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?	For in-network services: **$7,150** per person/**$14,300** family in network For out-of-network services: **$7,250** per person/**$14,500** family out of network	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?	No.	
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: **$10,000** per person/**$20,000** 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. It includes deductibles, coinsurance and any other expenditure required for an individual which is a qualified medical expense for the essential health benefits. This does include balance billing amounts for non-network providers and other out-of-network cost sharing.
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 Bronze Plan's website.	If you use a **network doctor** or other health care **provider**, you pay a **copayment** for most covered services. 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	No charge after deductible and OOP MAX	30% coinsurance; $0 after OOP MAX	----------none----------
	Specialist visit	No charge after deductible and OOP MAX	30% coinsurance; $0 after OOP MAX	----------none----------
	Other practitioner office visit	No charge after deductible and OOP MAX	30% coinsurance; $0 after OOP MAX	----------none----------
	Preventive care/screening/immunization	No charge	30% coinsurance; $0 after OOP MAX	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 (x-ray, blood work)	No charge after deductible and OOP MAX	30% coinsurance; $0 after OOP MAX	----------none----------
	Imaging (CT/PET scans, MRIs)	No charge after deductible and OOP MAX	30% coinsurance; $0 after OOP MAX	----------none----------
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	No charge after deductible and OOP MAX	30% coinsurance; $0 after OOP MAX	Prescription drugs are covered under your Prescription Drug Plan, which is separate from your medical plan.
	Preferred brand drugs	No charge after deductible and OOP MAX	30% coinsurance; $0 after OOP MAX	Prescription drugs are covered under your Prescription Drug Plan, which is separate from your medical plan.
	Non-preferred brand drugs	No charge after deductible and OOP MAX	30% coinsurance; $0 after OOP MAX	Prescription drugs are covered under your Prescription Drug Plan, which is separate from your medical plan.
	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.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge after deductible and OOP MAX	30% coinsurance; $0 after OOP MAX	----------none----------
	Physician/surgeon fees	No charge after deductible and OOP MAX	30% coinsurance; $0 after OOP MAX	----------none----------
If you need immediate medical attention	Emergency room services	No charge after deductible and OOP MAX	No charge after deductible and OOP MAX	----------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
	Emergency medical transportation	No charge after deductible and OOP MAX	30% coinsurance; $0 after OOP MAX	----------none----------
	Urgent care	No charge after deductible and OOP MAX	30% coinsurance; $0 after OOP MAX	----------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after deductible and OOP MAX	30% coinsurance; $0 after OOP MAX	Out-of-network: 70 days per calendar year
	Physician/surgeon fee	No charge after deductible and OOP MAX	30% coinsurance; $0 after OOP MAX	----------none----------
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No charge after deductible and OOP MAX	30% coinsurance; $0 after OOP MAX	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 and OOP MAX	30% coinsurance; $0 after OOP MAX	----------none----------
	Substance use disorder outpatient services	No charge after deductible and OOP MAX	30% coinsurance; $0 after OOP MAX	----------none----------
	Substance use disorder inpatient services	No charge after deductible and OOP MAX	30% coinsurance; $0 after OOP MAX	----------none----------
If you are pregnant	Prenatal and postnatal care	No charge after deductible and OOP MAX First prenatal visit covered in full	30% coinsurance; $0 after OOP MAX	----------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
	Delivery and all inpatient services	No charge after deductible and OOP MAX	30% coinsurance; $0 after OOP MAX	----------none----------
If you need help recovering or have other special health needs	Home health care	No charge after deductible and OOP MAX	30% coinsurance; $0 after OOP MAX	No day limit; must preauthorize with the PPO
	Rehabilitation services	No charge after deductible and OOP MAX	30% coinsurance; $0 after OOP MAX	There are visit limits on some rehabilitation services
	Habilitation services	No charge after deductible and OOP MAX	30% coinsurance; $0 after OOP MAX	Benefits provided for autism spectrum services in accordance with state mandate may be included in these services
	Skilled nursing care	No charge after deductible and OOP MAX	30% coinsurance; $0 after OOP MAX	240 days per year
	Durable medical equipment	No charge after deductible and OOP MAX	30% coinsurance; $0 after OOP MAX	Provided by DMEnsion Benefit Management, not by the Bronze Plan
	Hospice service	No charge after deductible and OOP MAX	30% coinsurance; $0 after OOP MAX	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 coverage	No coverage	
	Glasses	No coverage	No coverage	

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
	Dental check-up	No coverage	No coverage	

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
- Private duty nursing
- Non-emergency care when traveling outside the U.S.

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** $390
  You are responsible for $7,150 single/ $14,300 family annual deductible and Maximum Out-of-Pocket. This example assumes single coverage.
- **Patient pays** $7,150 (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	$7,150
Copays	N/A
Coinsurance	$0
Limits or exclusions	$0
Total	**$7,150**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $0
  You are responsible for $7,150 single/ $14,300 family annual deductible and Maximum Out-of-Pocket. This example assumes single coverage.
- **Patient pays** $5,400 (In-network)

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	$5,400
Copays	N/A
Coinsurance	$0
Limits or exclusions	$0
Total	**$5,400**

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.