PACE UNIVERSITY DOMESTIC 2019-2020 SUMMARY OF BENEFITS
Annual 8/15/2019-08/14/2020 Spring 01/01/2020-08/14/2020

	In Network Preferred Provider Member Cost-Share	In Network Participating Provider Member Cost-Share	Out-of-Network Non-Participating Provider Member Cost-Share
Plan Deductible	None	$100 Per Member, per Plan Year	$200 Per Member, per Plan Year
Out-of-Pocket Limit *After the Out-of-Pocket Limit has been satisfied, Covered Expenses will be paid at 100% for the remainder of the Plan Year subject to any applicable benefit maximums. Refer to the plan Certificate for details about how the Out-of-Pocket Limit applies.*	$7,900 Per Member, per Plan Year $15,800 For all Members in a Family, per Plan Year		
Coinsurance *All benefits are subject to satisfaction of the Deductible, specific benefit limitations, maximums and Copayments as described in the plan Certificate.*	0% of Allowed Amount[1] for Covered Expenses	20% of Allowed Amount[1] for Covered Expenses	40% of Allowed Amount[1] for Covered Expenses, except as noted in the Schedule of Benefits.
Prescription Drugs *Benefit paid under OptumRX*	N/A	$20 Copayment per prescription for Tier 1 generic drugs $40 Copayment per prescription for Tier 2 brand name $60 Copayment per prescription for Tier 3 non-preferred brand name Up to a 30 day supply per prescription filled at an OptumRX network pharmacy	Out-of-Network Prescription Drugs are not covered and you pay the full cost.
Preventive Care *Including but not limited to: annual physicals, GYN exams, routine screenings and immunizations. Please see https://www.healthcare.gov/preventive-care-benefits/ for complete details of the services provided for specific age and risk groups.*	Covered in full for available services, see Certificate for benefit details.	Covered in full	30% of Allowed Amount[1]
The following services have per Service Copayments *This list is not all inclusive. Please read the plan Certificate for complete listing of Copayments.*	Office Visits: No Copayments	Office Visits: $25	Office Visits: No Copayments
Pediatric Dental and Vision Benefits	Refer to the plan Certificate of Coverage for details (age limits apply).		

[1] The Allowed Amount for Preferred and Participating Providers is the amount we have negotiated with the Preferred and Participating Providers. The Allowed Amount for Out-of-Network Non-Participating Providers will be determined on the Usual, Customary and Reasonable charge based on the 80th percentile of the Fair Health rate.

Questions? Contact The Allen J. Flood Companies at 800.734.9326 or pace@ajfusa.com

NOTE: Benefits are subject to state and federal requirements. Company reserves the right to make any changes necessary to meet such requirements.