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?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes. You do not have a deductible in this plan.	A copayment may apply for some services. This plan covers certain preventive services without cost-sharing. 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 basic and major restorative dental 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 $7,350 individual / $14,700 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-billed 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 or call 1-800-522-7279 for a list of network providers.	This plan uses a provider network. 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.
Do you need a referral to see a specialist?	Yes. Contact your plan for details.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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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	$5 copay/visit	Not covered	None
	Specialist visit	$10 copay/visit	Not covered	None
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (blood work)	No charge	Not covered	None
	Imaging (X-ray, CT/PET scans, MRIs)	No charge	Not covered	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.pebtf.org www.caremark.com	Generic drugs (Tier 1)	$12 copay/prescription up to 30 days; $18 copay/prescription up to 90 days (CVS & mail order)	Submit claim form	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription and CVS/pharmacy). In addition, you may obtain your 90-day supplies at Rite Aid Pharmacy for higher copays – $24 generic, $60 preferred brand; $120 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 out-of-pocket limit). The prescription benefit manager uses a specialty pharmacy for dispensing specialty medications. In addition, you may obtain specialty medications at Rite Aid.
	Preferred brand drugs (Tier 2)	$30 copay/prescription up to 30 days; $45 copay/prescription up to 90 days (CVS & mail order)	Submit claim form	
	Non-preferred brand drugs (Tier 3)	$60 copay/prescription up to 30 days; $90 copay/prescription up to 90 days (CVS & mail order)	Submit claim form	
	Specialty drugs (Tier 4)	Same copays as above	N/A	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	Preauthorization is required.
	Physician/surgeon fees	No charge	Not covered	
If you need immediate medical attention	Emergency room care	$150 copay/visit	$150 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	Not covered	

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 have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	Preauthorization is required.
	Physician/surgeon fees	No charge	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$5 copay/visit	Not covered	Mental health and substance abuse benefits are provided by Optum, which is separate from your medical plan.
	Inpatient services	No charge	Not covered	
If you are pregnant	Office visits	No charge	Not covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	No charge	Not covered	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	You may receive 60 medically-necessary visits in a 90-day period. Benefit is renewed when 90 days without home health care have elapsed when medically necessary.
	Rehabilitation services	$5 copay/visit	Not covered	Combined maximum of 60 visits per year for all outpatient therapies. Benefits provided for autism spectrum services in accordance with state mandate (may be subject to specialist copay of $10/visit).
	Habilitation services	$5 copay/visit	Not covered	
	Skilled nursing care	No charge	Not covered	180 days/calendar year
	Durable medical equipment	No charge	Not covered	Provided by DMEnsion Benefit Management; see the SPD for items that may be dispensed under the medical plan.
	Hospice services	No charge	Not covered	No lifetime maximum; respite care is limited to a maximum of 10 days of facility care and 240 hours of in home care throughout the treatment period.

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 your child needs dental or eye care	Children's 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).
	Children's 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.) Coverage limited to one pair of glasses every 24 months (730 days) for children 16 years or older. Child to age 16, every 12 months (365 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:

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
- Private duty nursing
- Routine foot care
- Weight loss programs

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 $1,000 per year
- Hearing aids
- 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.cms.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 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 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.

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet 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)

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

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	$0
Specialist copayment	$10
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	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles*	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions**	$60
The total Peg would pay is	$60

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

The plan's overall deductible	$0
Specialist copayment	$10
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	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions**	$60
The total Joe would pay is	$360

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

The plan's overall deductible	$0
Specialist copayment	$10
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	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$0
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$200

*Note: The Custom HMO does not have an annual deductible.
** These represent over-the-counter (OTC) drug costs.

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