The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.pebtf.org or call 1-800-522-7279.For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-800-522-7279 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$400/individual or $800/family – in-network services; $800/individual or $1,600 /family – out-of-network services	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. For in-network services you must pay all of the costs up to the deductible amount for the following covered services: Hospital expenses (inpatient and outpatient) and medical/surgical expenses including physician services (except office visits), imaging, skilled nursing facility care and home health care.
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.pebtf.org.
Are there other deductibles for specific services?	Yes. $50 / individual annually under the Dental Plan.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For network providers $9,200 individual / $18,400 family; for out-of-network providers $9,200 individual / $18,400 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.pebtf.org/active/links to find the plan's provider directory or call 1-800-522-7279 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

* OMB control number: 0938-1146/Expiration date: 05/31/2026)
* For more information about limitations and exceptions, see the plan or policy document at www.pebtf.org.

Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit; deductible does not apply	30% coinsurance	None
	Specialist visit	$45 copay/visit; deductible does not apply	30% coinsurance	None
	Preventive care/screening/ immunization	No charge	30% coinsurance If not available in-network, full cost shall be covered without any cost sharing	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge after deductible	30% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.pebtf.org, Publications & Forms or www.caremark.com	Generic drugs (Tier 1)	$15 copay/prescription up to 30 days; $22.50 copay/prescription up to 90 days (CVS Maintenance Choice & mail order)	Full cost of drug up front. You can submit a claim form to be reimbursed based on the amount a Participating Network Pharmacy would have been paid by the Prescription Drug Plan for filling the prescription minus your copay.	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription and CVS Maintenance Choice Network. For Tier 2 and Tier 3, you pay the copay plus the cost difference between the brand and generic if one exists (cost difference does not apply to annual out-of-pocket limit).
	Preferred brand drugs (Tier 2)	$40 copay/prescription up to 30 days; $60 copay/prescription up to 90 days (CVS Maintenance Choice & mail order)	Full cost of drug up front. You can submit a claim form to be reimbursed based on the amount a Participating Network Pharmacy would have	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
			been paid by the Prescription Drug Plan for filling the prescription minus your copay.	The prescription benefit manager uses a specialty pharmacy for dispensing specialty medications.
	Non-preferred brand drugs (Tier 3)	$80 copay/prescription up to 30 days; $120 copay/prescription up to 90 days (CVS Maintenance Choice & mail order)	Full cost of drug up front. You can submit claim form to be reimbursed based on the amount a Participating Network Pharmacy would have been paid by the Prescription Drug Plan for filling the prescription minus your copay.	
	Specialty drugs (Tier 4)	$0 copay if you enroll in PrudentRX; 30% coinsurance if you do not	N/A	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge after deductible	30% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 20% of the total cost of the service.
	Physician/surgeon fees	No charge after deductible	30% coinsurance	
If you need immediate medical attention	Emergency room care	$200 copay/visit	$200 copay/visit	ER copay waived if the visit leads to an inpatient admission to the hospital.
	Emergency medical transportation	No charge	No charge	
	Urgent care	$50 copay/visit	30% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after deductible	30% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits could be reduced by 20% of the total cost of the service. Out-of-network: 70 days per calendar year.
	Physician/surgeon fees	No charge after deductible	30% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/visit; no charge after deductible for other outpatient services	30% coinsurance	Mental health and substance abuse benefits are provided by Optum, which is separate from your medical plan.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Inpatient services	No charge after deductible	30% coinsurance	
If you are pregnant	Office visits	No charge	30% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge after deductible	30% coinsurance	
	Childbirth/delivery facility services	No charge after deductible	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge after deductible	30% coinsurance	No day limit; must preauthorize with the PPO
	Rehabilitation services	$20 copay/visit;	30% coinsurance	There are limits on some rehabilitation services.
	Habilitation services	$20 copay/visit;	30% coinsurance	
	Skilled nursing care	No charge after deductible	30% coinsurance	240 days/calendar year
	Durable medical equipment	No charge	30% coinsurance	Covered in accordance with the medical plan's DME policy.
	Hospice services (outpatient and inpatient)	No charge Inpatient covered at network provider only; no out-of-network benefit	30% coinsurance (outpatient only)	No lifetime maximum. Inpatient covered 365 days per admission. Respite care is limited to a maximum of 10 days of facility care and 240 hours of in home care throughout the treatment period.
If your child needs dental or eye care	Children's eye exam	No charge	$38 maximum plan payment	Provided by National Vision Administrators, not by the PPO. Limited to one exam every 12 months (365 days).
	Children's glasses	Lens – covered in full at a participating provider; Frames – maximum $175 allowance	Lens reimbursement ranges based on type of lens; Frames - $175 maximum plan payment	Provided by National Vision Administrators, not by the PPO. Coverage limited to lenses once per year (365 days); frames every two years (730 days).
	Children's dental check-up	No charge	Full cost of service upfront. You may submit a form to be reimbursed up to the maximum allowable charge.	Provided by United Concordia, not by the PPO. Covered once every 6 months.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check the SPD or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Infertility treatment
- Long-term care
- Routine foot care
- Weight loss programs (except for medically necessary nutritional counseling

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your SPD or plan document.)

- Bariatric surgery (subject to medical plan's policy)
- Chiropractic care (6 medically necessary visits per year; then a treatment plan must be submitted for extra visits)
- Dental care up to $2,000 per year
- Hearing aids (one aid per year per 36-month period)
- Non-emergency care when traveling outside of the U.S.
- Private duty nursing (240 hours per year/8 hours per day)
- Routine eye care (Adult), as provided by the vision plan

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: [insert State, HHS, DOL, and/or other applicable agency contact information]. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Your medical plan (telephone number appears on your ID card) or the PEBTF at 1-800-522-7279 for instructions.

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-522-7279 (TTY: 711).
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-522-7279 (TTY: 711).
Chinese (中文): 如果需要中文的帮助，请拨打这个号码. 1-800-522-7279 (TTY: 711).
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-522-7279 (TTY: 711).
Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-800-522-7279 (TTY: 711) uff.
Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-800-522-7279 (TTY: 711).
Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-522-7279 (TTY: 711).
Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-800-522-7279 (TTY: 711).

* For more information about limitations and exceptions, see the SPD or plan or policy document at www.pebtf.org.

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

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* For more information about limitations and exceptions, see the SPD or plan or policy document at www.pebtf.org.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$400**
Specialist copayment	**$45**
Hospital (facility) coinsurance	**None**
Other coinsurance	**None**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$400
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions**	$60
The total Peg would pay is	**$470**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$400**
Specialist copayment	**$45**
Hospital (facility) coinsurance	**None**
Other coinsurance	**None**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles*	$0
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions**	$20
The total Joe would pay is	**$620**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$400**
Specialist copayment	**$45**
Hospital (facility) coinsurance	**None**
Other coinsurance	**None**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles*	$400
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$800**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-522-7279
*Note: The annual deductible applies to certain services. It does not apply to office visits where you pay a copay. See page 1 for a list of services that are subject to the annual deductible.
**Note: These represent over-the-counter (OTC) drug costs.

The plan would be responsible for the other costs of these EXAMPLE covered services.