




This document is intended to be used as an easy-to-read summary of benefits. It is not a contract or a certificate of coverage. Additional limitations and exclusions may apply to covered services. For an official description of benefits, please see the applicable certificate and riders. All payment amounts are based on the Cofinity Network approved amount, less any applicable deductible and/or copay amounts required by the plan.

About the Plan Options

Who is eligible to apply for the plan? - All **ACTIVE PESG Employees** along with their family members. You are considered an ACTIVE employee of PESG if you have worked for a PESG client district at any time within the prior six (6) calendar months from your voluntary benefits application date.

Are Pre-Existing Conditions covered? - Pre-Existing Medical conditions will be covered with no waiting period as long as you can provide verification of 18 months of continuous coverage from your previous carrier without a lapse in coverage of more than 60 days. Without verification of prior coverage a 12 month waiting period will apply.

		IN - Network		OUT - of - Network	
Medical Deductible Plan Options:					
A medical deductible is the amount of covered expenses you'll pay out of your pocket before your plan begins to pay the benefit levels as shown.		Individual:	Family:	Individual:	Family:
 Important Information to Know:		Plan 1	\$250 / \$500	\$500 / \$1,000	
<ul style="list-style-type: none">Deductibles start over each calendar yearThese plans have a separate deductible for certain conditions.		Plan 2	\$1,500 / \$3,000	\$3,000 / \$6,000	
		Plan 3	\$2,500 / \$5,000	\$5,000 / \$10,000	
		Plan 4	\$5,000 / \$10,000	\$10,000 / \$20,000	

		Individual:	Family:	Individual:	Family:
Accompanying Plan Co-Insurance:					
Co-Insurance represents the percentage of covered healthcare costs you have to pay, after meeting your deductible, while covered under this plan.					
	All Plans	25%		50%	

		Individual:	Family:	Individual:	Family:
Plan out-of-pocket Co-Insurance Maximums:					
The total amount you're required to pay toward the covered cost of your healthcare. This does not include monthly premiums, deductibles, access fees and any copays required by the plan.					
	Plan 1	\$2,500	\$5,000	\$5,000	\$10,000
	Plan 2	\$5,000	\$10,000	\$10,000	\$20,000
	Plan 3	\$5,000	\$10,000	\$10,000	\$20,000
	Plan 4	\$5,000	\$10,000	\$10,000	\$20,000

Plan Annual Maximum Benefit Amount:
The total amount your plan will pay for covered expenses in any given calendar year. \$2,000,000
This may be affected by the implementation of the PPACA of 2010

Plan Lifetime Maximum Benefit Amount:
The total amount your plan will pay for covered expenses in your lifetime. Unlimited
This may be affected by the implementation of the PPACA of 2010

Plan Coverage Summaries

All covered services apply to your plan IN-Network or
OUT-of-Network Deductible/Co-Insurance unless otherwise stated

To be covered, all expenses must be medically necessary and listed as covered in your Certificate of Coverage.

Preventative Care Services: Payment is limited to a combined maximum of \$1,000 per member per calendar year

	IN - Network	OUT - of - Network
Health Maintenance Exams - Includes Chest X-ray, EKG & select lab procedures Gynecological Exam Pap Smear Screening (laboratory & pathology services) Fecal Occult Blood Screening Flexible Sigmoidoscopy Exam Prostate Specific Antigen (PSA) Screening Immunizations - up through age 16 Well-Baby and Child Care Services <ul style="list-style-type: none"> • 6 visits, birth through 12 months • 6 visits, 13 months through 23 months • 2 visits, 24 months through 35 months • 2 visits, 36 months through 47 months • 1 visit per birth year, 48 months through age 15 	Preventative Services Covered at 100%; Each Service is limited to Once per Calendar Year per person unless otherwise stated. Does NOT APPLY to Plan Deductible/Co-Insurance	Preventative Services are NOT COVERED by an OUT-of-Network Provider

Mammography Services: Limited to one per calendar year with no age restrictions

	IN - Network	OUT - of - Network
Mammography Screening	Covered IN-Network	Covered OUT-of-Network

Physician Office Services: Plan Copays do not apply to your plan Deductible/Co-Insurance

	IN - Network	OUT - of - Network
Office Visits	\$35 Copay	Covered OUT-of-Network
Specialist Office Consultations	\$70 Copay	
Urgent Care Center Visits	\$150 Copay	
Outpatient and Home Visits	Covered IN-Network	

Emergency Medical Care: Copays are waived if patient is admitted or for an accidental injury

	IN - Network	OUT - of - Network
Hospital Emergency Room	\$250 Copay	\$500 Copay
Ambulance Services - if medically necessary	Covered IN-Network	Covered OUT-of-Network

Diagnostic Services:

	IN - Network	OUT - of - Network
Laboratory and Pathology Services	Covered IN-Network	Covered OUT-of-Network
Diagnostic Tests and X-rays		
Therapeutic Radiology		

Maternity Services Provided by a Physician: Includes delivery and care by a certified nurse midwife

	IN - Network	OUT - of - Network
Prenatal and Postnatal Care	Covered IN-Network	Covered OUT-of-Network
Delivery and Nursery Care		

Hospital Care: All NON-EMERGENCY services must be rendered by an IN-Network hospital

	IN - Network	OUT - of - Network
Semiprivate Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered IN-Network	Covered OUT-of-Network Unlimited Days
Inpatient Consultations	Covered IN-Network	Covered OUT-of-Network
Chemotherapy		

Alternatives to Hospital Care:

	IN - Network	OUT - of - Network
Skilled Nursing Care - Up to 120 days per calendar year	Covered IN-Network	Covered OUT-of-Network
Hospice Care - Limited to dollar maximum that is adjusted periodically		
Home Health Care - Unlimited Visits		

Plan Coverage Summaries

All covered services apply to your plan IN-Network or OUT-of-Network Deductible/Co-Insurance unless otherwise stated

To be covered, all expenses must be medically necessary and listed as covered in your Certificate of Coverage.

Surgical Services:

	IN - Network	OUT - of - Network
Surgery - includes related surgical services	Covered IN-Network	Covered OUT-of-Network
Voluntary Sterilization		

Human Organ Transplants:

	IN - Network	OUT - of - Network
Specified Organ Transplants - in designated facilities ONLY, MUST BE PRE-APPROVED THROUGH THE NETWORK, SPECIFIC PLAN/NETWORK CRITERIA MAY APPLY	Covered IN-Network	Covered OUT-of-Network
	Up to \$1 million per transplant type	
Bone Marrow Transplants - MUST BE PRE-APPROVED THROUGH THE NETWORK, SPECIFIC PLAN/NETWORK CRITERIA MAY APPLY	Covered IN-Network	Covered OUT-of-Network
Kidney, Cornea and Skin Transplants		

Mental Health & Substance Abuse: Condition Specific Deductible amounts are the same as your Medical Deductible



UNIQUE CONDITION SPECIFIC DEDUCTIBLE IS APPLIED AND DOES NOT COUNT TOWARDS YOUR MEDICAL DEDUCTIBLE/CO-INSURANCE

	IN - Network	OUT - of - Network
Inpatient Mental Health Care - Unlimited Number of Days		
Inpatient Substance Abuse Treatment - Unlimited Days, \$15,000 Annual Maximum, \$30,000 Lifetime Maximum	Condition Deductible	Condition Deductible
Outpatient Mental Healthcare	Then you pay 50%	Then you pay 50%
<ul style="list-style-type: none"> Facility and Clinic Physician's Office 		
Outpatient Substance Abuse Treatment - in approved facilities ONLY, up to the annual state-dollar amount		

Other Services:

	IN - Network	OUT - of - Network
Outpatient Diabetes Management Program (ODMP)	Covered IN-Network	
Allergy Testing and Therapy		
Chiropractic Spinal Manipulation - Up to 24 visits per calendar year	\$50 Copay	Covered OUT-of-Network
Outpatient Physical, Speech and Occupational Therapy	Covered IN-Network	
<ul style="list-style-type: none"> Facility and Clinic Physician's Office - PHYSICAL THERAPY ONLY 		
There is a COMBINED 60-Visit maximum per calendar year for outpatient physical therapy in Facility, Clinic or Physician's Office		
Durable Medical Equipment	Covered IN-Network	Covered OUT-of-Network
Prosthetic and Orthotic Appliances		
Private Duty Nursing	50% after Deductible	50% after Deductible

Prescription Drug Coverage: Plan 4 includes level 1, 2 & 3 Prescription Drugs ONLY.



The prescription drug card operates on a closed formulary and utilizes the Informed Rx Network and not the Cofinity Network

	IN - Network	OUT - of - Network
<ul style="list-style-type: none"> Level 1 Prescription Drugs Level 2 Prescription Drugs Level 3 Prescription Drugs Level 4 Prescription Drugs 	\$10 Copay \$20 Copay \$40 Copay You pay 25%	Not Covered

This prescription drug card is designed to save you money. Most prescriptions for insurance plans will fall in to the level 1, 2 or 3 categories. However, most companies will require you to pay the copay amount no matter what the actual cost of the drug is. On these plans, we make sure that you pay the LESSER OF the actual cost OR the copay so that you always get the highest value for your money.

Plan Pricing & FAQ

Standard Employee Plan Pricing Levels:

	Monthly Plan Pricing			
	Plan 1	Plan 2	Plan 3	Plan 4
Employee Only	\$464.54	\$357.22	\$329.05	\$274.24
Employee + One	\$1,044.00	\$719.91	\$657.94	\$537.35
Family Coverage	\$1,341.73	\$1,053.60	\$905.29	\$740.85



There is a Young Adult Healthy Discount available of up to 20% for applicants under 30 and up to 10% for applicants under age 35!!

How do I apply for the Medical Benefits Plan? - You can apply for the Medical Benefit Plans by submitting our application in one of the following methods:

By EMAIL: benefits@contractsubs.com

By FAX: (615) 361 - 4488

By Mail: PESG MEDICAL BENEFITS
402 BNA Dr, STE 202
Nashville, TN 37217

Applications may be obtained on the PESG website, by calling (877) 514 - 8782 or by request at benefits@contractsubs.com.

When can I apply for the Medical Benefit Plans? - Open Enrollment is during the months of July - August and during the first 60 days of your Active Employment with PESG. You may submit your application at any time during Open Enrollment or if you have a change of family status; losing coverage through your spouse.

What are my payment options for the plan? - All plans are billed on a monthly ACH withdrawal from your bank account. At this time no other form of payment is accepted.

What day of the month are the payments withdrawn for benefits? - Payments will be taken every month on the 20th for the coverage period during the following month. If there is a problem with the withdrawal of funds you will be notified via email or phone and a 2nd attempt will be made around the 25th of the month. If funds are unable to be withdrawn for coverage your coverage will be cancelled effected on the first of the month following the missed payment.
Please note: There will be a \$25.00 fee assessed for fund requests that are returned or denied because of NSF.

When will my coverage be effective? - Application will be taken throughout the month and processed as they come in. All applications for coverage must be in by the payment date on the 20th of the month to be eligible for coverage on the first of the following month. If your application arrives after the 20th of the month your coverage will begin on the first of the month following 30 days.

What if I have other questions or concerns about the plans? - If you have questions or concerns about the Medical Benefit Plans or would like assistance in applying, please call us at (877) 514 - 8782 and we would be happy to help you in any way that we can.

All plans are administrated by:



All plans are sold through:



Network agreements

Network providers agree to accept an agreed-upon amount as payment in full. Network providers aren't the agents, employees, or partners of a network or any of its affiliates or subsidiaries. They are independent contractors. The Network doesn't endorse or control your healthcare providers' clinical judgment or treatment recommendations. Your Summary Plan Description (SPD) explains your share of the cost for network and out-of-network providers including all deductibles, copayments, access fees, and co-insurances.

When you go to a network provider:

- The amount you pay is based on the agreed-upon amount.
- The provider **can't** "balance bill" you for charges greater than that amount.

When you go to an out-of-network provider:

- The amount you pay is based on the network's maximum allowable fee.
- The provider **can** "balance bill" you for charges greater than the maximum allowable fee. These charges don't apply to your out-of-pocket limit or deductible.

Pre-existing conditions

A pre-existing condition is a sickness or bodily injury for which, during the twelve month period immediately prior to the covered person's effective date of coverage: 1) the covered person sought, received or was recommended medical advice, consultation, diagnosis, care or treatment; 2) prescription drugs were prescribed; or 3) diagnosis was possible. Benefits for pre-existing conditions are not payable until the covered person's coverage has been in force for 12 consecutive months with us. Pre-existing conditions may be waived with verification of 18 months of continuous coverage from your previous carrier without a lapse in coverage of more than 60 days. The pre-existing condition limitation does not apply to a covered person who is under the age of 19.

Limitations & Exclusions (things not covered by the plan)

This is an outline of the limitations and exclusions for the group health plans listed above. It is designed for convenient reference. Please consult the SPD for a complete list of limitations and exclusions. Other termination provisions apply as listed in the SPD. Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items:

Service and Billing Exclusions

- Services incurred before the effective date, after the termination date, or when premium is past due
- Charges in excess of the maximum allowable fee
- Charges in excess of the lifetime maximum benefit or any other benefit maximum
- Services not authorized, furnished, or prescribed by a healthcare provider
- Services for which no charge is made
- Services provided by a family member or person who resides with the covered person
- Services rendered by a standby physician, surgical assistant, assistant surgeon, physician assistant, nurse or certified operating room technician unless medically necessary
- Services not medically necessary, except for routine preventive services as stated in the SPD

Elective and cosmetic services

- Cosmetic services, or any related complication
- Elective medical or surgical procedures
- Hair prosthesis, hair transplants, or hair implants
- Prophylactic services

Dental, foot care, hearing, and vision services

- Dental services (except for dental injury), appliances, or supplies
- Foot care services
- Hearing care that is routine
- Vision examinations or testing, eyeglasses, or contact lenses

Pregnancy and sexuality services

- Lactation therapy
- Elective medical or surgical abortion except as stated in the SPD
- Immunotherapy for recurrent abortion
- Home uterine activity monitoring
- Reversal of sterilization
- Infertility services
- Sex change services and sexual dysfunction
- Services rendered in a premenstrual syndrome clinic

Obesity-related services

- Any treatment for obesity
- Surgical procedures for the removal of excess skin and/or fat due to weight loss

Illness/injury circumstances

- Services or supplies provided in connection with a sickness or bodily injury arising out of, or sustained in the course of, any occupation, employment or activity for compensation, profit or gain, whether or not benefits are available under Workers' Compensation except as stated

in the SPD

- Sickness or bodily injury as a result of war, armed conflict, participation in a riot, influence of an illegal substance, being intoxicated, or engaging in an illegal occupation
- This plan does not cover and no benefits are payable for medical charges for services incurred, or for disability income benefits as a result of an automobile accident, including all automobiles, RVs, trucks and pick-up trucks.

Care in certain settings

- Private duty nursing
- Custodial or maintenance care
- Care furnished while confined in a hospital or institution owned or operated by the United States government or any of its agencies for any service-connected sickness or bodily injury

Hospital services

- Services received in an emergency room unless required because of emergency care
- Charges for a hospital stay that begins on a Friday or Saturday unless due to emergency care or surgery is performed on the day admitted
- Hospital inpatient services when the covered person is in observation status or when the stay is due to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not the result of mental health

Mental health services

- Court-ordered mental health services
- Services and supplies that are rendered in connection with mental illnesses not classified in the International Classification of Diseases of the U.S. Department of Health and Human Services
- Services and supplies that are extended beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities or for mental retardation
- Marriage counseling

Other payment available

- Services furnished by or payable under any plan or law through a government or any political subdivision, unless prohibited by law
- Charges for which any other insurance providing medical payments exists

Services not considered medical

- Charges for non-medical items that are used for environmental control or enhancement whether or not prescribed by a healthcare practitioner

Other

- Any expense incurred for services received outside of the United States while residing outside of the United States for more than six consecutive months in a year except as

required by law for emergency care services

- Biliary lithotripsy
- Chemonucleolysis
- Charges for growth hormones
- Cranial banding, unless otherwise determined by us
- Educational or vocational training or therapy, services, and schools
- Expense for employment, school, sports or camp physical examinations or for the purpose of obtaining insurance, premarital tests/examinations
- Genetic testing, counseling, or services
- Hyperhydrosis surgery
- Immunotherapy for food allergy
- Light treatment for Seasonal Affective Disorder (S.A.D.)
- Living expenses, travel, transportation, except as expressly provided in the SPD
- Prolotherapy
- Sensory integration therapy
- Services for care or treatment of non-covered procedures, or any related complication
- Alternative medicine including but not limited to holistic medicine, acupuncture, and naturopathy
- Services that are experimental, investigational, or for research purposes
- Sleep therapy
- Treatment for TMJ, CMJ, or any jaw joint problem
- Treatment of nicotine habit or addiction
- Any drug, medicine or device which is not FDA approved
- Contraceptive Devices
- Medications, drugs or hormones to stimulate growth
- Legend drugs not recommended or deemed necessary by a healthcare practitioner or drugs prescribed for a non-covered injury or sickness
- Drugs prescribed for intended use other than for indications approved by the FDA or recognized off-label indications through peer-reviewed medical literature; experimental or investigational use drugs
- Over the counter drugs (except insulin) or drugs available in prescription strength without a prescription
- Drugs used in treatment of nail fungus
- Prescription refills exceeding the number specified by the healthcare practitioner or dispensed more than one year from the date of the original order
- Vitamins, dietary products, and any other nonprescription supplements

Certain services and prescription drugs require pre-authorization and notification/prior authorization before services are rendered. Please read your SPD for the complete and detailed list.

This document contains a general summary of covered benefits, exclusions and limitations. Please refer to the Summary Plan Description (SPD) for the actual terms and conditions that apply. In the event there are discrepancies with the information given in this document, the terms and conditions of the SPD will govern. Certain plan provisions may be affected by the implementation of the PPACA of 2010.