2024

EMPLOYEE BENEFIT HANDBOOK

AMERICAN MEDICAL PLAN

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INTRODUCTION AND ENROLLMENT

Introduction

Our health insurance offerings aim to provide you and your family with a variety of choices. We have four core health plans, each tailored to different coverage levels and associated premiums. All four of these core health plans meet the individual mandate requirements of the Affordable Care Act (ACA), provided your state enforces it. We are confident that you will find value in what we offer, so please carefully consider the benefits, coverage, and any limitations of each plan.

Enrollment

According to federal law, there are specific periods during the year when you can enroll. You can sign up during our **annual open enrollment** period, within your **new hire window**, or in response to a **qualifying event**.

If you are a new hire, you must complete the enrollment process within 30 days from your hire date.

A qualifying event is defined as a change in your status due to circumstances such as marriage, divorce, the birth of a child, loss of coverage, change of residency, and more.

HEALTH BENEFITS

To meet the requirements of the Healthcare Reform Employer Mandate, we offer four core health plans, all providing the basic Minimum Essential Coverage to comply with the Federal ACA Mandate. Our more comprehensive plans (plans 2-4, namely MEC Plus, MEC Enhanced, and Hospital Indemnity) include a fixed benefit amount to assist in covering various medical services, such as doctor visits, diagnostic tests, x-rays, hospitalization, accidents, emergency room visits, surgeries, prescription drugs, intensive care, and more. Furthermore, these plans grant access to a National PPO network designed to manage costs.

In addition to the four core health plans, we offer a high-dollar deductible Minimum Value Plan to further adhere to the ACA Employer Mandate.

UNDERSTANDING YOUR BENEFITS

Our four core health insurance options are designed to offer a broad spectrum of coverage and flexibility that aligns with your budget.

Basic Minimum Essential Coverage (MEC), provides the fundamental level of coverage required under the Employer Mandate clause of the Affordable Care Act.

Plans 2-4 (MEC Plus, MEC Enhanced, and Hospital Indemnity) include the basic MEC and offer additional benefits. The higher the plan, the greater the coverage and benefits you receive. These plans operate on an indemnity basis, providing a fixed dollar amount to the healthcare provider, doctor, or hospital for each covered service, eliminating the need for up-front copayments or responsibility for deductibles and coinsurance, as is common with many health plans.

Please note that these plans utilize a national PPO network, so it's advisable to use in-network providers and hospitals for better pricing.

These plans are comprehensive and designed to address your day-to-day health needs, while the hospital indemnity plan focuses on providing substantial hospital and surgery benefits.

We strongly recommend that you carefully review each plan, its benefits, and any limitations before making a decision.

VIDEO RESOURCES

(CLICK ON THE LINKS BELOW)

PANABRIDGE ADVANTAGE - YOUR HEALTH PLAN EXPLAINED

GOING TO THE DOCTOR

PREVENTIVE CARE

HEALTHIEST YOU (TELEMEDICINE IN YOUR PLAN)

Preventive Care Plan

One of the most valuable benefits included with your benefit package is preventive care coverage which now covers 100% of eligible preventive service costs when performed in-network. That means that you pay nothing out of pocket for access to a variety of medical screenings, exams, and immunizations which may help reduce your risk of developing health conditions in the future and avoid expensive treatment down the road.

Understanding Preventive Care

Preventive care is the first step in knowing how healthy you are. The goal is to "prevent" a serious health condition by detecting problems early on. Preventive care includes screenings, tests, medicines and counseling performed or prescribed by your doctor or other health care provider to test for conditions which may develop even when you don't have signs or symptoms of an injury or illness. Your provider is able to deliver treatment which can prevent you from getting sick and by counseling you on beneficial lifestyle changes or offering prophylactic treatment.

Why is Preventive Care Important?

- Detection of health conditions early, when they are more easily treatable
- Identification of potential risks to your future health
- Provide adults with immunizations for illnesses such as influenza and pneumonia, as well as booster shots and required immunizations for children

Difference Between Preventive and Diagnostic Services

A preventive procedure starts with the intent of confirming your good health although you may appear asymptomatic. Diagnostic services differ in that they are requested in order to identify the cause of a reported health condition.

Services are considered Preventive Care when a person:

- Does not have symptoms indicating an abnormality
- Has had a screening done within the recommended age and gender guidelines with the results being considered normal
- Has had a diagnostic service with normal results, after which the physician recommends future preventive care screenings using the appropriate age and gender guidelines
- Has a preventive service that results in diagnostic care or treatment being done at the same time and as an integral part of the preventive service (e.g. polyp removal during a preventive colonoscopy), subject to benefit plan provisions

Services are considered Diagnostic Care when:

- Services are ordered due to current issues or symptoms(s) that require further diagnosis
- Abnormal test results on a previous preventive or diagnostic screening test requires further diagnostic testing or services
- Abnormal test results found on a previous preventive or diagnostic service requires the same test be repeated sooner than the normal age and gender guideline recommendations would require

PanaMed
Limited Benefit Indemnity Plan

PanaMed Limited Benefit Indemnity Plan

Pays fixed benefit amounts to help cover the costs of common medical services

Access to discounted PPO Network Rates

Your own Member Advocate is available to assist you to reduce medical costs and stressful billing situations

PanaMed is a limited benefit indemnity plan that pays clearly defined, fixed amounts to help you cover the cost of common medical services, such as doctor's office visits, hospitalization, intensive care, accidents, and much more. This limited benefit indemnity plan is designed to provide the most value for everyday healthcare expenses as opposed to plans that cover major illness and catastrophicinjuries.

In the following pages you will find a benefit grid that details each of the benefits included in our plans, along with how much each of them pays. You will also find important information regarding additional benefits and services included in your plan.

How to get the best from your Plan

1. Call or go online to locate an in-network provider (details in the PPO Provider Network section of this guide)
2. Schedule your appointment
3. Visit provider and present ID card
4. Provider files claim
5. PPO Network applies discounts and forwards claim to Pan-American Life (insurance carrier)
6. If the claim is less than the allowable benefit amount in your plan, you owe nothing
7. If the claim is more than the allowable benefit amount in your plan, you will owe the balance to the provider

NOTE – While PanaMed benefits may be used at any hospital or physician's office, members are encouraged to utilize the PPO Network for discounted provider prices.

Limited Benefit Indemnity Plan Pays

BENEFIT DESCRIPTION	PLAN 1	PLAN 2	PLAN 3
HOSPITAL ADMISSION INDEMNITY BENEFIT • Pays in addition to hospital indemnity • Once per admission, once per diagnosis • Benefit will not be payable for the same or related injury or illness	N/A	$1,000 first day when admitted as an inpatient into a hospital room	$2,000 first day when admitted as an inpatient into a hospital room
HOSPITAL INDEMNITY BENEFIT • Must be admitted as an inpatient into a hospital room • If hospital confinement falls into a category below a different maximum applies	$50 per day Overall calendar year max subject to 60 day(s) total for any inpatient stay in a hospital	$800 per day Overall calendar year max subject to 60 day(s) total for any inpatient stay in a hospital	$2,000 per day Overall calendar year max subject to 60 day(s) total for any inpatient stay in a hospital
Intensive Care If the participant is confined in a hospital intensive care unit	$100 per day Up to 30 day(s) calendar year max (applied to overall calendar year max)	$1,600 per day Up to 30 day(s) calendar year max (applied to overall calendar year max)	$4,000 per day Up to 30 day(s) calendar year max (applied to overall calendar year max)
Substance Abuse Must be diagnosed and admitted as an inpatient in a substance abuse unit	$25 per day Up to 30 day(s) calendar year max (applied to overall calendar year max)	$400 per day Up to 30 day(s) calendar year max (applied to overall calendar year max)	$1000 per day Up to 30 day(s) calendar year max (applied to overall calendar year max)
Mental Illness Must be diagnosed and admitted as an inpatient into a mental illness unit	$25 per day Up to 60 day(s) calendar year max (applied to overall calendar year max)	$400 per day Up to 60 day(s) calendar year max (applied to overall calendar year max)	$1000 per day Up to 60 day(s) calendar year max (applied to overall calendar year max)
Skilled Nursing Facility Must be admitted in skilled nursing facility following a covered hospital stay of at least 3 days	$25 per day Up to 57 day(s) calendar year max (applied to overall calendar year max)	$400 per day Up to 57 day(s) calendar year max (applied to overall calendar year max)	$1000 per day Up to 57 day(s) calendar year max (applied to overall calendar year max)
DOCTOR'S OFFICE BENEFIT Benefit pays one benefit per day if the patient is seen by a doctor for an illness or injury	$80 per day 4 day(s) per calendar year	$100 per day 6 day(s) per calendar year	$150 per day 6 day(s) per calendar year
OUTPATIENT DIAGNOSTIC LABS • Includes glucose test, urinalysis, CBC, and others • When hospital confinement is not required and the test is ordered or performed by a doctor	$25 per day 3 day(s) per calendar year	$35 per day 3 day(s) per calendar year	$45 per day 3 day(s) per calendar year
OUTPATIENT DIAGNOSTIC RADIOLOGY • Includes chest, broken bones, and others • When hospital confinement is not required and the test is ordered or performed by a doctor	$70 per day 2 day(s) per calendar year	$70 per day 4 day(s) per calendar year	$100 per day 2 day(s) per calendar year
OUTPATIENT ADVANCED STUDIES • Includes CT Scan, MRI, and others • When hospital confinement is not required and the test is ordered or performed by a doctor	$300 per day 2 day(s) per calendar year	$300 per day 2 day(s) per calendar year	$400 per day 2 day(s) per calendar year

Limited Benefit Indemnity Plan Pays

BENEFIT DESCRIPTION	PLAN 1	PLAN 2	PLAN 3
INPATIENT SURGICAL BENEFIT • Surgery must be performed due to an illness or injury as an inpatient stay in a hospital • Minor surgical procedures are excluded	N/A	$2,000 per day 1 day(s) per calendar year	$3,000 per day 1 day(s) per calendar year
INPATIENT ANESTHESIA BENEFIT 25% of the amount paid under the inpatient surgical benefit	N/A	$500 per day 1 day(s) per calendar year	$750 per day 1 day(s) per calendar year
OUTPATIENT SURGICAL BENEFIT • Surgery must be performed due to an illness or injury at an outpatient surgical facility center or hospital outpatient surgical facility • Minor surgical procedures are excluded	N/A	$1,000 per day 1 day(s) per calendar year	$1,500 per day 1 day(s) per calendar year
OUTPATIENT ANESTHESIA BENEFIT 25% of the amount paid under the outpatient surgical benefit	N/A	$250 per day 1 day(s) per calendar year	$375 per day 1 day(s) per calendar year
EMERGENCY ROOM SICKNESS BENEFIT Pays one benefit per day for services received in an ER as a result of an illness	$75 per day 2 day(s) per calendar year	$200 per day 1 day(s) per calendar year	$300 per day 2 day(s) per calendar year
SPECIFIED ILLNESS BENEFIT Lump Sum benefit for specified major health events (first diagnosis of invasive cancer, heart attack, and stroke). Waiting Period: • 30 day waiting period for heart attack and stroke • 90 day waiting period for invasive cancer	$1,500 lump sum Spouse 50% of lump sum Children 25% of lump sum	$5,000 lump sum Spouse 50% of lump sum Children 25% of lump sum	$5,000 lump sum Spouse 50% of lump sum Children 25% of lump sum

THE LIMITED BENEFIT INDEMNITY PLAN ALONE 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. HOWEVER, THE PREVENTIVE CARE PLAN OFFERED AS PART OF PANABRIDGE ADVANTAGE DOES MEET THE REQUIREMENT UNDER THE AFFORDABLE CARE ACT AS IT PROVIDES MINIMUM ESSENTIAL COVERAGE.

Group Medical Accident

with Accidental Death & Dismemberment

(Included with All Plans)

Covered Charges

Hospital room and board and general nursing care up to the semi-private room rate ● Hospital - miscellaneous expenses during hospital confinement such as the cost of operating room, laboratory tests, x-ray examinations, anesthesia, drugs (excluding take-home drugs) or medicines, therapeutic services and supplies ● Doctor's fees for surgery and anesthesia services ● Doctor's visits - inpatient and outpatient ● Hospital emergency care ● X-ray and laboratory services ● Prescription drug expense ● Dental treatment for injury to sound natural teeth ● Registered nurse expense.

BENEFIT	Plan 1	Plan 2	Plan 3
Accident Benefit* per occurrence	Up to **$2,500**	Up to **$5,000**	Up to **$10,000**
Deductible per accident, per insured	**$100** deductible	**$100** deductible	**$100** deductible
Accidental Death	**$5,000**	**$10,000**	**$20,000**
Accidental Dismemberment	Up to **$5,000**	Up to **$10,000**	Up to **$20,000**
Initial Treatment Period..... 12 weeks (Initial treatment must be incurred within 12 weeks of the date of the accident)		Benefit Period..... 52 weeks (Expenses must be incurred within 52 weeks of the date of the accident)	

**Pays "Off the Job" Accident Medical Benefits for Covered Expenses that result directly, and from no other cause, than from a covered accident. The insured's loss must occur within one year of the date of the accident.*

Medical Accident insurance is issued by Pan-American Life Insurance Company on policy form number SM-2003.

Global Repatriation

Helping to Provide Peace of Mind During Your Time of Need

The passing of a loved one is a difficult and emotional experience. When it occurs during travel, you or your loved ones may feel that help is no longer within reach.

Global Repatriation is a worldwide benefit designed to help your family when you or a covered dependent suffers a loss of life due to a covered accident or illness while traveling 100 miles or more away from their permanent residence. The benefit provides transportation of a covered member's remains to his/her primary place of residence in the United States and repatriation of foreign nationals to their home countries.

Benefit Includes:

- Expenses for preparations; embalming or cremation
- Transport casket or air tray
- Transportation of remains to place of residence or place of burial

All services must be authorized and arranged by AXA Assistance designated personnel and the maximum benefit per person is $20,000 USD per occurrence. No claims for reimbursement will be accepted.

To Activate Assistance Call: **1-888-558-2703 / 1-312-356-5963**

(Toll-Free in the U.S.) (Collect Outside of the U.S.)

Global Repatriation benefits are independently offered and administered by AXA Assistance USA, Inc. www.axa-assistance.us

Pan-American Life and AXA Assistance USA, Inc. are not affiliated. See policy for exclusions and limitations.

Prescription Drug Indemnity Benefits

Your prescription drug indemnity benefit will pay a maximum amount per day, per insured person, with a maximum amount either per month or per calendar year (check your plan below). There are no copayments, deductibles, or coinsurance

Prescription Drug Indemnity Pays (Included with Plan 1)

Generic - $15 per day
Monthly Maximum Limit for Generic is 2 days per insured

Brand - Discount Only

Prescription Drug Indemnity Pays (Included with Plan 2)

Generic or Brand - $20 per day
Monthly Maximum Limit for Generic or Brand is 2 days per insured

Prescription Drug Indemnity Pays (Included with Plan 3)

Generic - $25 per day
Calendar Year Maximum Limit for Generic is 36 days per insured

Brand - $50 per day
Calendar Year Maximum Limit for Brand is 36 days per insured

This Applies to All 3 Plans

- If the pharmacy's charge is less than the per day indemnity benefit, you will be mailed a check for the difference.
- If the pharmacy's charge is more than the per day indemnity benefit, you will be responsible for the difference.
- If maximum limit is met a Discount will be applied.

The R_xEDO pharmacy network includes **over 68,000** total participating retail pharmacy locations nationwide; all major chains are included as well as 20,000+ independent pharmacies.

Helpful Hints

- Show the pharmacist your identification card. It includes the BIN and PCN numbers, as well as any other information they will need to process your claim through R_XEDO.
- If your pharmacy has any questions concerning the process, please have them call the R_XEDO Pharmacy Help Desk at (800) 522-7487, which is printed on your new identification card.

For questions or drug look-up go to www.rxedo.com or call 1-888-879-7336.

Prescription drug indemnity benefits are insured by Pan-American Life Insurance Company on form number PA-IOPD-15-P and administered by RxEDO. Pan-American Life is not affiliated with RxEDO.

Prescription Drug Indemnity Benefit
Frequently Asked Questions

1. **What is the difference between a co-pay prescription benefit and the indemnity prescription benefit?** Instead of paying out-of-pocket for co-pays, your indemnity prescription plan will pay a fixed dollar amount per day for a maximum number of days per month or per year depending on your plan. In addition, your indemnity benefit is not limited to formulary restrictions.

2. **What if the per day benefit amount is greater than the cost of my prescription?**
A check for the difference will be mailed to you at the end of the month.

3. **What if the cost of my prescription is greater than the per day benefit amount?**
You will be responsible for any costs above the per day benefit amount at the pharmacy.

4. **How can I find out what my out-of-pocket cost will be under this plan before I go to the pharmacy?** For drug look-up you can go to www.RxEDO.com or call 1-888-879-7336. Prices may vary at each pharmacy, so it is best to contact the pharmacy directly.

5. **What if I have two generic prescriptions to fill on the same day?**
The plan will pay the fixed dollar amount per day regardless of the number of prescriptions you fill at the pharmacy. Please be aware that your pharmacy will apply your prescription indemnity benefit to only one prescription at the pharmacy. If there is any indemnity benefit remaining, you will receive that amount in the form of a check at the end of the month.

6. **What if I have a generic and a brand prescription to fill on the same day?**
If your plan covers brand prescriptions under the indemnity benefit, the plan will pay the fixed dollar amount per day for one generic, and the a fixed dollar amount per day for one brand prescription. If you have a combination plan, the plan will pay the fixed dollar amount for either one brand or one generic prescription per day, but not for both. All plans include discounts on prescriptions not covered and /or exceeding the one per day limit.

Here's how your Prescription Drug Indemnity Benefits work:

Example 1 – If your plan Pays:

Generic - $10 per day
Brand - $50 per day

Calendar Year Maximum Limit for Generic is 12 days per insured
Calendar Year Maximum Limit for Brand is 12 days per insured

In one day you or a covered dependent fills one Generic and one Brand prescription drugs as shown below:

1 Generic for a total cost of:	$4
Plan pays the pharmacy :	$4
Plan mails you a check for :	$6

1 Brand for a total cost of:	$38
Plan pays the pharmacy :	$38
Plan mails you a check for:	$12

This per day benefit for Generic and Brand drugs has been satisfied. Any additional prescriptions filled by that particular insured, on the same day, would have a discount applied.

Example 2 – If your plan Pays:

Generic - $25 per day
Brand - $50 per day

Calendar Year Maximum Limit for Generic is 12 days per insured
Calendar Year Maximum Limit for Brand is 12 days per insured

In one day you or a covered dependent fills one Generic and one Brand prescription drugs as shown below:

1 Generic for a total cost of:	$30
Plan pays the pharmacy :	$25
You are responsible for:	$5

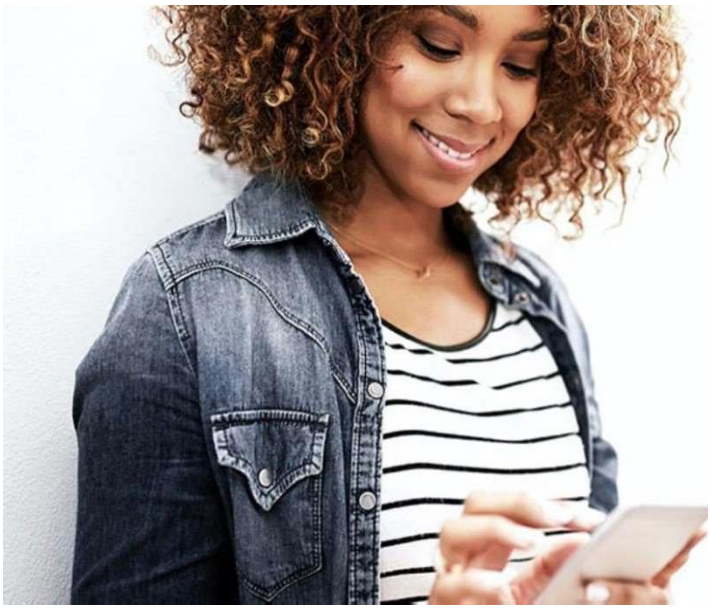
1 Brand for a total cost of:	$60
Plan pays the pharmacy :	$50
You are responsible for :	$10

This per day benefit for Generic and Brand drugs has been satisfied. Any additional prescriptions filled by that particular insured, on the same day, would have a discount applied.

(Included with All Plans)

Your healthcare just got a whole lot easier!

With HealthiestYou you can connect to a doctor, get treatment, and get prescriptions, 24 hours a day, 7 days a week over the phone or via the mobile app. Using HealthiestYou can SAVE YOU TONS OF MONEY and no more sitting around in waiting rooms. And best of all, it's FREE!



HY can handle over 70% of doctor office visits!

Top 9 Physician Consults

Allergies, Bronchitis, Earache, Sore Throat, Sinusitis, Pink Eye, Strep Throat, Respiratory Infection, and Urinary Tract Infection

24x7 UNLIMITED DOCTOR ACCESS
Are you sick? Call HealthiestYou first! Our physician network can diagnose, treat, and prescribe with no consult fees, anytime, anywhere. Really!

PRESCRIPTION SAVINGS
Need a prescription? Our geo-based Prescription search engine can save you up to 85% on your prescription and will often beat your co-pay.

SHOP & PRICE PROCEDURES
Do you need an MRI or an Ultrasound? Our app puts you in the driver's seat by providing a vehicle to search and price procedures in your direct area. Happy shopping!

HEALTH MANAGEMENT CONTENT
Are you stressed? Let HealthiestYou guide you to improved health and happiness with relevant health content delivered at your time of need.

REGISTER AND ACCESS YOUR ACCOUNT
member.healthiestyou.com

No internet? Call a doctor
(855) 894-9627

To learn how to connect with a doctor 24/7, shop and price procedures, prescription savings and more. Watch our video: **www.mypalic.com/videohy**

And don't forget to download the app

Download on the App Store

ANDROID APP ON Google play

HealthiestYou is not insurance and is provided by HY Holdings Inc. Pan-American Life and HY Holdings Inc. are not affiliated.

Health Insurance Premiums

MEC Basic	Weekly Payroll Deduction	Monthly Premium
Employee Only	$18.59	$74.37
Employee + Spouse	$27.42	$109.66
Employee + Child(ren)	$26.83	$107.31
Employee + Family	$37.62	$150.49

MEC Plus (Plan 1)	Weekly Payroll Deduction	Monthly Premium
Employee Only	$24.51	$98.03
Employee + Spouse	$43.36	$173.42
Employee + Child(ren)	$37.46	$149.82
Employee + Family	$59.14	$236.54

MEC Enhanced (Plan 2)	Weekly Payroll Deduction	Monthly Premium
Employee Only	$51.50	$205.98
Employee + Spouse	$100.81	$403.25
Employee + Child(ren)	$81.84	$327.37
Employee + Family	$138.20	$552.81

Hospital Indemnity (Plan 3)	Weekly Payroll Deduction	Monthly Premium
Employee Only	$76.25	$305.00
Employee + Spouse	$155.42	$621.68
Employee + Child(ren)	$123.61	$494.44
Employee + Family	$212.96	$851.82

PPO Provider Network

First Health Network

(Included with All Plans)

Using In-Network Providers Can Stretch Your Benefit Dollars

Your plan includes access to the First Health Network, which is more than a PPO Network, it is a full service Managed Care Organization offering savings opportunities on a national, directly contracted basis. It provides access to more than 5,000 Hospitals and 695,000 Physicians and health care professionals nationwide.

First Health is committed to patient safety at a high level by exercising care in the selection and evaluation of providers for our network. Thorough credentialing and re-credentialing processes minimize unfavorable risks, which in turn, impacts clinical and cost outcomes.

In addition to the First Health Network, our members also have access to a secondary, or Wrap Network that provides them and their covered dependents a broader access to Physicians and health care professionals in urban, suburban, and rural areas.

To locate in-network Physicians or Hospitals call **1-888-561-5759**
or visit **www.providerlocator.com/palicfh** to search online

PPO Provider services are provided by Competitive Health, Inc. *Pan-American Life and Competitive Health are not affiliated.*

Member Services

Our member service representatives are responsible for ensuring that customers receive the best assistance with their questions and concerns. Pan-American Life's customer service representatives interact with customers to provide information in response to inquiries about products and services. They communicate with administrators and members through a variety of means; by telephone, by e-mail, fax or mail.

We can assist members, companies and providers with:

- Member Advocacy
- ID Cards
- Policy Information
- Member Eligibility
- Verification of Benefits
- Prescription Benefits
- PPO Network Information
- Account Management
- Claims
- And more!

Monday through Friday, 7:30 AM – 5:00 PM, Central Time.

1-800-999-5382

Full bilingual (English-Spanish) services

OUTLINE OF COVERAGE FOR LIMITED BENEFIT INDEMNITY PLAN

This outline of coverage provides a brief summary of some important features of your insurance certificate. This outline of coverage is not an insurance contract and only the actual certificate provisions will control. Your certificate includes in detail the rights and obligations of you, your employer, and Pan-American Life Insurance Company. Please review your certificate carefully for additional information. You can access your certificate through our web portal at www.mypalic.com, or you can call our Member Services and request a copy.

Categories of Coverage: Your certificate includes **limited benefit indemnity plan**, also referred to as fixed indemnity coverage. Limited indemnity plans differ from major medical coverage and are not designed to cover all medical expenses or meet the minimum standards required by the Affordable Care Act for major medical coverage. Payments are based on a fixed per day dollar amounts in the Summary of Benefits rather than on a percentage of the provider's charge. If you need comprehensive major medical coverage, there may be other options available to you and your family members. Please go to www.healthcare.gov for more information.

Benefits: The benefit levels are described in your **Summary of Benefits**. Some benefits included in your plan may appear as riders and these can be found following your **Summary of Benefits**.

The **Table of Contents** shows where to find more information regarding: eligibility, benefits, exclusions and limitations, and other important terms and conditions.

Exceptions, Reductions, and Limitations: Your benefits are subject to certain exclusions, limitations, and terms for keeping the benefits in force.

Please refer to the section entitled "**Exclusions and Limitations**" for further details on these and other exclusions and limitations. The first page of the **Summary of Benefits** provides information on the **Waiting Period** and the **age-based reduction in Life Insurance Benefits**, if applicable.

Continuation of Coverage: Eligibility for coverage is described in the sections entitled **Eligibility for Employees** and **Eligibility for Dependents** of your certificate. Your coverage may not begin until after a waiting period, as described on the first page of the **Summary of Benefits**. The **Termination of Coverage** section of your certificate explains when your coverage will terminate. Under certain circumstances, you may continue your coverage for a limited time period if you should become disabled. See the **Extension Due to a Total Disability** section for details. In addition, you may be eligible for continued coverage under applicable COBRA laws. See the **Continuation Coverage Rights Under COBRA** section for further details.

Premium or Contribution: The cost of this coverage is included within the premiums paid for your benefit plan. Your contribution will be deducted by your employer from your paycheck.

GENERAL EXCLUSIONS AND LIMITATIONS FOR PANAMED

This is a general list of exclusions and limitations and may vary by state.

Benefits are not payable with respect to any charge, service or event excluded as set forth below.

1. Charges for medical or dental services of any kind, or any medical supplies or visual aids or hearing aids, or any food, supplement or vitamin, or medicine, it being understood that the Policy shall pay the Indemnity Benefits set forth in the Summary of Benefits for a hospitalization or other covered event, without regard to the actual charges made by a provider or supplier of goods or services.
2. Any claim relating to a hospitalization or other covered event where the hospitalization or other covered event was prior to the effective date of coverage under the Policy, or after coverage is terminated.
3. A claim arising out of insurrection, rebellion, participation in a riot, commission of or attempting to commit an assault, battery, felony, or act of aggression.
4. A claim arising out of declared or undeclared war or acts thereof. For life insurance: As a result of the special hazards incident to service in the military, naval or air forces of any country, combination of countries or international organization, if the cause of death occurs while the insured is serving in such forces, provided such death occurs within six (6) months after the termination of service in such forces.
5. A claim arising out of Accidental Bodily Injury occurring while serving on full time active duty in any Armed Forces of any country or international authority (any premium paid will be returned by Us pro rata for any period of active full time duty).
6. A claim related to an Injury or Illness arising out of or in the course of work for wage or profit or which is covered by any Worker's Compensation Act, Occupational Disease Law or similar law.
7. With respect to a death benefit, a claim related to bodily injuries received while the Covered Person was operating a motor vehicle under the influence of alcohol as evidenced by a blood alcohol level in excess of the state legal intoxication limit.
8. A claim arising from services in the nature of educational or vocational testing or training.
9. A claim related to Custodial Care.
10. A claim arising from medical services provided to the Covered Person for cosmetic purposes or to improve the self-perception of a person as to his or her appearance, except for: reconstructive plastic surgery following an Accident in order to restore a normal bodily function, or a surgery to improve functional impairment by anatomic alteration made necessary as a result of a birth defect, or breast reconstruction following a mastectomy.
11. Other than a claim for death benefits, any claim arising out of a surgical procedure for the treatment of obesity or the purpose of facilitating weight reduction.
12. Other than a claim for death benefits, any claim arising out of treatment of infertility.
13. For Specified Illness - Cancer does not include pre-malignancies, cancer in situ, and skin cancers except melanoma. Transient Ischemic Attacks (TIA) are excluded.

ACCIDENTAL DEATH AND DISMEMBERMENT RIDER
EXCLUSIONS AND LIMITATIONS

In addition to the General Exclusions and Limitation of the Policy, benefits are not provided for Loss, Injury or Illness of a Covered Employee which results directly or indirectly, wholly or partly from:

1. Suicide, self-destruction, attempted self-destruction or intentional self-inflicted injury while sane or insane.
2. Disease or disorder of the body or mind.
3. Medical or surgical treatment or diagnosis thereof.
4. Loss, Injury or Illness occurring after Termination of Coverage.
5. Ptomaines or bacterial infections, except pyogenic infections at the same time and as a result of a visible wound.
6. Asphyxiation from voluntarily or involuntarily inhaling gas and not the result of the Covered Person's job.
7. Travel or flight in any vehicle for aerial navigation, including boarding or alighting therefrom:
   a. While being used for any test or experimental purpose; or
   b. While the Covered Person is operating, learning to operate or serving as a member of the crew thereof; or
   c. Any such aircraft or device which is owned or leased by or on behalf of the Policyholder of any subsidiary or affiliate of the Policyholder, or by the Covered Person or any member of his household.
8. Voluntarily taking any drug or narcotic unless the drug or narcotic is prescribed by a Doctor.
9. Heart attack, stroke or other circulatory disease or disorder, whether or not known or diagnosed, unless the immediate cause of Loss is external trauma.

Disability benefit disclosure for New York residents

If your plan includes a Disability benefit: Pan-American Life Insurance Company can provide short term disability benefits for your employees under a Hospital Indemnity Policy issued to You as the Plan Sponsor. Under NY Law Section 1101(b)(2)(B)(i) (I)(aa) and 1101 (b)(2)(B)(ii) the Pan-American Policy may cover your employees in New York even though Pan-American Life Insurance Company is not a licensed carrier in New York. However, please be aware that the short term disability benefits provided for your New York employees will not satisfy the requirements of the New York Disability Benefits Law (DBL). In order to obtain appropriate coverage for your New York employees to comply with the New York Disability Benefits law, you should contact your agent for workers compensation coverage.

Frequently Asked Questions

Preventive Care Plan

1. **While the employee is a participant in the Preventive Care Plan, will the employee be eligible for a premium subsidy in connection with any plan offered on an Exchange established under the Affordable Care Act?**
   No.
2. **Are Preventive Care Services covered only when performed in-network?**
   Yes, preventive services are only covered under the preventive care plan when performed by an in-network provider.
3. **How does a member determine which providers participate in the network?**
   PPO participation may be verified with a simple phone call or online. The toll free number and website link can be found in the PPO Provider Network section of this guide, your ID card, and in our web portal. The insured is responsible for verifying the current PPO participation of their provider.
4. **Can dependents be insured in this plan?**
   Yes. If the member is covered by PanaBridge Advantage, dependents are also eligible for coverage.

PanaMed Limited Benefit Indemnity Plan

1. **Is PanaMed Major Medical coverage?**
   No. PanaMed is a limited benefit indemnity plan. This is not basic health insurance or major medical coverage and is not designed as a substitute for either coverage. PanaMed pays a fixed benefit amount to help cover the cost of common medical services. The plan is not designed to cover the costs of serious or chronic illnesses. It contains specific dollar limits that will be paid per day for medical events which may not be exceeded. Specific dollar limits are listed in the summary of benefits.
2. **Does PanaMed have any exclusions or limitations?**
   Benefits are subject to certain exclusions, limitations, and terms for keeping the benefits in force. For example, there are no benefits for the following medical events: infertility treatments, cosmetic surgery, counseling for mental illness or substance abuse, obesity, weight reduction or dietetic control, physical therapy. This is a partial list of non covered events. Members should refer to their certificate to determine which benefits are available. Additional information can be found in our web portal at www.mypalic.com.
3. **Will the PanaMed plan provide an indemnity benefit for any Physician or Hospital?**
   Yes. The member is free to seek the services of any licensed Physician or accredited Hospital. There is no requirement that the Physician or Hospital belong to a PPO network to receive benefits.
4. **What is a PPO and the advantage for using?**
   PPO is the abbreviation for Preferred Provider Organization. This organization of providers (referred to as a "network") has agreed to provide their services as a negotiated discount, reducing your out of pocket cost. While PanaMed may be used at any hospital or physician's office, members are encouraged to utilize the PPO network for discounted provider prices.
5. **Is there a pre-existing condition exclusion on the plan?**
   No, because this is a limited benefit indemnity plan there are no pre-existing condition exclusions.
6. **Are Medicare and Medicaid recipients eligible for this plan?**
   Only you can determine whether PanaMed is right for you. As you weigh your decision, be sure to consider that when Medicare or Medicaid benefits are coordinated with PanaMed coverage, that PanaMed is considered primary coverage. As a result, benefits available under PanaMed will be first applied to coverage before anything is paid by Medicare and/or Medicaid.
7. **Can the PanaMed plan be used if the insured has separate health insurance?**
   Yes. The specified benefits pay irrespective of any other private group coverage.