This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the Summary Plan Description (SPD) or Plan Document at www.pebtf.org or by calling 1-800-522-7279.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,000** person/$2,000 family – in-network services; **$2,000** person/$4,000 family – out-of-network services	For in-network services, you must pay all of the costs up to the **deductible** amount before this plan begins to pay for the following covered services you use: Diagnostic tests (labs) if not done at a Quest Diagnostics or LabCorp, imaging, hospital expenses (inpatient and outpatient) and medical/surgical expenses including physician services (except office visits), skilled nursing facility care and home health care. For out-of-network services, you must pay all the costs up to the **deductible** amount before the plan begins to pay for covered services you use. This is an annual deductible. See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes, **$50** per person annually under the Dental Plan.	You must pay all of the costs for basic and major restorative dental services up to your specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes, for in-network services: **$7,150** per person**/$14,300** family For out-of-network services: **$7,150** per person/**$14,300** family, plus the deductible	The **out-of-pocket limit** is the most you could pay during the year for your share of the cost of covered services. This limit helps you plan for health care expenses. The **out-of-pocket limit** includes costs for medical, mental health and substance abuse benefits and prescription drug costs.
What is not included in the out–of–pocket limit?	Balance-billed charges and health care services not covered by this plan.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.

Does this plan use a network of providers?	Yes. See www.pebtf.org to link to the Choice PPO plan's website.	If you use a **network** doctor or other health care **provider**, you pay a **copayment** for the following covered services: Office visits and outpatient therapy, emergency room and urgent care. Be aware, your **network** doctor or hospital may use an out-of-network **provider** for some services. Plans use the term **in-network**, **preferred** or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

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

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit	30% coinsurance	
	Specialist visit	$40 copay/visit	30% coinsurance	----------none----------
	Other practitioner office visit	$20 copay/visit for outpatient therapies	30% coinsurance	----------none----------
	Preventive care/screening/immunization	No charge	30% coinsurance	Refer to the Summary Plan Description for any time and age limitations for preventive care

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have a test	Diagnostic test (blood work)	No charge if you use Quest Diagnosics or LabCorp; no charge after deductible elsewhere	30% coinsurance	----------none----------
	Imaging (X-ray, CT/PET scans, MRIs)	No charge after deductible	30% coinsurance	----------none----------

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.pebtf.org and www.caremark.com.	Generic drugs	$10 copay up to 30 days/ $15 copay up to 90 days	Submit claim form	Prescription drugs are covered under your Prescription Drug Plan, which is separate from your PPO. In addition to mail order and CVS/pharmacy, you may obtain your generic 90-day supply at Rite Aid at a $20 copay.
	Preferred brand drugs	$20 copay up to 30 days; $30 copay up to 90 days, plus the cost difference between the brand and generic, if one exists (cost difference does not apply to annual out-of-pocket max)	Submit claim form	Prescription drugs are covered under your Prescription Drug Plan, which is separate from your PPO. In addition to mail order and CVS/pharmacy, you may obtain your preferred brand 90-day supply at Rite Aid at a $40 copay.
	Non-preferred brand drugs	$40 copay up to 30 days; $60 copay up to 90 days, plus the cost difference between the brand and generic, if one exists (cost difference does not apply to annual out-of-pocket max)	Submit claim form	Prescription drugs are covered under your Prescription Drug Plan, which is separate from your PPO. In addition to mail order and CVS/pharmacy, you may obtain your non-preferred brand 90-day supply at Rite Aid at a $80 copay.
	Specialty drugs	Same copays as above	N/A	The prescription benefit manager uses a specialty pharmacy for dispensing these types of drugs. Contact CVS Caremark. In addition, you may obtain specialty medications at Rite Aid.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge after deductible	30% coinsurance	----------none----------
	Physician/surgeon fees	No charge after deductible	30% coinsurance	----------none----------
If you need immediate medical attention	Emergency room services	$150 copay	$150 copay	**Copayment** waived if the visit leads to an inpatient admission to the hospital.
	Emergency medical transportation	No charge	No charge	----------none----------
	Urgent care	$50 copay	30% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after deductible	30% coinsurance	Out-of-network: 70 days per calendar year
	Physician/surgeon fee	No charge after deductible	30% coinsurance	----------none----------
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 copay/visit	30% coinsurance	Mental health and substance abuse benefits are provided by Optum, which is separate from your medical plan.
	Mental/Behavioral health inpatient services	No charge after deductible	30% coinsurance	----------none----------
	Substance use disorder outpatient services	No charge after deductible	30% coinsurance	----------none----------
	Substance use disorder inpatient services	No charge after deductible	30% coinsurance	----------none----------
If you are pregnant	Prenatal and postnatal care	No charge	30% coinsurance	----------none----------
	Delivery and all inpatient services	No charge after deductible	30% coinsurance	----------none----------

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need 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 visit limits on some rehabilitation services
	Habilitation services	$20 copay/visit	30% coinsurance	Benefits provided for autism spectrum services in accordance with state mandate (may be subject to specialist copay of $40/visit)
	Skilled nursing care	No charge after deductible	30% coinsurance	240 days per year
	Durable medical equipment	No charge	30% coinsurance	Provided by DMEnsion Benefit Management, not by the PPO
	Hospice service	No charge	30% coinsurance	No lifetime maximum; Respite care is limited to a maximum of 10 days of facility care or 240 hours of in home care throughout the treatment period
If your child needs dental or eye care	Eye exam	No charge	$28 maximum plan payment	Provided by National Vision Administrators, not by the PPO. Limited to one exam every 12 months (365 days)
	Glasses	Lens – wholesale cost plus 25%; Frames – wholesale price minus maximum allowance of $20 plus 20%	Lens reimbursement ranges based on type of lens; Frames – $20 maximum plan payment	Provided by National Vision Administrators, not by the PPO. Limited to one pair of glasses every 24 months (730 days)
	Dental check-up	No charge	Based on maximum plan allowance	Provided by United Concordia, not by the PPO. Covered once every 6 months

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check the SPD or Plan Document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Infertility treatments
- Long-term care
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check the SPD or Plan Document for other covered services and your costs for these services.)

- Chiropractic care
- Dental services up to $1,000 per year
- Hearing aids
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care (Adult), as provided by the Vision Plan

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the PEBTF at 1-800-522-7279. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U. S. Department of Health and Human Services at 1-877-267-2323, x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact your medical plan (telephone number appears on your ID card) or the PEBTF at 1-800-522-7279 for instructions.

Does this Coverage Provide Minimum Essential Coverage?

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

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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

About these Coverage Examples:

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

This is not a cost estimator.

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

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,540
- **Patient pays** $1,000 (In-network)

Sample care costs:

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

Patient pays:

Deductibles	$1,000
Copays	$0
Coinsurance	$0
Limits or exclusions	$0
Total	**$1,000**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $5,080
- **Patient pays** $320

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$320
Coinsurance	$0
Limits or exclusions	$0
Total	**$320**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

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

What does a Coverage Example show?

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

Does the Coverage Example predict my own care needs?

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

Does the Coverage Example predict my future expenses?

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

Can I use Coverage Examples to compare plans?

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

Are there other costs I should consider when comparing plans?

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

Discrimination is Against the Law

The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, PEBTF, Mailstop: CRAC,150 S. 43rd Street, Harrisburg, PA 17111, 1-800-522-7279, TTY number—711, Fax: 717-307-3372, Email: CivilRightsCoordinator@pebtf.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-522-7279 (TTY: 711).

注意: 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-522-7279 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-522-7279 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-522-7279 (TTY: 711).

Wann du Deitsch (Pennsylvania German / Dutch) schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-522-7279 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-522-7279 (TTY: 711). 번으로 전화해 주십시오.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-522-7279 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-522-7279 (رقم هاتف الصم والبكم: 1-800-522-7279.(TTY: 711)

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-522-7279 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-522-7279 (TTY: 711).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-522-7279 (TTY: 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-522-7279 (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-522-7279 (TTY: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-522-7279 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-522-7279 (TTY: 711).