




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](http://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:
<b>What is the overall <a href="#">deductible</a>?</b>	\$400/Individual or \$800/family – <a href="#">in-network</a> services; \$800/individual or \$1,600/family – <a href="#">out-of-network</a> services	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> . For <a href="#">in-network</a> services you must pay all of the costs up to the <a href="#">deductible</a> 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.
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Preventive care</a> , office visits, urgent and emergency room care are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="http://www.pebtf.org">www.pebtf.org</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	Yes. \$50/individual annually under the Dental Plan.	You must pay all of the costs for basic and major restorative dental services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	For <a href="#">network providers</a> \$9,200 individual / \$18,400 family; for <a href="#">out-of-network providers</a> \$9,200 individual / \$18,400 family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://www.pebtf.org">www.pebtf.org</a> or call 1-800-522-7279 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.

Important Questions	Answers	Why This Matters:
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$20 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply	30% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	\$45 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply	30% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening/immunization</a>	No charge	30% <a href="#">coinsurance</a> If not available in-network, full cost shall be covered without any cost sharing	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge if you use Quest Diagnostics or LabCorp; \$30 lab <a href="#">copay</a> elsewhere	30% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	No charge after <a href="#">deductible</a>	30% <a href="#">coinsurance</a>	
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="#">www.pebtf.org</a> <a href="#">www.caremark.com</a>	Generic drugs (Tier 1)	\$15 <a href="#">copay</a> /prescription up to 30 days; \$22.50 <a href="#">copay</a> /prescription up to 90 days (CVS Maintenance Choice & mail order)	Submit claim form	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription and CVS Maintenance Choice Network). In addition, you may obtain your 90-day supplies at Rite Aid Pharmacy for higher <a href="#">copays</a> – \$30 generic, \$80 preferred brand; \$160 non-preferred brand. 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 <a href="#">out-of-pocket limit</a> ).
	Preferred brand drugs (Tier 2)	\$40 <a href="#">copay</a> /prescription up to 30 days; \$60 <a href="#">copay</a> /prescription up to 90 days (CVS Maintenance Choice & mail order)	Submit claim form	

\* For more information about limitations and exceptions, see the SPD or [plan](#) document at [www.pebtf.org](#).

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)	
	Non-preferred brand drugs (Tier 3)	\$80 <a href="#">copay</a> /prescription up to 30 days; \$120 <a href="#">copay</a> /prescription up to 90 days (CVS Maintenance Choice & mail order)	Submit claim form	The prescription benefit manager uses a specialty pharmacy for dispensing specialty medications. In addition, you may obtain specialty medications at Rite Aid.
	<a href="#">Specialty drugs</a> (Tier 4)	Same <a href="#">copays</a> as above	N/A	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge after <a href="#">deductible</a>	30% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by 20% of the total cost of the service.
	Physician/surgeon fees	No charge after <a href="#">deductible</a>	30% <a href="#">coinsurance</a>	
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$200 <a href="#">copay</a> /visit	\$200 <a href="#">copay</a> /visit	ER <a href="#">copay</a> waived if the visit leads to an inpatient admission to the hospital.
	<a href="#">Emergency medical transportation</a>	No charge	No charge	
	<a href="#">Urgent care</a>	\$50 <a href="#">copay</a> /visit	30% <a href="#">coinsurance</a>	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after <a href="#">deductible</a>	30% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , benefits could be reduced by 20% of the total cost of the service. <a href="#">Out-of-network</a> : 70 days per calendar year
	Physician/surgeon fees	No charge after <a href="#">deductible</a>	30% <a href="#">coinsurance</a>	
If you need mental health, behavioral health, or substance abuse services	Office visits and outpatient services (all other)	\$20 <a href="#">copay</a> /visit; No charge after <a href="#">deductible</a> for all other outpatient services	30% <a href="#">coinsurance</a>	Mental health and substance abuse benefits are provided by Optum, which is separate from your medical plan
	Inpatient services	No charge after <a href="#">deductible</a>	30% <a href="#">coinsurance</a>	
If you are pregnant	Office visits	No charge	30% <a href="#">coinsurance</a>	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge after <a href="#">deductible</a>	30% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	No charge after <a href="#">deductible</a>	30% <a href="#">coinsurance</a>	

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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)	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	No charge after <a href="#">deductible</a>	30% <a href="#">coinsurance</a>	No day limit; must preauthorize with the PPO
	<a href="#">Rehabilitation services</a>	\$20 <a href="#">copay</a> /visit	30% <a href="#">coinsurance</a>	There are limits on some rehabilitation services.
	<a href="#">Habilitation services</a>	\$20 <a href="#">copay</a> /visit	30% <a href="#">coinsurance</a>	
	<a href="#">Skilled nursing care</a>	No charge after <a href="#">deductible</a>	30% <a href="#">coinsurance</a>	240 days/calendar year
	<a href="#">Durable medical equipment</a>	No charge	30% <a href="#">coinsurance</a>	Covered in accordance with the medical plan's DME policy.
	<a href="#">Hospice services (outpatient and inpatient)</a>	No charge Inpatient covered at network provider only; no out-of-network benefit	30% <a href="#">coinsurance (outpatient only)</a>	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.
<b>If your child needs dental or eye care</b>	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	Based on maximum plan allowance	Provided by United Concordia, not by the PPO. Covered once every 6 months.

**Excluded Services & Other Covered Services:**

<b>Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check the SPD or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a>.)</b>		
<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Cosmetic surgery</li> </ul>	<ul style="list-style-type: none"> <li>• Infertility treatment</li> <li>• Long-term care</li> </ul>	<ul style="list-style-type: none"> <li>• Routine foot care</li> <li>• Weight loss programs, except for medically necessary nutritional counseling</li> </ul>

\* For more information about limitations and exceptions, see the SPD or [plan](#) document at [www.pebtf.org](http://www.pebtf.org).

**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 particular restrictions)
- Chiropractic care
- Dental care up to \$2,000 per year
- Hearing aids
- Non-emergency care when traveling outside of the U.S.
- Private duty nursing
- 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: Department of Health & Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323, X61565 or [www.cciio.coms.gov](http://www.cciio.coms.gov). 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](http://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, kwijigo holne' 1-800-522-7279 (TTY: 711)

*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](#) document at [www.pebtf.org](http://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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$400
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions**	\$10
<b>The total Peg would pay is</b>	<b>\$410</b>

**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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$350
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$350</b>

**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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$100
<a href="#">Copayments</a>	\$530
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$630</b>

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.

\*\* These represent over-the-counter (OTC) drug costs.

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.