2021 & 2022

You know how important it is to offer high-quality, affordable health and dental coverage that meets the needs of your business and your employees. We can help by offering flexibility, choice, and the convenience of online application and account management.

That's where we come in.

PIBT + PIA SAN DIEGO

GROUP BENEFITS

PIBT PIA|SD

858.800.6900 I piasdinsurance.com I karen@piasd.org

Since 1989 The Printing Industry Benefits Trust has been offering and supporting employee benefits insurance for companies from 2 to 500 employees in the printing, graphic arts and web media industries. Our mission is to present solutions that help control costs while delivering meaningful healthcare benefits and to be a trusted source of support and assistance.

- **Health Net, Kaiser, and PIBT Freedom - Health insurance plans offered together**
- **Industry leading service center - one call for service and support**
- **No cost COBRA Administration**
- **No cost Section 125 Premium Only Plan Document**
- **Access to full Flexible Spending Account (Section 125 Cafeteria Plan)**

MEDICAL	health net. PIBT freedom
DENTAL	DELTA DENTAL Humana. Western Dental
VISION	eyeMed vsp individual vision plans
CHIROPRACTIC & ACUPUNCTURE	LANDMARK HEALTHPLAN
LIFE: BASIC & VOLUNTARY	SYMETRA
EMPLOYEE ASSISTANCE PROGRAM	MHN A Health Net Company
EXECUTIVE MEDICAL REIMBURSEMENT PLAN	ULTIMATE HEALTH by ArmadaCare
VOLUNTARY BENEFITS	Colonial Life *
FLEX SPENDING ACCOUNT	TASC *

* *Billed separately*

Benefits at a Glance

Health Net PPO				
Plan Name	HN PPO 30/2000		HN PPO 30/4000	
Network	Full [1]		Full [1]	
Services Rendered at	Network	Out of Network	Network	Out of Network
Calendar Year Deductible (Individual/Family)	$2,000 [2] / $6,000 [2]	$4,000 [2] / $12,000 [2]	$4,000 [2] / $11,000 [2]	$8,000 [2] / $22,000 [2]
Out-of-pocket maximum (Individual/Family)	$5,000 / $10,000	$10,000 / $30,000	$6,600 / $13,200	$13,200 / $39,600
Office Visit (PCP)	$30 (No Deductible)	50%	$30 (No Deductible)	50%
Specialist Visit	$50(No Deductible)	50%	$50 (No Deductible)	50%
Outpatient Surgery/Treatment	30% per procedure	50%per procedure	30% per procedure	50%per procedure
Hospital Admission	30% per admission	50% per admission	30% per admission	50% per admission
X-ray	30%	50%	30%	50%
Laboratory	30%	50%	30%	50%
Urgent Care	$50 (No Deductible)	50%	$50 (No Deductible)	50%
Emergency Room	$100 per visit + 30%		$100 per visit + 30%	
Preventive Care	No Charge (No Deductible)	Not Covered	No Charge (No Deductible)	Not Covered
Mental Health Office Visit	$30 (No Deductible)	50%	$30 (No Deductible)	50%
Prescription Drugs	**Generic/Brand/Non-formulary/Specialty**		**Generic/Brand/Non-formulary/Specialty**	
Separate calendar year deductible	$300 Brand-Name Drugs (per member)		$300 Brand-Name Drugs (per member)	
Rx out-of-pocket maximum (Individual/Family)	Combined with the Medical out-of-pocket maximum		Combined with the Medical out-of-pocket maximum	
Retail prescriptions (30 day supply)	$15 / $40 / $60 / 30% ($250 max per prescription) [10]		$15 / $40 / $60 / 30% ($250 max per prescription) [10]	
Mail order (up to 90-day supply)	$30 / $100 / $150 / Not Available		$30 / $100 / $150 / Not Available	
Dental Coverage				
Pediatric dental coverage	Not Covered		Not Covered	
Vision				
Routine exam	$50 No Deductible (up to age 16)	Not Covered	$30 No Deductible (up to age 16)	Not Covered
Frames and lenses	Not Covered		Not Covered	
Plan ID	9651		9653	

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• Prescription drug benefits listed are for participating pharmacies only.

[1] When you receive Covered Services from a Non-Participating Provider (Out of Network) you are responsible for both the copayment or coinsurance, and any charges above the allowable amount. [2] A calendar year deductible is the amount you pay each calendar year before the carrier pays for covered services under the benefit plan. [10] Some drugs may require prior authorization and are covered only when dispensed by network select participating pharmacies. Mail service may not be covered. A separate drug copay and deductible may apply.

Benefits at a Glance

Health Net PPO		
Plan Name	HN PPO 60/5000	
Network	Full [1]	
Services Rendered at	Network	Out of Network
Calendar Year Deductible (Individual/Family)	$5,000 [2] / $10,000 [2]	$10,000 [2] / $20,000 [2]
Out-of-pocket maximum (Individual/Family)	$6,350 / $12,700	$12,700 / $38,100
Office Visit (PCP)	$60 (No Ded. x3) [13]	50%
Specialist Visit	$80(No ded.x3) [13]	50%
Outpatient Surgery/Treatment	30% per procedure	50%per procedure
Hospital Admission	30% per admission	50% per admission
X-ray	30%	50%
Laboratory	30%	50%
Urgent Care	$80 (No Ded. x3) [13]	50%
Emergency Room	$100 per visit + 30%	
Preventive Care	No Charge (No Deductible)	Not Covered
Mental Health Office Visit	$60 (No Ded. x3) [13]	50%
Prescription Drugs	**Generic/Brand/Non-formulary/Specialty**	
Separate calendar year deductible	$300 Brand-Name Drugs (per member)	
Rx out-of-pocket maximum (Individual/Family)	Combined with the Medical out-of-pocket maximum	
Retail prescriptions (30 day supply)	$15 / $40 / $60 / 30% ($250 max per prescription) [10]	
Mail order (up to 90-day supply)	$30 / $100 / $150 / Not Available	
Dental Coverage		
Pediatric dental coverage	Not Covered	
Vision		
Routine exam	$60 (up to age 18)	Not Covered
Frames and lenses	Not Covered	
Plan ID	9654	

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• Prescription drug benefits listed are for participating pharmacies only.

[1] When you receive Covered Services from a Non-Participating Provider (Out of Network) you are responsible for both the copayment or coinsurance, and any charges above the allowable amount. [2] A calendar year deductible is the amount you pay each calendar year before the carrier pays for covered services under the benefit plan. [10] Some drugs may require prior authorization and are covered only when dispensed by network select participating pharmacies. Mail service may not be covered. A separate drug copay and deductible may apply. [13] No Deductible for the first 1-3 visits. Visits 4-unlimited deductible applies.

Benefits at a Glance

Health Net HMO		
Plan Name	HN EC HMO 20	HN EC HMO 30
Network	ExcelCare [9]	ExcelCare [9]
Calendar Year Deductible (Individual/Family)	Not Applicable	Not Applicable
Out-of-pocket maximum (Individual/Family)	$3,000 / $9,000	$3,000 / $9,000
Office Visit (PCP)	$20	$30
Specialist Visit	$40	$50
Outpatient Surgery/Treatment	$500 per procedure	$1,000 per procedure
Hospital Admission	$500 per admission	$1,000 per admission
X-ray	No Charge	No Charge
Laboratory	No Charge	No Charge
Urgent Care	$40	$50
Emergency Room	$100 per visit	$100 per visit
Preventive Care	No Charge	No Charge
Mental Health Office Visit	$20	$30
Prescription Drugs	**Generic/Brand/Non-formulary/Specialty**	**Generic/Brand/Non-formulary/Specialty**
Separate calendar year deductible	Not Applicable	$300 Brand-Name Drugs (per member)
Rx out-of-pocket maximum (Individual/Family)	Combined with the Medical out-of-pocket maximum	Combined with the Medical out-of-pocket maximum
Retail prescriptions (30 day supply)	$10 / $30 / $50 / 30% ($250 max per prescription) [10]	$15 / $40 / $60 / 30% ($250 max per prescription) [10]
Mail order (up to 90-day supply)	$20 / $75 / $125 / Not Available	$30 / $100 / $150 / Not Available
Dental Coverage		
Pediatric dental coverage	Not Covered	Not Covered
Vision		
Routine exam	$20	$30
Frames and lenses	Not Covered	Not Covered
Plan ID	11004	11005

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• Prescription drug benefits listed are for participating pharmacies only.

[9] Plan service available ONLY in certain California counties and cities. You must live or work in this select service area in order to enroll in this plan. [10] Some drugs may require prior authorization and are covered only when dispensed by network select participating pharmacies. Mail service may not be covered. A separate drug copay and deductible may apply.

Benefits at a Glance

Health Net HMO		
Plan Name	HN EC ADV HMO 30	HN EC ADV HMO 45
Network	ExcelCare [9]	ExcelCare [9]
Calendar Year Deductible (Individual/Family)	Not Applicable	Not Applicable
Out-of-pocket maximum (Individual/Family)	$3,000 / $9,000	$5,000 / $10,000
Office Visit (PCP)	$30	$45
Specialist Visit	$50	$45
Outpatient Surgery/Treatment	30% per procedure	45% per procedure
Hospital Admission	30% per admission	45% per admission
X-ray	No Charge	No Charge
Laboratory	No Charge	No Charge
Urgent Care	$50	$50
Emergency Room	$100 per visit	$100 per visit
Preventive Care	No Charge	No Charge
Mental Health Office Visit	$30	$45
Prescription Drugs	**Generic/Brand/Non-formulary/Specialty**	**Generic/Brand/Non-formulary/Specialty**
Separate calendar year deductible	$300 Brand-Name Drugs (per member)	$300 Brand-Name Drugs (per member)
Rx out-of-pocket maximum (Individual/Family)	Combined with the Medical out-of-pocket maximum	Combined with the Medical out-of-pocket maximum
Retail prescriptions (30 day supply)	$15 / $40 / $60 / 30% ($250 max per prescription) [10]	$20 / $40 / $60 / 30% ($250 max) [10]
Mail order (up to 90-day supply)	$30 / $100 / $150 / Not Available	$40 / $100 / $150 / Not Available
Dental Coverage		
Pediatric dental coverage	Not Covered	Not Covered
Vision		
Routine exam	$30	$45
Frames and lenses	Not Covered	Not Covered
Plan ID	11003	9068

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• Prescription drug benefits listed are for participating pharmacies only.

[9] Plan service available ONLY in certain California counties and cities. You must live or work in this select service area in order to enroll in this plan. [10] Some drugs may require prior authorization and are covered only when dispensed by network select participating pharmacies. Mail service may not be covered. A separate drug copay and deductible may apply.

Benefits at a Glance

Health Net HMO		
Plan Name	HN SC HMO 30	HN SC HMO 40
Network	SmartCare [9]	SmartCare [9]
Calendar Year Deductible (Individual/Family)	Not Applicable	Not Applicable
Out-of-pocket maximum (Individual/Family)	$4,500 / $9,000	$6,500 / $13,000
Office Visit (PCP)	$30	$40
Specialist Visit	$50	$60
Outpatient Surgery/Treatment	$250 per procedure	50% per procedure
Hospital Admission	$250 per day ($750 Maximum per admit)	$1,500 per day ($4,500 Maximum per admit)
X-ray	No Charge	$10
Laboratory	No Charge	$10
Urgent Care	$50	$60
Emergency Room	$100 per visit	30% per visit
Preventive Care	No Charge	No Charge
Mental Health Office Visit	$30	$40
Prescription Drugs	**Generic/Brand/Non-formulary/Specialty**	**Generic/Brand/Non-formulary/Specialty**
Separate calendar year deductible	$300 Brand-Name Drugs (per member)	$100 Brand-Name Drugs (per member)
Rx out-of-pocket maximum (Individual/Family)	Combined with the Medical out-of-pocket maximum	Combined with the Medical out-of-pocket maximum
Retail prescriptions (30 day supply)	$15 / $40 / $60 / 30% ($250 max per prescription) [10]	$15 / $35 / $55 / 30% ($250 max per prescription) [10]
Mail order (up to 90-day supply)	$30 / $100 / $150 / Not Available	$30 / $87.50 / $137.50 / Not Available
Dental Coverage		
Pediatric dental coverage	Not Covered	Not Covered
Vision		
Routine exam	$30	$40
Frames and lenses	Not Covered	Not Covered
Plan ID	9059	9060

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• Prescription drug benefits listed are for participating pharmacies only.

[9] Plan service available ONLY in certain California counties and cities. You must live or work in this select service area in order to enroll in this plan. [10] Some drugs may require prior authorization and are covered only when dispensed by network select participating pharmacies. Mail service may not be covered. A separate drug copay and deductible may apply.

Benefits at a Glance

Health Net HMO	
Plan Name	HN SC HMO 50
Network	SmartCare [9]
Calendar Year Deductible (Individual/Family)	Not Applicable
Out-of-pocket maximum (Individual/Family)	$5,350 / $10,700
Office Visit (PCP)	$50
Specialist Visit	$50
Outpatient Surgery/Treatment	$1,500 per procedure
Hospital Admission	$1,500 per day ($4,500 Maximum per admit)
X-ray	No Charge
Laboratory	No Charge
Urgent Care	$75
Emergency Room	$300 per visit
Preventive Care	No Charge
Mental Health Office Visit	$50
Prescription Drugs	**Generic/Brand/Non-formulary/Specialty**
Separate calendar year deductible	$300 Brand-Name Drugs (per member)
Rx out-of-pocket maximum (Individual/Family)	Combined with the Medical out-of-pocket maximum
Retail prescriptions (30 day supply)	$15 / $40 / $60 /30% ($250 max) [10]
Mail order (up to 90-day supply)	$30 / $80 / $120 / Not Available
Dental Coverage	
Pediatric dental coverage	Not Covered
Vision	
Routine exam	$50
Frames and lenses	Not Covered
Plan ID	9061

IMPORTANT NOTICE: This benefit comparison is provided to help you quickly compare plans and is not intended to be a comprehensive description of plans and benefits. Refer to the Summary of Benefits, Summary of Benefits and Coverage (SBC) and Evidence of Coverage for a detailed description of coverage and benefits limitations. In the event of a discrepancy on this comparison, Evidence of Coverage and Plan contract shall prevail. (Please visit www.pibt.org - Forms and Documents.)

• Prescription drug benefits listed are for participating pharmacies only.

[9] Plan service available ONLY in certain California counties and cities. You must live or work in this select service area in order to enroll in this plan. [10] Some drugs may require prior authorization and are covered only when dispensed by network select participating pharmacies. Mail service may not be covered. A separate drug copay and deductible may apply.

Benefits at a Glance

Health Net EOA	health net		health net	
Plan Name	HN EC EOA 30		HN EC EOA 40	
Network	ExcelCare [9]		ExcelCare [9]	
Services Rendered at	PCP	Open Access	PCP	Open Access
Calendar Year Deductible (Individual/Family)	Not Applicable		Not Applicable	
Out-of-pocket maximum (Individual/Family)	$3,000 / $9,000	$5,000 / $10,000	$5,500 / $11,000	$7,500 / $15,000
Office Visit (PCP)	$30	$50	$40	$60
Specialist Visit	$50		$60	
Outpatient Surgery/Treatment	$1,000 per procedure	Not Covered	40% per procedure	Not Covered
Hospital Admission	$1,000 per admission	Not Covered	40% per admission	Not Covered
X-ray	No Charge		No Charge	
Laboratory	No Charge		No Charge	
Urgent Care	$50 [45]		$60 [45]	
Emergency Room	$100 per visit [45]		$100 per visit [45]	
Preventive Care	No Charge		No Charge	
Mental Health Office Visit	$30		$40	
Prescription Drugs	**Generic/Brand/Non-formulary/Specialty**		**Generic/Brand/Non-formulary/Specialty**	
Separate calendar year deductible	Not Applicable		$300 Brand-Name Drugs (per member)	
Rx out-of-pocket maximum (Individual/Family)	Combined with the Medical out-of-pocket maximum		Combined with the Medical out-of-pocket maximum	
Retail prescriptions (30 day supply)	$10 / $30 / $50 / 30% ($250 max per prescription) [10]		$15 / $40 / $60 / 30% ($250 max per prescription) [10]	
Mail order (up to 90-day supply)	$20 / $75 / $125 / Not Available		$30 / $100 / $150 / Not Available	
Dental Coverage				
Pediatric dental coverage	Not Covered		Not Covered	
Vision				
Routine exam	$30	$50	$40	$60
Frames and lenses	Not Covered		Not Covered	
Plan ID	9072		9647	

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• Prescription drug benefits listed are for participating pharmacies only.

[9] Plan service available ONLY in certain California counties and cities. You must live or work in this select service area in order to enroll in this plan. [10] Some drugs may require prior authorization and are covered only when dispensed by network select participating pharmacies. Mail service may not be covered. A separate drug copay and deductible may apply. [45] When services are provided that meet the criteria for emergency care, weather within our outside the service area, the services are covered through Open Access.

Benefits at a Glance

Health Net EOA		
Plan Name	HN EC EOA 50	
Network	ExcelCare [9]	
Services Rendered at	PCP	Open Access
Calendar Year Deductible (Individual/Family)	Not Applicable	
Out-of-pocket maximum (Individual/Family)	$5,850 / $11,700	$7,850 / $15,700
Office Visit (PCP)	$50	$70
Specialist Visit	$70	
Outpatient Surgery/Treatment	50% per procedure	Not Covered
Hospital Admission	$1,500 per day ($4,500 max per admit)	Not Covered
X-ray	$10	30%
Laboratory	$10	30%
Urgent Care	$70 [45]	
Emergency Room	30% per visit [45]	
Preventive Care	No Charge	
Mental Health Office Visit	$50	
Prescription Drugs	**Generic/Brand/Non-formulary/Specialty**	
Separate calendar year deductible	$300 Brand-Name Drugs (per member)	
Rx out-of-pocket maximum (Individual/Family)	Combined with the Medical out-of-pocket maximum	
Retail prescriptions (30 day supply)	$15 / $40 / $60 / 30% ($250 max per prescription) [10]	
Mail order (up to 90-day supply)	$30 / $100 / $150 / Not Available	
Dental Coverage		
Pediatric dental coverage	Not Covered	
Vision		
Routine exam	$50	$70
Frames and lenses	Not Covered	
Plan ID	9648	

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• Prescription drug benefits listed are for participating pharmacies only.

[9] Plan service available ONLY in certain California counties and cities. You must live or work in this select service area in order to enroll in this plan. [10] Some drugs may require prior authorization and are covered only when dispensed by network select participating pharmacies. Mail service may not be covered. A separate drug copay and deductible may apply. [45] When services are provided that meet the criteria for emergency care, weather within our outside the service area, the services are covered through Open Access.

Benefits at a Glance

Health Net Salud Y Mas				
Plan Name	HN Salud HMO 10		HN Salud HMO 40	
Network	Salud Y Mas [12]		Salud Y Mas [12]	
Services Rendered at	Salud	SIMNSA	Salud	SIMNSA
Calendar Year Deductible (Individual/Family)	Not Applicable		Not Applicable	
Out-of-pocket maximum (Individual/Family)	$1,500 / $3,000 (Salud)	$1,500 / $4,500 (SIMNSA)	$5,500 / $11,000 (Salud)	$1,500 / $4,500 (SIMNSA)
Office Visit (PCP)	$10	$5	$40	$5
Specialist Visit	$30	$5	$60	$5
Outpatient Surgery/Treatment	$250 per procedure	No Charge	40% per procedure	No Charge
Hospital Admission	$250 per admission	No Charge	40% per admission	No Charge
X-ray	No Charge		No Charge	
Laboratory	No Charge		No Charge	
Urgent Care	$30	$10	$60	$10
Emergency Room	$100 per visit	$10 per visit	$100 per visit	$10 per visit
Preventive Care	No Charge		No Charge	
Mental Health Office Visit	$10	$5	$40	$5
Prescription Drugs	**Generic/Brand/Non-formulary/Specialty**		**Generic/Brand/Non-formulary/Specialty**	
Separate calendar year deductible	$100 Brand-Name Drugs (per member)		$100 Brand-Name Drugs (per member)	
Rx out-of-pocket maximum (Individual/Family)	Combined with the Medical out-of-pocket maximum		Combined with the Medical out-of-pocket maximum	
Retail prescriptions (30 day supply)	$15 / $35 / $55 / 30% ($250 max per prescription) [11]		$15 / $35 / $55 / 30% ($250 max per prescription) [11]	
Mail order (up to 90-day supply)	$30 / $87.50 / $137.50 / Not Available		$30 / $87.50 / $137.50 / Not Available	
Dental Coverage				
Pediatric dental coverage	Not Covered		Not Covered	
Vision				
Routine exam	$10 (up to age 17)	$5 (up to age 17)	$40 (up to age 17)	$5 (up to age 17)
Frames and lenses	Not Covered		Not Covered	
Plan ID	11006		9644	

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• Prescription drug benefits listed are for participating pharmacies only.

[11] $5 for drugs dispensed through SIMNSA/retail order Not covered/mail order. [12] Plan service area encompasses regions in Southern California and Baja California Mexico (within fifty miles of the California-Mexico Border). Subscribers must live or work in the Salud Plan service area in California (Salud Network). Dependents must live or work in the Salud Plan service area in California (Salud Network) OR the approved Salud Plan service are in Mexico (SIMNSA).

PIBT freedom -FAQ

This Q&A answers the most frequently asked questions about the PIBT Freedom Plans.

1. Are PIBT Freedom Plans the right choice for me?

These plans are a good choice for you if:

- You want to control your costs
- You prefer to choose your provider
- You like the idea of having an advocate help you navigate the healthcare system
- You are willing to be engaged with your health plan occasionally

2. Who administers the PIBT Freedom Plans?

PIBT designed the plans and their benefits and engaged GPA and ELAP to administer and manage claims under the Freedom Plans.

- GPA is a third-party administrator who manages claims and provides support teams to advise members including Nurse Navigators and HealthWatch.
- ELAP audits and settles claims from facilities such as hospitals and outpatient centers. Both companies work on behalf of PIBT. In all cases, the staff of PIBT is always here to assist you. You should never hesitate to call us.

3. What doctors and other healthcare providers can I use?

Virtually all practitioners accept this plan. Although these plans use a national network, MultiPlan PHCS Practitioner and Ancillary network, that includes physicians, labs, urgent care and similar types of providers, you are not restricted to this network and your benefits are the same whether you seek care from a preferred or non-preferred practitioner.

If you are looking for a new doctor, we recommend that you check the MultiPlan PHCS Practitioner and Ancillary network and select a suitable doctor from the list. You may also ask GPA's Nurse Navigator to find the top practitioners in your area for the medical issue you have.

If you know which doctor you want to see and they are not in the network, bring along your new ID card and your GPA Practitioner Guidance Flyer If they still have questions, ask them to call GPA. We will explain how our plan works and get you seen. **If you know which doctor you want to see and they are not in the preferred network**, bring along your new ID card and your GPA Practitioner Guidance Flyer If they still have questions, ask them to call GPA. We will explain how our plan works and get you seen. It is very rare that we are unsuccessful.

For facilities - like hospitals, outpatient facilities, and surgical centers - there is no network. You may go to virtually any facility you choose. If they need to contact GPA to confirm your coverage, the information for them to contact us is on your ID card.

If you like, you may contact GPA prior to any appointments, and we will contact the doctor or facility to make sure there are no problems when you arrive for your appointment.

Note that certain healthcare providers and facilities, Kaiser for example, only treat patients who are part of their health system. Kaiser will typically not accept the PIBT Freedom Plans except for emergency medical conditions.

4. What if a healthcare provider says they don't recognize my insurance plan?

Give them the GPA Practitioner Guidance Flyer which should answer their questions. If they still have questions, ask them to call GPA at the number on your ID card. We are almost always able to work out a solution for you and get you seen and treated. Although very rare, if a solution can't be found with your provider, a Nurse Navigator will locate other top-tier provider options for you to select from for your medical services.

5. What if a healthcare provider asks me to pay upfront?

Call GPA immediately, even if you are in the provider's office. You should not pay any amounts higher than your plan co-pay, coinsurance or deductible, depending on the type of treatment you are receiving. We will explain to the provider how our plan works and get you seen without an upfront payment higher than these amounts. Again, it is very rare that we are unsuccessful.

6. Who can I turn to with questions or for help?

The staff at PIBT can answer many of your questions related to eligibility, benefits and various administrative issues. GPA also has Member Services Professionals who are available to answer more detailed questions.

One of the most valued resources provided under the Freedom Plans is GPA's ***Nurse Navigator***. These advocates are available to help you:

- Navigate the complex healthcare system
- Find the best healthcare providers in your area
- Better understand a diagnosis and learn about treatment options
- Ensure your physician's office understands the plan and you get seen
- And much more

7. What happens if a healthcare provider doesn't accept the payment amount and bills me for the balance?

Balance bills do not happen very often, but if you receive a balance bill, send it to us or ELAP directly as soon as possible. You will be contacted within 24 hours by an ELAP Member Advocate who will work closely with you until the balance bill is resolved. Our commitment to you is that, if you follow our process, you will only be responsible for co-pays, deductibles and co-insurance based on your chosen health insurance plan. If the bill is sent to collections, your assigned legal representative will contact the collection agency to remove you from the process, and then work with the collection agency to resolve the bill so that your credit is not impaired.

8. Are these plans HMOs, PPOs or POS plans?

These plans are PPO level benefits, but you can seek care at virtually any provider. The MultiPlan PHCS Practitioner and Ancillary network gives you an excellent starting point. You can check to see if your current doctor is there, or you can find a new doctor, but ultimately you are free to seek care at any provider that you choose.

Benefits at a Glance

PIBT Freedom		
Plan Name	PIBT 35/1000	PIBT 40/1500
Network	Not Applicable [37]	Not Applicable [37]
Calendar Year Deductible (Individual/Family)	$1,000 / $2,000 [2]	$1,500 / $3,000 [2]
Out-of-pocket maximum (Individual/Family)	$4,000 / $7,000	$5,000 / $10,000
Office Visit (PCP)	$35 (No Deductible)	$40 (No Deductible)
Specialist Visit	$35 (No Deductible)	$40 (No Deductible)
Outpatient Surgery/Treatment	10% per visit (After Deductible)	20% per visit (After Deductible)
Hospital Admission	$300 copay + 10% per admission (After Deductible)	$200 copay + 20% per admission (After Deductible)
X-ray	$35 per visit [40] (After Deductible)	$40 per visit [40] (After Deductible)
Laboratory	$35 per visit [40] (After Deductible)	$40 per visit [40] (After Deductible)
Urgent Care	$35 (No Deductible)	$40 (No Deductible)
Emergency Room	$200 copay + 10% per visit (After Deductible)	$250 copay + 20% per visit (After Deductible)
Preventive Care	No Charge (No Deductible)	No Charge (No Deductible)
Mental Health Office Visit	$35 (No Deductible)	$40 (No Deductible)
Prescription Drugs	**Generic/Brand/Non-Pref. Brand/Specialty**	**Generic/Brand/Non-Pref. Brand/Specialty**
Separate calendar year deductible	$250 per member (Except Generic) [5]	$250 per member (Except Generic) [5]
Rx out-of-pocket maximum (Individual/Family)	Not Applicable	Not Applicable
Retail prescriptions (30-90 day supply)	$15 / $30 / $50 / Specialty Drugs Program [6] [44]	$15 / $30 / $45 / Specialty Drugs Program [6] [44]
Mail order (30-90-day supply)	$30 / $60 / $100 / Specialty Drugs Program [6] [44]	$30 / $60 / $90 / Specialty Drugs Program [6] [44]
Dental Coverage		
Pediatric dental coverage	Not Covered	Not Covered
Vision		
Routine exam	No Charge [8]	No Charge [8]
Frames and lenses	Not Covered	Not Covered
Plan ID	11363	11364

IMPORTANT NOTICE: This benefit comparison is provided to help you quickly compare plans and is not intended to be a comprehensive description of plans and benefits. Refer to the Summary of Benefits, Summary of Benefits and Coverage (SBC) and Evidence of Coverage for a detailed description of coverage and benefits limitations. In the event of a discrepancy on this comparison, Evidence of Coverage and Plan contract shall prevail. (Please visit www.pibt.org - Forms and Documents.)

• Prescription drug benefits listed are for participating pharmacies only.

[2] A calendar year deductible is the amount you pay each calendar year before the carrier pays for covered services under the benefit plan. [5] Accrues toward the calendar year out-of-pocket maximum. [6] Some drugs require prior authorization for medical necessity, or when effective, lower cost alternatives are available. [8] Routine vision screening for children only. [37] Some services require pre-authorization. If these services are rendered by providers as a facility, please refer to the appropriate category under level I of the Benefit Summary for the benefit. [40] For outpatient department of a Hospital, copay may differ. [44] Participation in the Specialty Drugs Program is required for specialty drugs or a 100% copay applies. See your plan document for information about drugs that require prior authorization and drugs that are excluded.

Benefits at a Glance

PIBT Freedom		
Plan Name	PIBT 45/3000	PIBT 50/5000
Network	Not Applicable [37]	Not Applicable [37]
Calendar Year Deductible (Individual/Family)	$3,000 / $6,000 [2]	$5,000 / $10,000 [2]
Out-of-pocket maximum (Individual/Family)	$7,000 / $14,000	$8,000 / $16,000
Office Visit (PCP)	$45 (No Deductible)	$50 (No Deductible)
Specialist Visit	$45 (No Deductible)	$50 (No Deductible)
Outpatient Surgery/Treatment	20% per visit (After Deductible)	30% per visit (After Deductible)
Hospital Admission	$200 copay + 20% per admission (After Deductible)	$200 copay + 30% per admission (After Deductible)
X-ray	$45 per visit [40] (After Deductible)	$50 per visit [40] (After Deductible)
Laboratory	$45 per visit [40] (After Deductible)	$50 per visit [40] (After Deductible)
Urgent Care	$45 (No Deductible)	$50 (No Deductible)
Emergency Room	$200 copay + 20% per visit (After Deductible)	$200 copay + 30% per visit (After Deductible)
Preventive Care	No Charge (No Deductible)	No Charge (No Deductible)
Mental Health Office Visit	$45 (No Deductible)	$50 (No Deductible)
Prescription Drugs	**Generic/Brand/Non-Pref. Brand/Specialty**	**Generic/Brand/Non-Pref. Brand/Specialty**
Separate calendar year deductible	$250 per member (Except Generic) [5]	$250 per member (Except Generic) [5]
Rx out-of-pocket maximum (Individual/Family)	Not Applicable	Not Applicable
Retail prescriptions (30-90 day supply)	$15 / $30 / $45 / Specialty Drugs Program [6] [44]	$15 / $30 / 50% $100 max [6] / Specialty Drugs Program [44]
Mail order (30-90-day supply)	$30 / $60 / $90 / Specialty Drugs Program [6] [44]	$30 / $60 / 50% $200 max [6] / Specialty Drugs Program [44]
Dental Coverage		
Pediatric dental coverage	Not Covered	Not Covered
Vision		
Routine exam	No Charge [8]	No Charge [8]
Frames and lenses	Not Covered	Not Covered
Plan ID	11365	11366

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• Prescription drug benefits listed are for participating pharmacies only.

[2] A calendar year deductible is the amount you pay each calendar year before the carrier pays for covered services under the benefit plan. [5] Accrues toward the calendar year out-of-pocket maximum. [6] Some drugs require prior authorization for medical necessity, or when effective, lower cost alternatives are available. [8] Routine vision screening for children only. [37] Some services require pre-authorization. If these services are rendered by providers as a facility, please refer to the appropriate category under level I of the Benefit Summary for the benefit. [40] For outpatient department of a Hospital, copay may differ. [44] Participation in the Specialty Drugs Program is required for specialty drugs or a 100% copay applies. See your plan document for information about drugs that require prior authorization and drugs that are excluded.

Benefits at a Glance

PIBT Freedom	
Plan Name	PIBT HSA 6000
Network	Not Applicable [37]
Calendar Year Deductible (Individual/Family)	$6,000 / $12,000 [2]
Out-of-pocket maximum (Individual/Family)	$7,500 / $15,000
Office Visit (PCP)	20% (After Deductible)
Specialist Visit	20% (After Deductible)
Outpatient Surgery/Treatment	20% per visit (After Deductible)
Hospital Admission	$200 + 20% per admission (After Deductible)
X-ray	20% [40] (After Deductible)
Laboratory	20% [40] (After Deductible)
Urgent Care	20% (After Deductible)
Emergency Room	$250 + 20% per visit (After Deductible)
Preventive Care	No Charge (No Deductible)
Mental Health Office Visit	20% (After Deductible)
Prescription Drugs	**Generic/Brand/Non-Pref. Brand/Specialty**
Separate calendar year deductible	Subject to the calendar year deductible
Rx out-of-pocket maximum (Individual/Family)	Not Applicable
Retail prescriptions (30-90 day supply)	$10 / $25 /$40 / Specialty Drugs Program [6] [44]
Mail order (30-90-day supply)	$20 / $50 / $80 / Specialty Drugs Program [6] [44]
Dental Coverage	
Pediatric dental coverage	Not Covered
Vision	
Routine exam	No Charge [8]
Frames and lenses	Not Covered
Plan ID	11367

IMPORTANT NOTICE: This benefit comparison is provided to help you quickly compare plans and is not intended to be a comprehensive description of plans and benefits. Refer to the Summary of Benefits, Summary of Benefits and Coverage (SBC) and Evidence of Coverage for a detailed description of coverage and benefits limitations. In the event of a discrepancy on this comparison, Evidence of Coverage and Plan contract shall prevail. (Please visit www.pibt.org - Forms and Documents.)

• Prescription drug benefits listed are for participating pharmacies only.

[2] A calendar year deductible is the amount you pay each calendar year before the carrier pays for covered services under the benefit plan. [6] Some drugs require prior authorization for medical necessity, or when effective, lower cost alternatives are available. [8] Routine vision screening for children only. [37] Some services require pre-authorization. If these services are rendered by providers as a facility, please refer to the appropriate category under level I of the Benefit Summary for the benefit. [40] For outpatient department of a Hospital, copay may differ. [44] Participation in the Specialty Drugs Program is required for specialty drugs or a 100% copay applies. See your plan document for information about drugs that require prior authorization and drugs that are excluded.

Health Net Monthly Rates by age, effective 12/1/2021

Dependent monthly rates do not include the employee portion.

Plan Name & ID	HN PPO 30/2000, Plan ID #9651						
Age/Tier	**Under 30**	**Under 40**	**Under 50**	**Under 55**	**Under 60**	**Under 65**	**65 & Over**
Employee	618.02	710.73	896.14	1,182.51	1,485.73	1,819.26	1,819.26
+Spouse	723.10	828.16	1,044.47	1,376.57	1,734.36	2,128.53	2,128.53
+Child(ren)	488.24	562.40	710.73	939.94	1,182.51	1,437.21	1,437.21
+Spouse & Child(ren)	1,297.87	1,495.63	1,884.98	2,486.32	3,123.06	3,820.43	3,820.43
Plan Name & ID	**HN PPO 30/4000, Plan ID #9653**						
Age/Tier	**Under 30**	**Under 40**	**Under 50**	**Under 55**	**Under 60**	**Under 65**	**65 & Over**
Employee	562.60	646.99	815.76	1,076.45	1,352.47	1,656.09	1,656.09
+Spouse	658.24	753.89	950.79	1,253.10	1,578.81	1,937.61	1,937.61
+Child(ren)	444.45	511.97	646.99	855.65	1,076.45	1,308.30	1,308.30
+Spouse & Child(ren)	1,181.46	1,361.49	1,715.93	2,263.32	2,842.95	3,477.77	3,477.77
Plan Name & ID	**HN PPO 60/5000, Plan ID #9654**						
Age/Tier	**Under 30**	**Under 40**	**Under 50**	**Under 55**	**Under 60**	**Under 65**	**65 & Over**
Employee	512.62	589.50	743.29	980.82	1,232.30	1,508.95	1,508.95
+Spouse	599.75	686.90	866.32	1,141.77	1,438.53	1,765.47	1,765.47
+Child(ren)	404.96	466.48	589.50	779.63	980.82	1,192.07	1,192.07
+Spouse & Child(ren)	1,076.48	1,240.53	1,563.47	2,062.23	2,590.36	3,168.78	3,168.78
Plan Name & ID	**HN EC HMO 20, Plan ID #11004**						
Age/Tier	**Under 30**	**Under 40**	**Under 50**	**Under 55**	**Under 60**	**Under 65**	**65 & Over**
Employee	426.76	490.77	618.79	816.54	1,025.90	1,256.21	1,256.21
+Spouse	499.30	571.86	721.21	950.53	1,197.59	1,469.77	1,469.77
+Child(ren)	337.13	388.34	490.77	649.05	816.54	992.41	992.41
+Spouse & Child(ren)	896.19	1,032.75	1,301.61	1,716.83	2,156.50	2,638.04	2,638.04
Plan Name & ID	**HN EC HMO 30, Plan ID #11005**						
Age/Tier	**Under 30**	**Under 40**	**Under 50**	**Under 55**	**Under 60**	**Under 65**	**65 & Over**
Employee	407.75	468.89	591.22	780.17	980.20	1,200.24	1,200.24
+Spouse	477.05	546.37	689.08	908.19	1,144.24	1,404.29	1,404.29
+Child(ren)	322.12	371.05	468.89	620.13	780.17	948.19	948.19
+Spouse & Child(ren)	856.26	986.74	1,243.60	1,640.33	2,060.42	2,520.52	2,520.52
Plan Name & ID	**HN EC ADV HMO 30, Plan ID #11003**						
Age/Tier	**Under 30**	**Under 40**	**Under 50**	**Under 55**	**Under 60**	**Under 65**	**65 & Over**
Employee	383.62	441.17	556.25	734.01	922.21	1,129.24	1,129.24
+Spouse	448.84	514.05	648.32	854.46	1,076.55	1,321.22	1,321.22
+Child(ren)	303.06	349.09	441.17	583.44	734.01	892.11	892.11
+Spouse & Child(ren)	805.60	928.36	1,170.05	1,543.30	1,938.54	2,371.42	2,371.42
Plan Name & ID	**HN EC ADV HMO 45, Plan ID #9068**						
Age/Tier	**Under 30**	**Under 40**	**Under 50**	**Under 55**	**Under 60**	**Under 65**	**65 & Over**
Employee	370.67	426.27	537.46	709.23	891.07	1,091.10	1,091.10
+Spouse	433.68	496.70	626.43	825.61	1,040.19	1,276.60	1,276.60
+Child(ren)	292.82	337.31	426.27	563.74	709.23	861.97	861.97
+Spouse & Child(ren)	778.40	897.01	1,130.54	1,491.18	1,873.07	2,291.33	2,291.33
Plan Name & ID	**HN EC EOA 30, Plan ID #9072**						
Age/Tier	**Under 30**	**Under 40**	**Under 50**	**Under 55**	**Under 60**	**Under 65**	**65 & Over**
Employee	407.59	468.72	591.01	779.86	979.83	1,199.79	1,199.79
+Spouse	476.88	546.16	688.81	907.84	1,143.79	1,403.74	1,403.74
+Child(ren)	321.98	370.90	468.72	619.89	779.86	947.83	947.83
+Spouse & Child(ren)	855.93	986.36	1,243.13	1,639.71	2,059.62	2,519.53	2,519.53

Health Net Monthly Rates by age, effective 12/1/2021

Dependent monthly rates do not include the employee portion.

Plan Name & ID	HN EC EOA 40, Plan ID #9647						
Age/Tier	**Under 30**	**Under 40**	**Under 50**	**Under 55**	**Under 60**	**Under 65**	**65 & Over**
Employee	356.81	410.32	517.36	682.70	857.74	1,050.28	1,050.28
+Spouse	417.46	478.10	602.99	794.72	1,001.27	1,228.85	1,228.85
+Child(ren)	281.88	324.70	410.32	542.65	682.70	829.73	829.73
+Spouse & Child(ren)	749.27	863.46	1,088.24	1,435.40	1,803.00	2,205.61	2,205.61
Plan Name & ID	**HN EC EOA 50, Plan ID #9648**						
Age/Tier	**Under 30**	**Under 40**	**Under 50**	**Under 55**	**Under 60**	**Under 65**	**65 & Over**
Employee	329.23	378.61	477.38	629.94	791.45	969.13	969.13
+Spouse	385.19	441.17	556.39	733.31	923.91	1,133.88	1,133.88
+Child(ren)	260.09	299.60	378.61	500.72	629.94	765.61	765.61
+Spouse & Child(ren)	691.38	796.74	1,004.14	1,324.48	1,663.67	2,035.17	2,035.17
Plan Name & ID	**HN SC HMO 30, Plan ID #9059**						
Age/Tier	**Under 30**	**Under 40**	**Under 50**	**Under 55**	**Under 60**	**Under 65**	**65 & Over**
Employee	293.34	337.33	425.33	561.50	705.47	863.86	863.86
+Spouse	343.21	393.07	495.75	653.66	823.54	1,010.72	1,010.72
+Child(ren)	231.74	266.94	337.33	446.33	561.50	682.45	682.45
+Spouse & Child(ren)	616.02	709.88	894.68	1,180.61	1,482.96	1,814.10	1,814.10
Plan Name & ID	**HN SC HMO 40, Plan ID #9060**						
Age/Tier	**Under 30**	**Under 40**	**Under 50**	**Under 55**	**Under 60**	**Under 65**	**65 & Over**
Employee	280.28	322.32	406.40	536.49	674.07	825.38	825.38
+Spouse	327.92	375.56	473.66	624.54	786.87	965.70	965.70
+Child(ren)	221.42	255.04	322.32	426.44	536.49	652.06	652.06
+Spouse & Child(ren)	588.58	678.27	854.83	1,128.03	1,416.90	1,733.31	1,733.31
Plan Name & ID	**HN SC HMO 50, Plan ID #9061**						
Age/Tier	**Under 30**	**Under 40**	**Under 50**	**Under 55**	**Under 60**	**Under 65**	**65 & Over**
Employee	267.99	308.19	388.59	512.99	644.52	789.20	789.20
+Spouse	313.55	359.10	452.90	597.17	752.38	923.38	923.38
+Child(ren)	211.72	243.87	308.19	407.77	512.99	623.46	623.46
+Spouse & Child(ren)	562.79	648.54	817.37	1,078.58	1,354.80	1,657.33	1,657.33
Plan Name & ID	**HN Salud HMO 10, Plan ID #11006**						
Age/Tier	**Under 30**	**Under 40**	**Under 50**	**Under 55**	**Under 60**	**Under 65**	**65 & Over**
Employee	276.91	318.43	401.51	529.83	665.68	815.11	815.11
+Spouse	323.97	371.05	467.97	616.76	777.07	953.68	953.68
+Child(ren)	218.75	251.99	318.43	421.15	529.83	643.94	643.94
+Spouse & Child(ren)	581.50	670.11	844.56	1,113.99	1,399.27	1,711.73	1,711.73
Plan Name & ID	**HN Salud HMO 40, Plan ID #9644**						
Age/Tier	**Under 30**	**Under 40**	**Under 50**	**Under 55**	**Under 60**	**Under 65**	**65 & Over**
Employee	246.78	283.80	357.84	472.19	593.27	726.46	726.46
+Spouse	288.74	330.70	417.07	549.68	692.55	849.95	849.95
+Child(ren)	194.96	224.58	283.80	375.34	472.19	573.90	573.90
+Spouse & Child(ren)	518.26	597.23	752.70	992.82	1,247.07	1,525.55	1,525.55

PIBT Freedom Monthly Rates by age, effective 12/1/2021

Dependent monthly rates do not include the employee portion.

Plan Name	PIBT 35/1000				PIBT 40/1500			
Plan ID	11363				11364			
Region	19				19			
Emp. Age	Employee	+Spouse	+Child(ren)	+Family	Employee	+Spouse	+Child(ren)	+Family
18	384.57	499.95	269.20	730.69	355.09	461.62	248.56	674.68
19	384.57	499.95	269.20	730.69	355.09	461.62	248.56	674.68
20	384.57	499.95	269.20	730.69	355.09	461.62	248.56	674.68
21	432.08	561.70	302.45	820.94	398.96	518.64	279.26	758.02
22	440.36	572.48	308.26	836.70	406.60	528.59	284.63	772.56
23	449.24	584.02	314.47	853.57	414.80	539.25	290.37	788.13
24	458.73	596.35	321.12	871.59	423.57	550.63	296.50	804.77
25	468.83	609.47	328.18	890.77	432.88	562.75	303.03	822.49
26	479.54	623.42	335.69	911.14	442.78	575.63	309.95	841.30
27	490.89	638.18	343.64	932.72	453.27	589.24	317.29	861.21
28	502.90	653.78	352.03	955.52	464.34	603.66	325.06	882.27
29	515.56	670.24	360.90	979.58	476.04	618.86	333.23	904.49
30	528.90	687.58	370.24	1,004.93	488.36	634.87	341.85	927.88
31	542.94	705.81	380.05	1,031.58	501.31	651.71	350.92	952.50
32	557.67	724.99	390.37	1,059.59	514.92	669.40	360.45	978.36
33	573.13	745.08	401.21	1,088.97	529.20	687.96	370.45	1,005.49
34	589.34	766.17	412.55	1,119.77	544.17	707.42	380.92	1,033.92
35	606.33	788.22	424.43	1,152.03	559.84	727.81	391.90	1,063.72
36	624.08	811.33	436.87	1,185.78	576.24	749.13	403.38	1,094.88
37	642.65	835.46	449.86	1,221.06	593.39	771.41	415.38	1,127.45
38	662.06	860.69	463.45	1,257.92	611.31	794.71	427.92	1,161.49
39	682.32	887.03	477.63	1,296.41	630.01	819.02	441.01	1,197.04
40	703.46	914.50	492.42	1,336.58	649.53	844.40	454.68	1,234.13
41	725.51	943.16	507.86	1,378.46	669.89	870.87	468.93	1,272.80
42	748.49	973.03	523.94	1,422.13	691.11	898.44	483.78	1,313.11
43	772.43	1,004.18	540.71	1,467.64	713.22	927.19	499.25	1,355.12
44	797.37	1,036.58	558.16	1,515.01	736.24	957.13	515.37	1,398.87
45	823.32	1,070.34	576.34	1,564.34	760.22	988.28	532.14	1,444.41
46	850.35	1,105.45	595.24	1,615.66	785.16	1,020.71	549.61	1,491.80
47	878.44	1,141.99	614.92	1,669.06	811.11	1,054.44	567.78	1,541.11
48	907.67	1,179.98	635.38	1,724.59	838.09	1,089.52	586.67	1,592.37
49	938.04	1,219.48	656.64	1,782.30	866.14	1,125.98	606.30	1,645.66
50	969.62	1,260.51	678.74	1,842.28	895.29	1,163.89	626.71	1,701.06
51	1,002.42	1,303.14	701.69	1,904.60	925.57	1,203.25	647.90	1,758.60
52	1,036.48	1,347.43	725.54	1,969.32	957.03	1,244.14	669.92	1,818.36
53	1,071.85	1,393.41	750.30	2,036.53	989.69	1,286.59	692.78	1,880.41
54	1,108.57	1,441.14	775.99	2,106.28	1,023.58	1,330.67	716.51	1,944.81
55	1,146.66	1,490.67	802.67	2,178.67	1,058.76	1,376.39	741.13	2,011.66
56	1,186.19	1,542.05	830.33	2,253.77	1,095.26	1,423.84	766.68	2,081.00
57	1,227.19	1,595.35	859.03	2,331.66	1,133.12	1,473.05	793.19	2,152.93
58	1,269.70	1,650.62	888.79	2,412.44	1,172.37	1,524.09	820.66	2,227.51
59	1,313.78	1,707.92	919.64	2,496.18	1,213.07	1,576.99	849.15	2,304.83
60	1,359.46	1,767.30	951.62	2,582.97	1,255.24	1,631.83	878.67	2,384.97
61	1,406.79	1,828.84	984.76	2,672.91	1,298.94	1,688.64	909.27	2,468.01
62	1,455.83	1,892.58	1,019.08	2,766.08	1,344.22	1,747.50	940.96	2,554.04
63	1,506.62	1,958.61	1,054.63	2,862.58	1,391.12	1,808.46	973.79	2,643.14
64+	1,574.76	2,047.19	1,102.34	2,992.06	1,454.04	1,890.26	1,017.83	2,762.69

PIBT Freedom Monthly Rates by age, effective 12/1/2021

Dependent monthly rates do not include the employee portion.

Plan Name	PIBT 45/3000				PIBT 50/5000			
Plan ID	11365				11366			
Region	19				19			
Emp. Age	Employee	+Spouse	+Child(ren)	+Family	Employee	+Spouse	+Child(ren)	+Family
18	310.82	404.06	217.57	590.55	278.79	362.43	195.15	529.70
19	310.82	404.06	217.57	590.55	278.79	362.43	195.15	529.70
20	310.82	404.06	217.57	590.55	278.79	362.43	195.15	529.70
21	349.20	453.97	244.45	663.51	313.22	407.20	219.27	595.14
22	355.91	462.68	249.13	676.23	319.23	415.01	223.47	606.55
23	363.08	472.01	254.16	689.86	325.67	423.38	227.97	618.78
24	370.75	481.98	259.53	704.42	332.55	432.31	232.78	631.84
25	378.91	492.58	265.23	719.93	339.87	441.83	237.91	645.75
26	387.57	503.85	271.30	736.40	347.64	451.93	243.35	660.52
27	396.74	515.79	277.73	753.84	355.87	462.63	249.11	676.16
28	406.45	528.39	284.52	772.26	364.57	473.95	255.20	692.69
29	416.68	541.69	291.68	791.71	373.75	485.88	261.63	710.13
30	427.46	555.71	299.23	812.19	383.42	498.45	268.40	728.51
31	438.80	570.45	307.17	833.74	393.59	511.67	275.52	747.83
32	450.72	585.94	315.50	856.37	404.28	525.56	282.99	768.13
33	463.22	602.19	324.25	880.11	415.49	540.14	290.84	789.43
34	476.31	619.22	333.43	905.01	427.24	555.42	299.07	811.76
35	490.04	637.06	343.02	931.08	439.55	571.41	307.68	835.14
36	504.39	655.72	353.08	958.36	452.42	588.16	316.70	859.61
37	519.40	675.23	363.58	986.87	465.88	605.66	326.13	885.20
38	535.08	695.62	374.57	1,016.67	479.95	623.94	335.97	911.92
39	551.46	716.90	386.02	1,047.78	494.64	643.03	346.25	939.82
40	568.54	739.11	397.98	1,080.24	509.96	662.96	356.98	968.94
41	586.36	762.28	410.46	1,114.09	525.94	683.74	368.17	999.31
42	604.93	786.42	423.46	1,149.38	542.60	705.40	379.83	1,030.96
43	624.28	811.58	437.01	1,186.15	559.96	727.96	391.98	1,063.94
44	644.44	837.78	451.11	1,224.45	578.04	751.46	404.63	1,098.29
45	665.42	865.06	465.80	1,264.31	596.86	775.92	417.81	1,134.04
46	687.26	893.44	481.08	1,305.80	616.44	801.39	431.52	1,171.26
47	709.97	922.96	496.98	1,348.95	636.82	827.87	445.77	1,209.96
48	733.59	953.67	513.51	1,393.83	658.00	855.41	460.61	1,250.21
49	758.14	985.60	530.71	1,440.48	680.02	884.04	476.03	1,292.06
50	783.65	1,018.77	548.56	1,488.96	702.91	913.79	492.04	1,335.54
51	810.16	1,053.23	567.13	1,539.33	726.69	944.70	508.68	1,380.71
52	837.69	1,089.01	586.39	1,591.63	751.38	976.80	525.97	1,427.64
53	866.28	1,126.17	606.40	1,645.94	777.02	1,010.14	543.92	1,476.35
54	895.95	1,164.75	627.18	1,702.32	803.64	1,044.73	562.55	1,526.92
55	926.75	1,204.77	648.72	1,760.83	831.26	1,080.64	581.88	1,579.40
56	958.69	1,246.31	671.08	1,821.52	859.91	1,117.89	601.94	1,633.84
57	991.83	1,289.39	694.29	1,884.48	889.63	1,156.53	622.75	1,690.32
58	1,026.18	1,334.05	718.34	1,949.77	920.45	1,196.60	644.32	1,748.87
59	1,061.81	1,380.36	743.27	2,017.45	952.40	1,238.14	666.69	1,809.58
60	1,098.73	1,428.35	769.11	2,087.59	985.52	1,281.18	689.87	1,872.50
61	1,136.98	1,478.09	795.89	2,160.27	1,019.83	1,325.79	713.89	1,937.70
62	1,176.62	1,529.61	823.64	2,235.58	1,055.38	1,372.00	738.77	2,005.24
63	1,217.67	1,582.96	852.37	2,313.56	1,092.20	1,419.87	764.54	2,075.19
64+	1,272.74	1,654.57	890.92	2,418.21	1,141.60	1,484.09	799.12	2,169.05

PIBT Freedom Monthly Rates by age, effective 12/1/2021

Dependent monthly rates do not include the employee portion.

Plan Name	PIBT HSA 6000			
Plan ID	11367			
Region	19			
Emp. Age	Employee	+Spouse	+Child(ren)	+Family
18	248.15	322.59	173.71	471.49
19	248.15	322.59	173.71	471.49
20	248.15	322.59	173.71	471.49
21	278.80	362.45	195.16	529.73
22	284.15	369.40	198.91	539.89
23	289.87	376.86	202.92	550.79
24	295.99	384.81	207.21	562.41
25	302.52	393.27	211.76	574.78
26	309.43	402.27	216.61	587.93
27	316.75	411.80	221.74	601.85
28	324.50	421.86	227.16	616.57
29	332.67	432.48	232.88	632.09
30	341.28	443.66	238.89	648.44
31	350.34	455.43	245.24	665.64
32	359.84	467.80	251.90	683.71
33	369.82	480.77	258.88	702.68
34	380.28	494.37	266.20	722.54
35	391.24	508.62	273.87	743.36
36	402.70	523.51	281.88	765.13
37	414.68	539.10	290.29	787.90
38	427.20	555.37	299.05	811.69
39	440.28	572.36	308.19	836.53
40	453.91	590.10	317.75	862.45
41	468.14	608.59	327.70	889.48
42	482.98	627.86	338.08	917.64
43	498.42	647.95	348.90	947.01
44	514.51	668.87	360.17	977.59
45	531.26	690.65	371.89	1,009.41
46	548.70	713.31	384.09	1,042.53
47	566.82	736.89	396.78	1,076.99
48	585.69	761.39	409.98	1,112.82
49	605.29	786.88	423.71	1,150.05
50	625.66	813.36	437.97	1,188.76
51	646.82	840.87	452.78	1,228.97
52	668.80	869.45	468.16	1,270.74
53	691.62	899.12	484.14	1,314.10
54	715.32	929.91	500.72	1,359.11
55	739.90	961.88	517.94	1,405.82
56	765.40	995.03	535.79	1,454.28
57	791.86	1,029.42	554.30	1,504.55
58	819.29	1,065.08	573.51	1,556.66
59	847.73	1,102.05	593.41	1,610.69
60	877.21	1,140.38	614.05	1,666.71
61	907.75	1,180.08	635.44	1,724.74
62	939.39	1,221.21	657.58	1,784.85
63	972.16	1,263.82	680.52	1,847.13
64+	1,016.13	1,320.98	711.30	1,930.66

Dental DPO Benefits at a Glance

Plan Features	Humana		Humana	
Plan Name	Humana PPO CA		Humana Trad Pref PPO	
Services Rendered At	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Calendar Year Deductible (Individual/Family)	$25 / $75	$50 / $150	$50 / $150 [24]	
Calendar Year Maximum	$1,500 per plan period [22]		$1,500 per plan period [22]	
Waiting Period/Major Services	None		None	
Benefit Levels	Contracted Rate	Contracted Allowance	Contracted Rate	Contracted Allowance
Preventative Services				
Oral Exams	No Charge (No Deductible)		No Charge (No Deductible)	
Cleanings	No Charge (No Deductible)		No Charge (No Deductible)	
Bitewing X-rays	No Charge (No Deductible)		No Charge (No Deductible)	
Complete X-rays	No Charge (No Deductible)		No Charge (No Deductible)	
Basic Services				
Fillings (composite resin)	10%	20%	20%	
Oral Surgery	10%	20%	20%	
Major Services				
Crowns (high noble)	40%	50%	50%	
Orthodontics				
Lifetime Maximum	$1,000 per child		$1,000 per child	
Children up to 19th Birthday	50% (No Deductible)		50% (No Deductible)	
Adults	Not Covered		Not Covered	
Monthly Rates, effective 12/01/2021				
Employee	56.64		41.93	
+Spouse	71.77		55.65	
+Child	60.00		46.70	
+Children	60.00		46.70	
+Family	135.21		103.87	
Plan ID	8663		9126	

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[22] After annual maximum is reached, members receive 30% coinsurance on preventive, basic, and major services for the rest of the plan year (excludes orthodontia). [24] Non-participating dentist can bill you for charges above the amount covered by your dental plan. To ensure you do not receive additional charges, visit a participating PPO network dentist.

Dental DPO Benefits at a Glance

Plan Features	DELTA DENTAL®		DELTA DENTAL®	
Plan Name	Delta DPO Plan 1		Delta DPO Plan 2	
Services Rendered At	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Calendar Year Deductible (Individual/Family)	$25 / $75	$50 / $150 [24]	$50 / $150 [24]	
Calendar Year Maximum	$1,500 per person		$1,500 per person [38]	
Waiting Period/Major Services	None [25]		None [25]	
Benefit Levels	Contracted Rate / Contracted Allowance		Contracted Rate / Contracted Allowance	
Preventative Services				
Oral Exams	No Charge (No Deductible)		No Charge (No Deductible)	
Cleanings	No Charge (No Deductible)		No Charge (No Deductible)	
Bitewing X-rays	No Charge (No Deductible)		No Charge (No Deductible)	
Complete X-rays	No Charge (No Deductible)		No Charge (No Deductible)	
Basic Services				
Fillings (composite resin)	10%	20%	20%	
Oral Surgery	10%	20%	20%	
Major Services				
Crowns (high noble)	40%	50%	50%	
Orthodontics				
Lifetime Maximum	$1,000		$1,000	
Children up to 19th Birthday	50% (No Deductible) [21]		50% (No Deductible) [21]	
Adults	50% (No Deductible) [21]		Not Covered	
Monthly Rates, effective 12/01/2021				
Employee	62.27		42.80	
+Spouse	58.08		39.87	
+Child	77.56		56.59	
+Children	77.56		56.59	
+Family	153.85		109.74	
Plan ID	10424		10425	

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[21] In order to be covered, orthodontic treatment must be received in one continuous course of treatment; must be received in consecutive months and must not exceed 24 consecutive months. [24] Non-participating dentist can bill you for charges above the amount covered by your dental plan. To ensure you do not receive additional charges, visit a participating PPO network dentist. [25] Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees. [38] Non-Delta Dental PPO dentists: $1,000 per person each calendar year.

Dental DMO Benefits at a Glance

Plan Features	DELTA DENTAL®	Humana
Plan Name	Delta USA 11	Humana DMO LS300
Calendar Year Deductible (Individual/Family)	None	None
Calendar Year Maximum	None	None
Waiting Period/Major Services	None	None
Benefit Levels	Fee Schedule	Fee Schedule
Preventative Services		
Oral Exams	No Charge	No Charge
Cleanings	No Charge (1 per 6 months)	$8 (2 per 12 months) [26]
Bitewing X-rays	No Charge	No Charge
Complete X-rays	No Charge (1 every 24 months)	No Charge
Basic Services		
Fillings (composite resin)	No Charge	$16 Copay
Oral Surgery	$5 Copay [20]	$15 Copay [20]
Major Services		
Crowns (high noble)	$240 Copay	$185 Copay [39]
Orthodontics		
Lifetime Maximum	Refer to Schedule of Benefits	Refer to Schedule of Benefits
Children up to 19th Birthday	$1,700 Copay [21]	$1,550 Copay [21]
Adults	$1,900 Copay [21]	$1,695 Copay [21]
Monthly Rates, effective 12/01/2021		
Employee	20.77	11.75
+Spouse	21.00	8.81
+Child	21.87	8.81
+Children	21.87	16.66
+Family	47.72	16.66
Plan ID	11303	7703

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[20] Surgical removal of erupted tooth, impacted tooth, and tooth root. [21] In order to be covered, orthodontic treatment must be received in one continuous course of treatment; must be received in consecutive months and must not exceed 24 consecutive months. [26] No charge for the first 2 per 12 months. $8 for 3rd or more per 12 months. [39] The total amount chargeable to the member for elective upgraded procedures is $250.00 per tooth. Providers are required to explain covered benefits as well as any elective differences in materials and fees prior to providing an elective upgraded procedure.

Dental DMO Benefits at a Glance

Plan Features	Western Dental	Western Dental
Plan Name	WD DMO 7730	WD DMO 7740
Calendar Year Deductible (Individual/Family)	None	None
Calendar Year Maximum	None	None
Waiting Period/Major Services	None	None
Benefit Levels	Fee Schedule	Fee Schedule
Preventative Services		
Oral Exams	No Charge (every 6 months)	No Charge (every 6 months)
Cleanings	No Charge (2 per 12 months)	No Charge (2 per 12 months)
Bitewing X-rays	No Charge (every 6 months)	No Charge (every 6 months)
Complete X-rays	No Charge (every 2 years)	No Charge (every 2 years)
Basic Services		
Fillings (composite resin)	$0 Copay	$5 Copay
Oral Surgery	$25 Copay [20]	$35 copay [20]
Major Services		
Crowns (high noble)	$115 Copay	$145 Copay
Orthodontics		
Lifetime Maximum	Refer to Schedule of Benefits	Refer to Schedule of Benefits
Children up to 19th Birthday	$1,600 Copay [21]	$1,600 Copay [21]
Adults	$2,100 Copay [21]	$2,100 Copay [21]
Monthly Rates, effective 12/01/2021		
Employee	12.77	9.34
+Spouse	10.34	8.00
+Child	10.34	8.00
+Children	23.51	18.76
+Family	23.51	18.76
Plan ID	6444	6443

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[20] Surgical removal of erupted tooth, impacted tooth, and tooth root. [21] In order to be covered, orthodontic treatment must be received in one continuous course of treatment; must be received in consecutive months and must not exceed 24 consecutive months.

Vision Benefits at a Glance

Plan Features		
Plan Name	EyeMed High	EyeMed Base
Plan ID	10423	8763
Provider	EyeMed Provider	EyeMed Provider
Eye Exam	$5 Copay	$5 Copay
Frames	$0 Copay. $200 allowance, 20% off on balance over $200	$0 Copay. $130 allowance, 20% off on balance over $130
Lenses		
Single	$15 Copay	$15 Copay
Bifocal	$15 Copay	$15 Copay
Trifocal	$15 Copay	$15 Copay
Contact Lenses (instead of glasses)	$0 Copay. $200 plan allowance 15% off balance over $200	$0 Copay. $130 plan allowance 15% off balance over $130
Frequency		
Examination	Once every 12 months	Once every 12 months
Frame	Once every 12 months	Once every 12 months
Lenses or Contact Lenses	Once every 12 months	Once every 12 months
Monthly Rates, effective 12/01/2021		
Employee	7.74	6.08
+Spouse	6.95	5.45
+Child	6.95	5.45
+Children	13.83	10.86
+Family	13.83	10.86
Plan ID	10423	8763

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Vision Benefits at a Glance

Plan Features		
Plan Name	EyeMed Kaiser	VSP Premium
Plan ID	8764	10884
Provider	Kaiser Faciliy and EyeMed Provider [34]	VSP Provider [30]
Eye Exam	Plan office visit copay at Kaiser facility	$10 Copay
Frames	$150 plan allowance, 20% off on balance over $150 for frames, lens and lens options	$20 Copay. $200 plan allowance, 20% off balance over allowance
Lenses		
Single	$150 plan allowance, 20% off on balance over $150	$20 Copay
Bifocal	$150 plan allowance, 20% off on balance over $150	$20 Copay
Trifocal	$150 plan allowance, 20% off on balance over $150	$20 Copay
Contact Lenses (instead of glasses)	$0 Copay. $150 plan allowance 15% off balance over $150	$200 plan allowance [31]
Frequency		
Examination	Once every 12 months	Every 12 months
Frame	Once every 12 months	Every 12 months
Lenses or Contact Lenses	Once every 12 months	Every 12 months
Monthly Rates, effective 12/01/2021		
Employee	0.00	13.55
+Spouse	0.00	4.10
+Child	0.00	4.10
+Children	0.00	15.60
+Family	0.00	15.60
Plan ID	8764	10884

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[30] 20% off for certain materials and services accessed through a VSP provider . [31] Allowance for contacts and contact lens exam (fitting and evaluation). [34] Benefits apply for Kaiser participants only. Plan cannot be added to your plan menu.

Vision Benefits at a Glance

Plan Features	
Plan Name	VSP Standard
Plan ID	10883
Provider	VSP Provider [30]
Eye Exam	$10 Copay
Frames	$20 Copay. $150 plan allowance, 20% off balance over allowance
Lenses	
Single	$20 Copay
Bifocal	$20 Copay
Trifocal	$20 Copay
Contact Lenses (instead of glasses)	$150 plan allowance [31]
Frequency	
Examination	Every 12 months
Frame	Every 24 months
Lenses or Contact Lenses	Every 12 months
Monthly Rates, effective 12/01/2021	
Employee	10.92
+Spouse	2.62
+Child	2.62
+Children	11.45
+Family	11.45
Plan ID	10883

IMPORTANT NOTICE: This benefit comparison is provided to help you quickly compare plans and is not intended to be a comprehensive description of plans and benefits. Refer to the Summary of Benefits, Summary of Benefits and Coverage (SBC) and Evidence of Coverage for a detailed description of coverage and benefits limitations. In the event of a discrepancy on this comparison, Evidence of Coverage and Plan contract shall prevail. (Please visit www.pibt.org - Forms and Documents.)

[30] 20% off for certain materials and services accessed through a VSP provider . [31] Allowance for contacts and contact lens exam (fitting and evaluation).

Basic Group Life and AD&D Benefits at a Glance

Distributed by PIA-SC, Insurance Services Inc.

Plan Features	
Accelerated Death Benefit	If an employee has been diagnosed as terminally ill, Symetra Life Insurance Company may pay a portion of the death benefit in advance to the member.
Conversion	A conversion benefit is available that allows you to convert your group coverage to an individual policy if certain conditions apply.
Portability	This coverage may be continued at group rates upon termination of employment. Certain restrictions apply.
AD&D Riders	Includes Seat Belt, Airbag, Repatriation, Child Education, Day Care and Spouse Education benefits.
Value Added Services	
Beneficiary Companion	Support services for beneficiaries who have experienced a loss.
Travel Assist	Travel assistance services for employees and eligible dependents traveling more than 100 miles from home.
Monthly Rates, effective 1/1/2022	
Basic Life $4K	1.52
Basic Life $6K	2.28
Basic Life $8K	3.04
Basic Life $10K	3.80

IMPORTANT NOTICE: This comparison is provided to help you compare coverage benefits at a glance only. Before making your plan choice, you should refer to the Evidence of Coverage and Plan Contract for a detailed description of coverage benefits and limitations. In the event of any difference between this summary versus the Evidence of Coverage or Plan Contract, the Evidence of Coverage and Plan Contract shall prevail.

Voluntary Life and AD&D Benefits at a Glance

Distributed by PIA-SC, Insurance Services Inc.

Plan Features	
Amount	Increments of $10,000
Maximum Amount	Lesser of $500,000 or 10 x Earnings
Guarantee Issue (GIA)	$120,000 (New Hires only)
Age Reduction (Original Benefit Amount reduced to)	65% at age 70 50% at age 75
Eligibility	Full time employee (of participating employer) and their eligible dependents
Evidence of Insurability (EOI)	EOI is required for all amounts of insurance selected after the initial 31-day eligibility period and for any amount in excess of the GIA.
Accelerated Death Benefit	If an employee has been diagnosed as terminally ill, Symetra Life Insurance Company may pay a portion of the death benefit in advance to the member.
Spouse	
Amount	Increments of $5,000
Maximum Amount	$250,000 not to exceed 100% of employee coverage
Guarantee Issue	$25,000
Child	
Child Amount (Birth to 26 yrs.)	$5,000 or maximum of $10,000

Monthly Employee Rates, effective 1/1/2022

Non-Smoker Benefit	$10,000	$50,000	$80,000	$120,000
Under 25	0.86	4.30	6.88	10.32
25-29	0.86	4.30	6.88	10.32
30-34	0.95	4.75	7.60	11.40
35-39	1.05	5.25	8.40	12.60
40-44	1.62	8.10	12.96	19.44
45-49	2.28	11.40	18.24	27.36
50-54	3.33	16.65	26.64	39.96
55-59	5.99	29.95	47.92	71.88
60-64	9.69	48.45	77.52	116.28
65-69	17.48	87.40	139.84	209.76
70-74	35.72	178.60	285.76	428.64
75+	35.72	178.60	285.76	428.64
Smoker Benefit	**$10,000**	**$50,000**	**$80,000**	**$120,000**
Under 25	1.24	6.20	9.92	14.88
25-29	1.24	6.20	9.92	14.88
30-34	1.33	6.65	10.64	15.96
35-39	1.90	9.50	15.20	22.80
40-44	3.04	15.20	24.32	36.48
45-49	4.75	23.75	38.00	57.00
50-54	7.22	36.10	57.76	86.64
55-59	11.59	57.95	92.72	139.08
60-64	16.82	84.10	134.56	201.84
65-69	26.70	133.50	213.60	320.40
70-74	48.93	244.65	391.44	587.16
75+	48.93	244.65	391.44	587.16

Employee Assistance Program Benefits at a Glance

Plan Features	MHN A Health Net Company℠
Plan Name	EAP MHN
Employee Assistance Program	Counseling services for various life management problems for employees and dependents
Office Visits	$0 copay with authorization
Deductible	None
Clinical Counseling	
Visits	6 visits per incident per plan period, unlimited incidents
Telephone Couseling	As needed
Web Video Couseling	As needed
Monthly Rates, effective 12/01/2021, Employer Sponsored Plan	
Employee	5.44
Plan ID	3715

IMPORTANT NOTICE: This benefit comparison is provided to help you quickly compare plans and is not intended to be a comprehensive description of plans and benefits. Refer to the Summary of Benefits, Summary of Benefits and Coverage (SBC) and Evidence of Coverage for a detailed description of coverage and benefits limitations. In the event of a discrepancy on this comparison, Evidence of Coverage and Plan contract shall prevail. (Please visit www.pibt.org - Forms and Documents.)

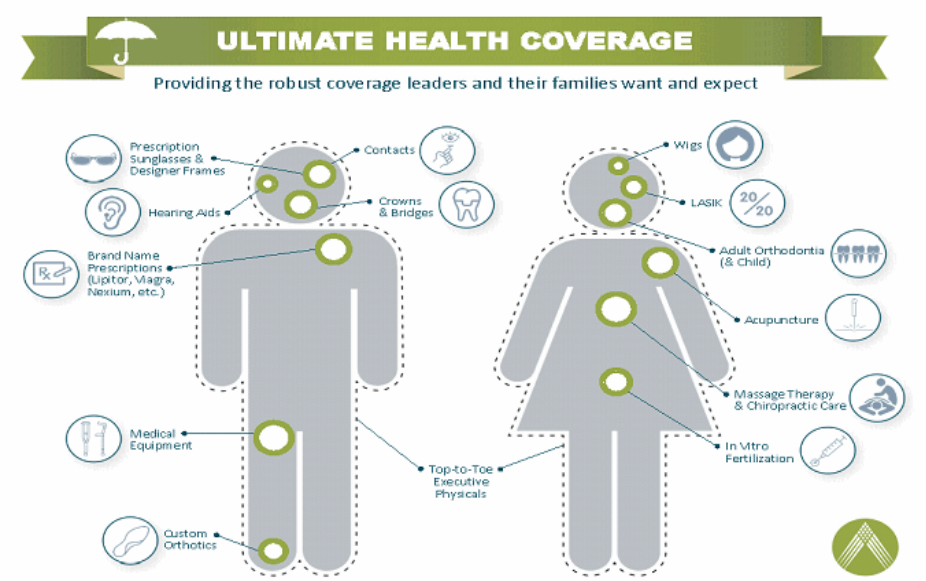
Chiropractic Benefits at a Glance

Plan Features	LANDMARK HEALTHPLAN℠	LANDMARK HEALTHPLAN℠
Plan Name	Landmark Advantage	Landmark Basic
Chiropractor	Landmark Directory	Landmark Directory
Acupuncturist	Landmark Directory	Not Covered
Benefits and Copayments		
Office Visit	$20 Copay	$20 Copay
Maximum Annual Visits	30 visits	20 visits
X-ray Services	$75 annual maximum benefit [32]	$75 annual maximum benefit [32]
Durable Equipment	$50 Maximum Plan Benefit [33] [36]	$50 Maximum Plan Benefit [33]
Acupuncture Herbal Therapy	$5 Copay per Bottle. $500 Maximum Plan Benefit	Not Covered
Monthly Rates, effective 12/01/2021		
Employee	7.69	4.36
+One Dependent	6.43	3.95
+Two Dependents	12.54	8.32
Plan ID	3714	3711

IMPORTANT NOTICE: This benefit comparison is provided to help you quickly compare plans and is not intended to be a comprehensive description of plans and benefits. Refer to the Summary of Benefits, Summary of Benefits and Coverage (SBC) and Evidence of Coverage for a detailed description of coverage and benefits limitations. In the event of a discrepancy on this comparison, Evidence of Coverage and Plan contract shall prevail. (Please visit www.pibt.org - Forms and Documents.)

[32] Durable Medical Equipment must be prescribed by a Participating Chiropractor. [33] X-ray Services must be prescribed by a Participating Chiropractor. [36] Herbal therapies must be prescribed by a Participating Acupuncturist .

ArmadaCare®



The Ultimate Health Coverage plan is an innovative and convenient way to give an extra level of coverage for employees. It reimburses for many medical expenses not covered by the employer-sponsored base health plan. For more information contact Evie Bañaga at 800.449.4898 ext. 224.

Supplemental Medical Benefits	Samples of What is Eligible **(Not a Complete List)***	Platinum	Diamond	Diamond Plus (Requires 15+ to enroll)
Per-Occurrence (each injury, condition or illness) for medical out-of-pocket costs	Deductibles, co-pays, balance bills and other out-of-pocket costs for medically necessary services	$2,500	$3,000	$10,000
Other Supplemental Benefits		Per Covered Person per Year	Per Covered Person per Year	Per Covered Person per Year
Prescriptions	Co-pays, brand name and lifestyle prescriptions	$2,500	$3,000	$10,000
Mental Health	Counseling and substance abuse programs	$2,000	$3,000	$10,000
Medical Equipment	Durable medical equipment, wigs, hearing aids, orthotics	$2,000	$5,000	$10,000
Wellness Treatments	Acupuncture, massage therapy and chiropractic care (if not covered by primary plan)	$1,000	$1,500	$10,000
Executive Physicals	Comprehensive physicals for the primary member and enrolled spouse	$2,000 each	$2,500 each	$10,000 each
Ancillary Benefits		Per Covered Person per Year		
Dental Treatments	Routine care, child and adult orthodontia, crowns and bridges	$4,000	$5,000	$10,000
Vision Treatments	LASIK, contact lenses and prescription glasses & sunglasses	$1,000	$1,500	$10,000
Annual Family Maximum		$50,000	$50,000	$100,000

The levels are for each covered person, whether that person is the enrolled employee or his/her enrolled family member. All the reimbursed expenses across the benefit categories, including medical per occurrences, roll up to the overall annual family maximum, which is the same for a family of one or a family of six.

*These are examples of 213(d)- eligible expenses that are typically covered by the Ultimate Health plan. We cannot pre-certify specific medical treatments or procedures. A claim must be submitted for review before a claim will be accepted or denied for reimbursement.

TASC

Save money with FSA pretax benefit accounts.

A Flexible Spending Account (FSA) puts more money in your pocket by reducing your taxable income when you contribute pretax dollars to pay for common expenses like these:

HEALTHCARE

- Medical/dental office visit co-pays
- Dental/orthodontic care services
- Prescriptions and vaccinations
- Eye exams; prescription glasses/lenses

DEPENDENT CARE

- Daycare expenses
- Before & after school care
- Nanny/nursery school
- Elder care

TIPS

- You can choose to enroll in a Healthcare FSA, Dependent Care FSA, and more
- Your employer may offer other types of Benefit Accounts too; ask for details
- For a complete list of eligible expenses, see IRS Publications 502 & 503 at **irs.gov**

Increase your take-home pay by reducing your taxable income.

Each $1 you contribute to your FSA reduces your taxable income by $1.
With less tax taken, your take-home pay increases!

Consider this example:
(For illustration only)

Richard has:

- Gross monthly pay of $3,500
- $600 per month in eligible expenses

Here is his net monthly take-home pay:

Without FSA ($600 spent using post-tax dollars)	With FSA ($600 spent using pretax dollars)
$1,932	$2,098

That's a net increase in take-home pay of $166 every month!

To estimate potential savings based on your income and expenses, use the Tax Savings Calculator at www.tasconline.com/tasc-calculators/tasc-flexsystem-calculator/

See how easy it is to start saving with a TASC Benefit Account. See details on reverse.

Financial protection that fits your needs

Colonial Life

Choices to protect what you've worked so hard to build

Voluntary benefits from Colonial Life on both an individual and group platform offer a broad range of financial protection options for employees and their families.

Group Accident 4000/Accident insurance offers multiple coverage levels to help with expenses related to covered accidents. No participation requirement. ***Guaranteed Issue***

Supplemental PPO Dental insurance up to an additional $2K annual maximum. With this coverage, you have the freedom to choose any dentist. Plan can be used to cover the shared cost from your primary dental plan. Waiting periods waived on Major services for groups who add dental coverage before December 31, 2020. No minimum participation required.

Group hospital confinement or Individual hospital confinement indemnity provide a lump-sum benefit for a covered hospital confinement, covered outpatient surgery, and diagnostic procedure to help with co-payments and deductibles that are not covered by most major medical plans. ***Guaranteed Issue up to $3000 for hospital confinement.***

Disability insurance can replace a portion of your income to help make ends meet if you become disabled from a covered accident or covered sickness. ***Guaranteed Issue benefit amounts up to $4,000 per month, up to 60% of income, for benefit periods of 6 or 12 months.***

Group Critical Illness or Individual Critical Illness provides initial lump-sum benefits when a covered critical illness is diagnosed.
Group Critical Illness Guaranteed Issue up to $30K
Individual Critical Illness Guaranteed Issue up to $20K

Cancer insurance helps offset covered out-of-pocket expenses related to cancer.

Individual Whole Life 1000 w/Long Term Care Rider offers a death benefit as well as guaranteed level premiums and guaranteed cash value accumulation. This plan is only available for employees. Spouse and eligible dependent child coverage are available with term riders.
Guaranteed Issue up to $30 per week, up to $150K

Expand your benefits not your budget! (No purchase required; all employees receive the following complementary programs when you offer Colonial benefits)

Discount Well-card provides discounts on:
- Entertainment movies, amusement parks, hotels, rental cars and much more!
- Fitness memberships, LA Fitness, Planet fitness,
- Medical prescriptions (retail and mail order), vision, dental, access to a telemedicine provider and medical bill consultation.

KOFE offers financial education through phone access to financial counselors, webinars and calculators.
- Personal Finance
- Credit Reports
- Budget
- Savings
- Debt

CONTACT US

PIBT CUSTOMER SERVICE TEAM				
Customer Service	**Phone**	**Ext.**	**Personal Fax #**	**Email**
Relationship Keepers	800-449-4898	N/A	323-215-1796	OnlineHelpDesk@piasc.org
Portal Help Desk				
Stephanie Hernandez	323-728-9500	259	323-271-0138	stephanie@pibt.org
PIBT Benefits Director				
Evie Banaga	323-728-9500	224	323-629-4527	evie@pibt.org
Form Submission	**Email**	**Fax**		
Processing Department	pibt@pibt.org	323-215-1796		All forms sent must be encrypted with your personalized or assigned password.
Portal Upload	www.pibt.org	N/A		Securely upload multiple documents when you sign in to the portal.
PIBT Website	**Online Inquires**	**Portal Registration**		
www.pibt.org	OnlineHelpDesk@piasc.org	https://www.pibt.org/EmployerRegistration.aspx		

LOCAL ASSOCIATION OFFICE			
Local Agency Contacts	**Title**	**Phone #**	**Email**
Karen Fulton	President	858-800-6900	karen@piasd.org

CARRIER MEMBER SERVICES		
Medical Plans	**Phone**	**Website**
PIBT Freedom	800-449-4898	www.pibt.org
Kaiser	800-464-4000	www.kp.org
Health Net	800-361-3366	www.healthnet.com
Ancillary Plans	**Phone**	**Website**
Western Dental	800-992-3366	www.westerndentalbenefits.com
Humana Dental (DPO)	800-233-4013	www.humana.com
Humana Dental (DMO)	877-873-2241	www.libertydentalplan.com
Delta Dental (DPO)	800-765-6003	www.deltadentalins.com
DeltaCare Dental (DMO)	888-282-9501	www.deltadentalins.com
VSP Vision	800-877-7195	www.vsp.com
EyeMed Vision	800-334-7591	www.eyemedvisioncare.com
Landmark Chiro	800-298-4875	www.lhp-ca.com
EAP Mental Health	800-777-9355	www.members.mhn.com

PAYMENT METHODS

ONLINE

PIBT has made it easier to pay your invoice online. You can set up automatic recurring payments or make a one-time payment with a debit card, credit card or e-check! Only credit card transactions are subject to a small processing fee.

PIBT: https://bit.ly/payment-PIBT PIBT COBRA: https://bit.ly/payment-PIBT-COBRA

To set up automatic payments, follow one of the payment links above, enter the invoice payment amount, add to cart, enter the account number, then click on the ”yes” check box under "please make this monthly”. Finally, enter the number of payments for the remainder of the plan year, and indicate the date you wish your automatic payments to be drafted (must be
between the 1st- 15th).

MAIL

LOCKBOX PAYMENT (regular mail): All paper checks generated by you or auto issued by your bank (under Bill Pay services)

PIBT, File # 2319
1801 W. Olympic Blvd.
Pasadena, CA 91199-2319

OVERNIGHT (courier service i.e., Federal Express, Messenger, UPS etc.)

PIBT, File # 2319
1801 W. Olympic Blvd
4th Floor Lockbox
Los Angeles, CA 90006

Wire Transfers, ACH, EFT Payments

Name of Account: **PIBT**
Name of Bank: **City National Bank**
Routing Number: **122016066**
Account No.: **300035493**
City and Zipcode: **Los Angeles, CA 90071**