Barbeque Integrated, Inc. dba Smokey Bones: PanaBridge Advantage

Coverage Period: 01/01/2017 – 12/31/2017

The attached Summary of Benefits and Coverage (SBC) is required under the new Affordable Care Act (ACA). Under these rules, health plans are required to provide a summary of benefits and coverage, and a list of definitions, designed to make it easier for you to compare your options, and understand exactly what you are buying.

This summary **only describes the Wellness benefits** offered under the PanaBridge Advantage plan. For a full list of benefits offered under the Limited Benefit Plan, please refer to your Benefit Enrollment Guide.

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Employee & Dependent

Plan Type: Wellness

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the Plan Document at www.mypalic.com or by calling 1-800-999-5382.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Not Applicable; there are no deductibles under this Plan	You do not have to meet a deductible for services covered under this Plan.
Are there other deductibles for specific services?	Not Applicable; there are no deductibles under this Plan	You do not have to meet a deductible for services covered under this Plan.
Is there an out–of–pocket limit on my expenses?	There are no out of pocket limits under this Plan	Out-of-Pocket expenses under this Plan include premium and preventive services not covered under this Plan. This includes all services other than in-network preventive services.
What is not included in the out–of–pocket limit?	Preventive services this plan does not cover.	This includes all services other than in-network preventive services.
Is there an overall annual limit on what the plan pays?	No	There are no overall annual limits on what this Plan pays.
Does this plan use a network of providers?	Yes	If you use a network doctor or other health care provider, this Plan will pay 100% of the covered preventive services.
Do I need a referral to see a specialist?	No.	You do not need a referral to see a specialist. Please note that this Plan will only pay for 100% of covered in-network preventive services.
Are there services this plan doesn't cover?	Yes	This plan will not pay for out of network services. Some of the services this Plan does not cover are listed in this Summary of Benefits under the Section titled Excluded Services. Ask your employer for a copy of your Plan Document for additional information about excluded services.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Not covered	Not covered	No coverage for primary care visits to treat an injury or illness
	Specialist visit	Not covered	Not covered	No coverage for a specialist visit except for covered in-network preventive services.
	Other practitioner office visit	Not covered	Not covered	No coverage for a practitioner office visit except for covered in-network preventive services.
	Preventive care/screening/immunization	$0	Not covered	Out of Network preventive services are not covered.
If you have a test	Diagnostic test (x-ray, blood work)	$0	Not covered	Coverage is only provided for covered in-network preventive services
	Imaging (CT/PET scans, MRIs)	$0	Not covered	Coverage is only provided for covered in-network preventive services

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.rxedo.com.	Generic drugs	$0	Not covered	Coverage is only provided for covered in-network preventive services
	Preferred brand drugs	$0	Not covered	Coverage is only provided for covered in-network preventive services
	Non-preferred brand drugs	$0	Not covered	Coverage is only provided for covered in-network preventive services
	Specialty drugs	Not covered	Not covered	Coverage is not provided for specialty drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered	Not covered	No coverage for facility fees
	Physician/surgeon fees	Not covered	Not covered	No coverage for physician/surgeon fees
If you need immediate medical attention	Emergency room services	Not covered	Not covered	No coverage for emergency room services
	Emergency medical transportation	Not covered	Not covered	No coverage for emergency medical transportation
	Urgent care	Not covered	Not covered	No coverage for urgent care
If you have a hospital stay	Facility fee (e.g., hospital room)	Not covered	Not covered	No coverage for facility fees
	Physician/surgeon fee	Not covered	Not covered	No coverage for physician/surgeon fees

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Not covered	Not covered	No coverage for mental/behavioral health outpatient services
	Mental/Behavioral health inpatient services	Not covered	Not covered	No coverage for mental/behavioral health inpatient services
	Substance use disorder outpatient services	Not covered	Not covered	No coverage for substance use disorder outpatient services
	Substance use disorder inpatient services	Not covered	Not covered	No coverage for disorder inpatient services
If you are pregnant	Prenatal and postnatal care	Not covered	Not covered	Coverage is only provided for covered in-network preventive services
	Delivery and all inpatient services	Not covered	Not covered	No coverage for delivery and all inpatient services
If you need help recovering or have other special health needs	Home health care	Not covered	Not covered	No coverage for home health care
	Rehabilitation services	Not covered	Not covered	No coverage for rehabilitation services
	Habilitation services	Not covered	Not covered	No coverage for habilitation services
	Skilled nursing care	Not covered	Not covered	No coverage for skilled nursing
	Durable medical equipment	Not covered	Not covered	No coverage for durable medical equipment
	Hospice service	Not covered	Not covered	No coverage for hospice care
If your child needs dental or eye care	Eye exam	No Charge for child screening	Not covered	Coverage is only provided for covered in-network preventive services
	Glasses	Not covered	Not covered	No coverage for glasses
	Dental check-up	Not covered	Not covered	No coverage for dental check-up

Excluded Services & Other Covered Services:

Services Your Plan Does Not Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

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

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

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

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal laws provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at 1-800-999-5382. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: 1-800-999-5382. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and http://cciio.cms.gov/prgrams/consumer/capgrants/index.html".

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does not meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-999-5382.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $40
- **Patient pays** $7,500

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Co-pays	$0
Co-insurance	$0
Limits or exclusions	$7,500
Total	**$7,500**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $4,100
- **Plan pays** $140
- **Patient pays** $ 3,960

Sample care costs:

Prescriptions	$1,500
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$730
Education	$290
Laboratory tests	$140
Vaccines, other preventive	$140
Total	**$4,100**

Patient pays:

Deductibles	$0
Co-pays	$0
Co-insurance	$0
Limits or exclusions	$3,960
Total	**$3,960**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

- For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.