



HAH Holdings, LLC dba Help at Home

2026 BENEFIT GUIDE

Preventive + PanaMed

Summary of Benefits and Coverage

To obtain an electronic copy of the Summary of Benefits and Coverage and Benefit Guide, please visit www.panamericanbenefitsenrollment.com, enter your group ID **SE719**, and then select View Summary.

You may also request a paper copy at any time by contacting us at 1-800-999-5382.

2027 Enrollment

We are excited to be a part of your employee benefits program. This guide has the information you need to familiarize yourself with the benefits choices available to you during your Open Enrollment period. Your program offers meaningful benefits that provides access to the care you and your family need to lead healthy, productive lives.

Among the benefits offered, your program includes a Minimum Essential Coverage plan to help identify potential health risks for early diagnosis and treatment. Additionally, there is a Limited Medical Indemnity plan that pays a fixed benefit amount per day to help cover the out-of-pocket cost of common services, such as doctor's office visits, hospitalization, accidents, and much more.

Your Pan-American Service Team



To learn more about your benefit plan, watch enrollment video at www.mypalac.com/videopba

When To Enroll In The Plan

You are eligible to enroll in the benefit plan within 30 days of your hire date or during your employer's annual open enrollment period. If you do not enroll during one of these time periods, you will have to wait until the next annual open enrollment, unless you have a qualifying life event. You have 30 days from the date of the qualifying life event to enroll.

A qualifying life event is defined as a change in your status due to one of the following: Marriage or divorce, birth or adoption of a child(ren), termination, death of an immediate family member, Medicare entitlement, employer bankruptcy, loss of dependent status, loss of prior coverage.

How To Enroll

Enrollment is *easy, fast* and *convenient*.

You will be able to enroll online, or through Aptia's toll-free Enrollment Center Dedicated line in just a few minutes.

Online: You can easily and conveniently enroll online 24/7 at https://aptia365.com/Help_at_Home

By Phone: To enroll now, call Aptia's toll-free Enrollment Center and a representative will answer your questions and enroll you over the phone.

Call **1-855-746-3198**,
Monday - Friday, 6:00 AM - 8:00 PM, CST.
Full bilingual (English-Spanish) services.

Once you enroll in the plan, you will receive your ID Card(s) by mail. The information in your card will help you register to our online member portal at mypalac.com, where you will have 24-hour access to:

- Review claims
- Access plan documents
- See your benefits
- Find in-network providers
- Print ID cards
- Download forms
- Frequently Asked Questions
- And much more...

The information provided in this guide is a brief outline of benefits. Your summary plan description and certificate of coverage governs the terms and conditions of your plan.

Preventive Care Plan

(Included with Plans 1 & 2)



Preventive care

Receive routine immunization, wellness exams, & medicines at no-cost when in-network

Stay healthy by catching potential illnesses before they start

Arm yourself with the tools you need to make smart choices for your future

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

Preventive Care Plan

(Included with Plans 1 & 2)

Are Preventive Care Services covered only when performed in-network?

Yes, these preventive services are only covered under the preventive care plan when performed by an in-network provider. Your plan includes access to one of the largest Provider Networks. Details for locating an in-network provider can be found in the Provider Network section of this guide.

Covered Preventive Services for Adults

Screenings for:

- Abdominal aortic aneurysm (one-time screening for men of specified ages who have ever smoked)
- Alcohol misuse
- Blood pressure
- Cholesterol (for adults of certain ages or at higher risk)
- Colorectal cancer (for adults over 45)
- Depression
- Type 2 diabetes (for adults with high blood pressure)
- Hepatitis B (for virus infection in persons with high risk)
- Hepatitis C (for infection in persons at high risk) (one-time screening for HCV to adults born between 1945-1965)
- HIV (for all adults at higher risk)
- Lung Cancer (for adults age 55-80 with a 30-pack per year smoking history and who currently smoke or quit within the past 15 years)
- Obesity
- Tobacco use
- Syphilis (for all adults at higher risk)

Counseling for:

- Alcohol misuse
- Aspirin use for men and women of certain ages and cardiovascular risk factors
- Diet (for adults with higher risk for chronic disease)
- Human Immunodeficiency Virus (HIV) for sexually active women
- Obesity
- Sexually transmitted infection (STI) prevention (for adults at higher risk)
- Tobacco use (including programs to help you stop using tobacco)

Immunizations:

- Doses, recommended ages, and recommended populations vary.
- Diphtheria, pertussis, tetanus (DPT)
- Hepatitis A
- Hepatitis B
- Herpes zoster
- Human papillomavirus (HPV)
- Influenza (Flu)
- Measles, mumps, rubella (MMR)
- Meningococcal (meningitis)
- Pneumococcal (pneumonia)
- Varicella (chicken pox)

Additional Covered Preventive Services for Women

- Aspirin (low dose as preventive after 12 weeks gestation in women who are at high risk for preeclampsia)
- Breast Cancer preventive medications for women with increased risk (tamoxifen or raloxifene).
- Contraception (FDA approved and ACA required contraceptive methods, sterilization procedures, and patient education and counseling)
- Well-woman visits (to obtain recommended preventive services for women under 65)

Screenings for:

- Breast cancer (mammography every 1 to 2 years for women over 40)
- Cervical cancer (for sexually active women)
- Chlamydia infection (for younger women and other women at higher risk)
- Domestic and interpersonal violence
- Gestational diabetes (for those at high risk)
- Gonorrhea (for all women at higher risk)
- Human Immunodeficiency Virus (HIV) (for sexually active women)
- Human Papillomavirus (HPV) DNA Test: High risk HPV DNA testing every three years for women with normal cytology results who are 30 or older
- Syphilis (for all pregnant women or other women at increased risk)
- Osteoporosis (for women over age 60 depending on risk factors)

Preventive Care Plan

(Included with Plans 1 & 2)

Counseling for:

- BRCA: Genetic counseling and testing for women at higher risk (family history is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes) and screening, genetic counseling, and testing for women who are asymptomatic and have not received a BRCA-related cancer diagnosis, but who previously had breast, ovarian, or other cancer; women whose family history is associated with an increased risk of BRCA-related cancer; women with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA testing.
- Breast cancer chemoprevention (for women at higher risk)
- Contraception (education and counseling)
- Domestic and interpersonal violence
- Folic acid supplements (for women of child-bearing ages)
- Human Immunodeficiency Virus (HIV) (for sexually active women)
- Sexually Transmitted Infections (STI): Counseling for sexually active women

Additional services for pregnant women:

- Anemia screenings
- Bacteriuria urinary tract or other infection screenings
- Breast feeding interventions to support and promote breast feeding after delivery
- Expanded counseling on tobacco use
- Gestational diabetes (screening for women 24 to 28 weeks pregnant)
- Hepatitis B counseling (at the first prenatal visit)
- Rh incompatibility screening, with follow-up testing for women at higher risk

Covered Preventive Services for Children

Screenings and assessments for:

- Alcohol and drug use (for adolescents)
- Autism (for children at 18 and 24 months)
- Behavioral issues
- Blood pressure (screening for children)
- Cervical dysplasia (for sexually active females)
- Congenital hypothyroidism (for newborns)
- Depression (screening for adolescents)
- Developmental (screening for children under age 3, and surveillance throughout childhood)
- Dyslipidemia (screening for children at higher risk of lipid disorders)

- Hearing (for all newborns)
- Height, weight and body mass index measurements
- Hæmatocrit or hemoglobin
- Hæmoglobinopathies or sickle cell (for newborns)
- HIV (for adolescents at higher risk)
- Lead (for children at risk of exposure)
- Medical history
- Obesity
- Oral health risk assessment (for young children)
- Phenylketonuria (PKU) (newborns)
- Tuberculin testing (for children at higher risk of tuberculosis)
- Vision (screening as part of physical exam, not separate eye exam)

Medications and supplements:

- Gonorrhea preventive medication for the eyes of all newborns

Counseling for:

- Fluoride (prescription chemoprevention supplements for children without fluoride in their water source)
- Obesity
- Sexually transmitted infection (STI) prevention (for adolescents at higher risk)
- Tobacco use (education and counseling to prevent initiation of tobacco use in school-aged children and adolescents)

Immunizations:

From birth to age 18. Doses, recommended ages, and recommended populations vary.

- Diphtheria, pertussis, tetanus (DPT)
- Hæmophilus influenzae type b
- Hepatitis A
- Hepatitis B
- Human papillomavirus (HPV)
- Inactivated poliovirus
- Influenza (Flu)
- Measles, mumps, rubella (MMR)
- Meningococcal (meningitis)
- Pneumococcal (pneumonia)
- Rotavirus
- Varicella (chicken pox)

For more information regarding preventive care recommendations and immunizations, please visit the websites for the [Centers for Disease Control](#) and [Preventions](#) or the [United States Department of Human Services](#).

Preventive Care Plan

(Included with Plans 1 & 2)

Prescription Drug Coverage*

The following chart shows categories of pharmaceuticals available to you at no cost. As lists may change, please note that in order to determine which specific drugs or brands within each of the below categories are covered under your prescription benefits, you will need to contact RxEDO at 1-888-879-7336 or go online to rxedo.com for more information.

Item	Availability	Coverage
Aspirin	Adult men and women 45 years or more	Generic, OTC
Folic Acid supplements	Adult women Up to 55 years	Generic, OTC
Fluoridated drugs	6 months – 5 years	Brand, generic
Tobacco Cessation	Adult men and women	• Generic or OTC only on nicotine replacement products • Limit to Generic Zyban
Additional Covered Preventive Services for Women		
Oral Contraceptives	Adult women	Generic, single source brands
Emergency contraception		Generic, OTC, single source brands**
Injectable contraceptives		Generic, single source brands**
Transdermal patch		Generic, single source brands**
Diaphragm and cervical cap		Generic, single source brands**

*Under PPACA, certain medications and prescription drugs that prevent illness and disease are covered at no-cost as long as services are rendered by a physician who participates in the plan's network. This chart lists the preventive medications that are covered at 100% under the PanaBridge Advantage Plan. In order for these medications to be covered at 100%, a prescription is required from your physician, including over-the-counter (OTC) drugs. Drugs may be subject to quantity limitations.

**Single source brands are brand named drugs which do not have generic alternatives.

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 Provider 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 catastrophic injuries.

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 Provider Network section of this guide)
2. Schedule your appointment
3. Visit provider and present ID card
4. Provider files claim
5. Provider 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 Provider Network for discounted provider prices.

Limited Benefit Indemnity Plan Pays



BENEFIT DESCRIPTION	PLAN 1	PLAN 2
HOSPITAL ADMISSION INDEMNITY BENEFIT - Pays in addition to hospital indemnity benefit - Once per admission, once per diagnosis - Benefit will not be payable for the same or related injury or illness.	N/A	\$1,500 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	\$100 per day Overall calendar year max subject to 180 days total for any inpatient stay in a hospital	\$700 per day Overall calendar year max subject to 180 days total for any inpatient stay in a hospital
Intensive Care If the participant is confined in a hospital intensive care unit	\$200 per day Up to 90 days calendar year max (applied to overall calendar year max)	\$1,400 per day Up to 90 days calendar year max (applied to overall calendar year max)
Substance Abuse Must be diagnosed and admitted as an inpatient in a substance abuse unit	\$50 per day Up to 90 days calendar year max (applied to overall calendar year max)	\$350 per day Up to 90 days calendar year max (applied to overall calendar year max)
Mental Illness Must be diagnosed and admitted as an inpatient into a mental illness unit	\$50 per day Up to 180 days calendar year max (applied to overall calendar year max)	\$350 per day Up to 180 days 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	\$50 per day Up to 177 days calendar year max (applied to overall calendar year max)	\$350 per day Up to 177 days 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	\$100 per day 6 days per calendar year	\$125 per day 6 days 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	\$35 per day 3 days per calendar year	\$45 per day 3 days 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	\$100 per day 2 days per calendar year	\$100 per day 4 days 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	\$400 per day 2 days per calendar year	\$500 per day 2 days per calendar year

Limited Benefit Indemnity Plan Pays



BENEFIT DESCRIPTION	PLAN 1	PLAN 2
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	\$500 per day 1 day per calendar year
INPATIENT ANESTHESIA BENEFIT 25% of the amount paid under the inpatient surgical benefit	N/A	\$125 per day 1 day 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	\$250 per day 1 day per calendar year
OUTPATIENT ANESTHESIA BENEFIT 25% of the amount paid under the outpatient surgical benefit	N/A	\$62.50 per day 1 day 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 and major organ transplants	N/A	\$1,500 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 INDIVIDUAL RESPONSIBILITY REQUIREMENT UNDER THE AFFORDABLE CARE ACT AS IT PROVIDES MINIMUM ESSENTIAL COVERAGE.		

Group Medical Accident

With Accidental Death & Dismemberment

Covered Charges

Hospital room and board, and general nursing care, up to the semi-private room rate • Hospital miscellaneous expense during Hospital Confinement such as the cost of the 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.

	PLAN 1	PLAN 2
Accident Benefit* per occurrence	Up to \$5,000	Up to \$10,000
Deductible per accident, per insured	\$100 deductible	\$100 deductible
Accidental Death	\$10,000	\$20,000
Accidental Dismemberment	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.

Medical Accident is NOT available to residents in WA.

Global Repatriation

(Included with Plans 1 & 2)

Helping to Provide Peace of Mind During Your Time of Need

The passing of a loved one can be 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 - \$10 per day

Brand - Discount Only

Monthly Maximum Limit for Generic is **3 days** per insured



Prescription Drug Indemnity Pays (Included with Plan 2)

Generic - \$10 per day

Brand - \$50 per day

Monthly Maximum Limit for Generic is **2 days** per insured

Monthly Maximum Limit for Brand is **2 days** per insured

This Applies to Both 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

Pharmacy Network

The RxEDO 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 # 610220 and PCN # 03980000, as well as any other information they will need to process your claim through RxEDO.
- If your pharmacy has any questions concerning the process, please have them call the RxEDO 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.

Frequently Asked Questions

Prescription Drug Indemnity Benefit

- 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.

Using In-Network Providers Can Stretch Your Benefits Dollars



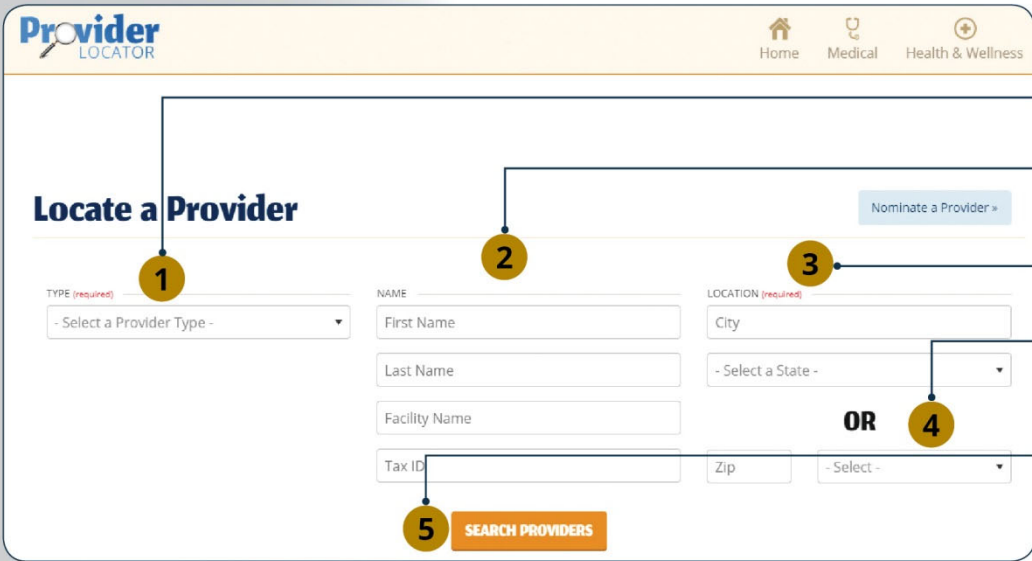
Your plan includes access to the First Health Network, which is more than a Provider Network, it is a full-service Managed Care Organization offering savings opportunities on a national, directly contracted basis. It provides access to more than 5,000 Hospitals and 695,000 Physicians and health care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

Provider Locator



Follow These Steps

1. Select the specialty and/or type of provider you want to locate.
2. (Optional) Complete these fields if searching for a specific provider.
3. Select location by city, state, or zip code.
4. (Optional) You can also select the distance from your location.
5. Click here to start your search.

Provider Network services are provided by Recuro Health. Pan-American Life and Recuro Health are not affiliated.

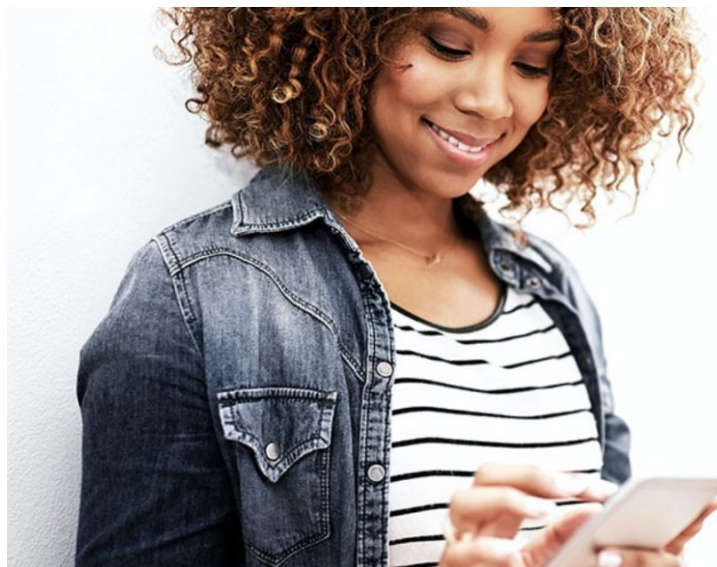
Your healthcare just got a whole lot easier!

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!



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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!



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member.healthiestyou.com

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



PRESCRIPTION SAVINGS

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



HEALTH MANAGEMENT CONTENT

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



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



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

Member Advocacy

What is a member advocate?

A member advocate is an in-house representative that works exclusively on behalf of our members to reduce medical costs and stressful billing situations. They are able to help members find community programs, hospitals, pharmaceutical companies, and provider offices who have affordable treatment costs. Also, they serve as a single point-of-contact to help resolve on-going or challenging billing issues. They're even available to speak with members individually, as well as their physicians and medical facilities, so everyone has a full understanding of how the benefits work and can make the most informed choices with regard to planning medical treatment.

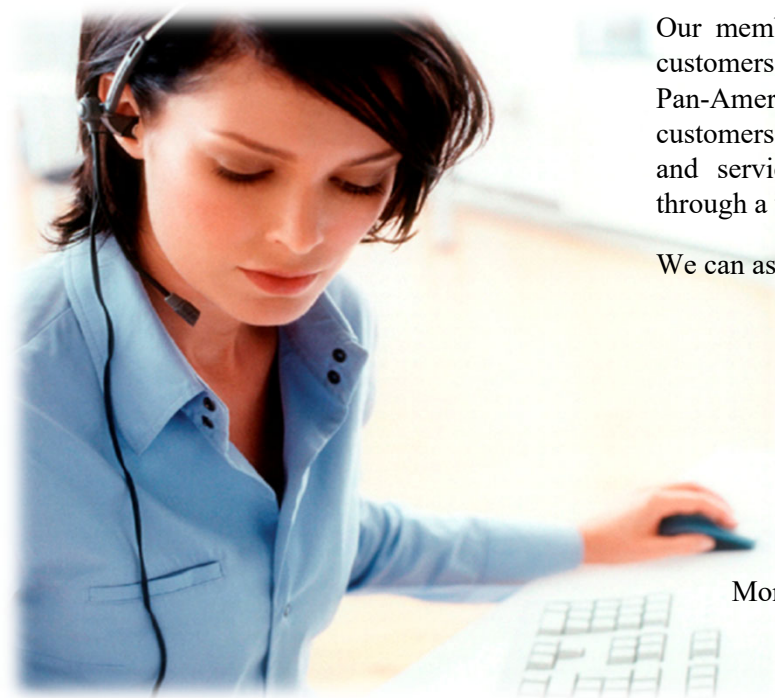
Advocates can assist with:

- Medical bills & Prescription costs
- Lab work & X-rays
- CAT Scans / MRIs
- Durable medical equipment
- Diabetic supplies
- Complicated claims and billing issues

They help lower costs by:

- Finding providers that offer sliding-scale treatment pricing
- Arranging payment plans for previously incurred bills
- Requesting discounted lump-sum payments to settle balances
- Locating community programs for specialized services or frequently recurring expenses due to chronic conditions
- Contacting discount pharmacies

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 | • Prescription Benefits |
| • ID Cards | • Provider Network Information |
| • Policy Information | • Account Management |
| • Member Eligibility | • Claims |
| • Verification of Benefits | • 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.mypallic.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?**
Participation may be verified with a simple phone call or online. The toll-free number and website link can be found in the Provider Network section of this guide, your ID card, and in our web portal. The insured is responsible for verifying the current 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.mypalico.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 Provider Network to receive benefits.
- 4. 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.
- 5. 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.
- 6. 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.