental Benefits

Dental Benefits (per insured)	
<b>Charges we cover (coinsurance)</b>	
Preventive - Type I	100%
Basic - Type II	80%
Major - Type III	50%
<b>Calendar Year Deductible</b>	
Preventive - Type I	Waived
Basic - Type II & Major - Type III	\$50
<b>Calendar Year Maximum - (Types I - III)</b>	
\$1,500	
<b>Waiting Period</b>	
Preventive - Type I	None
Basic - Type II	None
Major - Type III	None

<sup>1</sup>Savings depend on the dentist's location and type of service.

**To locate a DentalGuard Preferred Select network dentist call 1-800-627-4200, or go to [www.GuardianLife.com](http://www.GuardianLife.com), and follow these steps:**

1. Select "Find a Provider" at the top of the site towards the right hand side.
2. At the bottom of the page, Select "Have a plan that is not provided by Guardian? Do you have access to the DentalGuard Preferred Select Network?"
3. Enter information to look up multiple providers in your area by Zip Code or City and State.
4. To look up a specific provider in your area, enter providers last name.

If there is a (1) next to your chosen provider, please be advised that this Dentist is participating through another network ("Partner Network"). To ensure that your provider is covered under the DentalGuard Preferred Select Network, please contact that office directly before utilizing your dental benefits.

Dental Provider Network services are provided by The Guardian Life Insurance Company of America. [www.guardianlife.com](http://www.guardianlife.com). Pan-American Life and The Guardian Life Insurance Company of America are not affiliated.

# Vision

(Included with Plan 1)

## Highlights

- Allowance on eyewear
- \$0 copay for exams
- \$0 copay for standard lens options
- No in-network claim paperwork
- Free 1-year breakage warranty
- Fixed lens pricing
- Discounts on LASIK surgery included
- Hearing aid discounts

For more details about the plan, visit [davisvision.com/member](http://davisvision.com/member) and enter your Client Code [9001] or call 1 (800) 836-2094 and enter your Client Code when prompted.

As a member, you have access to the Exclusive Collection of Frames. The Exclusive Collection of frames is available at nearly 9,000 locations across the U.S.

Log in to browse frames, and find a Collection near you. The frame icon indicates that the provider carries the Collection.



## Fashion Value Vision Plan Overview

Benefits	In-Network
Eye Exams – every 12 months	\$0 copay
<b>Prescription Eyewear</b>	
Frames – every 24 months	\$110 frame allowance + 20% off overage <sup>1</sup>
Exclusive Collections Frames (Fashion/Designer/Premier)	Covered-in-full / \$15 charge / \$40 charge
Lenses – every 24 months	\$0 copay for standard lenses
Specialty Coatings and Tints	Varies by lens type - see backside for details
Contacts <sup>2</sup> Evaluation and Fitting – every 24 months (in lieu of eyeglasses)	\$0 copay for conventional lens; Fitting covered-in-full
	\$0 copay for specialty lens; \$60 allowance for fitting
	\$110 materials allowance + 15% off overage <sup>1</sup>
LASIK (refractive surgery)	40% to 50% off the overall national average

### Vision plan administered by Davis Vision

1. Some limitations apply to additional discounts; discounts not applicable at all in-network providers.
2. Contact lens coverage varies by product selection. Visually Required contacts are covered in full with prior approval. Davis Vision has done its best to accurately reflect plan coverage herein. If differences exist between this document and the plan contract, the contract will prevail.

	Copays for lens options and upgrades
Clear plastic single-vision, bifocal, trifocal or lenticular lenses (any RX)	\$0
Oversized lenses	\$0
Plastic lenses	\$0
Polycarbonate lenses (children / adults)	\$0 / \$35
High index lenses	\$60
Polarized lenses	\$75
Progressive lenses (Standard / Premium / Ultra)	\$65 / \$105 / \$140
Anti-reflective (AR) coating (Standard / Premium / Ultra)	\$40 / \$55 / \$69
Ultraviolet coating	\$15
Tinting of plastic lenses (Solid / Gradient)	\$15
Plastic Photochromic Lenses (Transitions® Signature™)	\$70
Scratch-resistant coating	\$0
Scratch protection plan (Single vision / Multifocal)	\$20 / \$40

### *Out-of-network Benefits*

You may receive services from an out-of-network provider, although you will receive the greatest value and maximize your benefit dollars if you select a provider who participates in the network.

### Out-of-network Reimbursement Schedule (up to)

Eye exam: \$40	Trifocal Lenses: \$80
Frame: \$50	Lenticular Lenses: \$100
Single-Vision Lenses: \$40	Elective Contact Lenses: \$80
Bifocal / Progressive Lenses: \$60	Visually Required Contacts: \$225

*For questions, call:*



**1-877-923-2847**

Enter Client Code 9001,  
when prompted

*Enter your client code in the “Member Sign In” section of our website at [davisvision.com/member](http://davisvision.com/member) to find a provider.*