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, call Benecard PBF at 1-877-723-6005 or visit us at www.benecardpbf.com. 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 www.benecardpbf.com or call 1-877-723-6005 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? | No. | You will have to meet the deductible before the plan pays for any services. |
| Are there other deductibles for specific services? | No. | You don't have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan? | $2,120 individual / $4,340 family | The out-of-pocket limit is the most you could pay in a calendar 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 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.benecardpbf.com or call 1-877-723-6005 for a list of participating pharmacies | You will pay the most if you use an out-of-network pharmacy. If you use a non-participating pharmacy, you will be required to pay the pharmacy the full retail cost. You can be reimbursed only what we would have paid to a participating pharmacy less your copay by filling out a drug reimbursement claim form at www.benecardpbf.com. Please note you may be reimbursed less than what you actually paid at a non-participating pharmacy. |
| Do you need a referral to see a specialist? | No. | |

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 | Not applicable. | Not applicable. | |
| | Specialist visit | Not applicable. | Not applicable. | |
| | Preventive care/screening/ immunization | Not applicable. | Not applicable. | |
| If you have a test | Diagnostic test (x-ray, blood work) | Not applicable. | Not applicable. | |
| | Imaging (CT/PET scans, MRIs) | Not applicable. | Not applicable. | |
| If you need drugs to treat your illness or condition<br>More information about prescription drug coverage is available at www.benecardpbf.com | Generic drugs | $20 copay/prescription (retail & mail order) | 100% | Retail: 1 - 30 days (1 copay), 31 - 60 days (2 copays), 61 - 90 days (3 co-pays).<br>Mail Order: Up to a 90-day supply. |
| | Preferred brand drugs | $40 copay/prescription (retail & mail order) | 100% | Retail: 1 - 30 days (1 copay), 31 - 60 days (2 copays), 61 - 90 days (3 co-pays).<br>Mail Order: Up to a 90-day supply. |
| | Non-preferred brand drugs | $40 copay/prescription (retail & mail order) | 100% | Retail: 1 - 30 days (1 copay), 31 - 60 days (2 copays), 61 - 90 days (3 co-pays).<br>Mail Order: Up to a 90-day supply. |
| | Specialty drugs | $20 copay/ for Generic prescription<br>$40 copay/ for Brand prescription<br>(retail & mail order) | 100% | Retail: 1 - 30 days (1 copay), 31 - 60 days (2 copays), 61 - 90 days (3 co-pays).<br>Mail Order: Up to a 90-day supply. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | Not applicable. | Not applicable. | |
| | Physician/surgeon fees | Not applicable. | Not applicable. | |
| If you need immediate medical attention | Emergency room care | Not applicable. | Not applicable. | |
| | Emergency medical transportation | Not applicable. | Not applicable. | |
| | Urgent care | Not applicable. | Not applicable. | |
| If you have a hospital stay | Facility fee (e.g., hospital room) | Not applicable. | Not applicable. | |
| | Physician/surgeon fees | Not applicable. | Not applicable. | |

[* For more information about limitations and exceptions, see the plan or policy document at www.benecardpbf.com.]

| 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 need mental health, behavioral health, or substance abuse services | Outpatient services | Not applicable. | Not applicable. | |
| | Inpatient services | Not applicable. | Not applicable. | |
| If you are pregnant | Office visits | Not applicable. | Not applicable. | |
| | Childbirth/delivery professional services | Not applicable. | Not applicable. | |
| | Childbirth/delivery facility services | Not applicable. | Not applicable. | |
| If you need help recovering or have other special health needs | Home health care | Not applicable. | Not applicable. | |
| | Rehabilitation services | Not applicable. | Not applicable. | |
| | Habilitation services | Not applicable. | Not applicable. | |
| | Skilled nursing care | Not applicable. | Not applicable. | |
| | Durable medical equipment | Not applicable. | Not applicable. | |
| | Hospice services | Not applicable. | Not applicable. | |
| If your child needs dental or eye care | Children's eye exam | Not applicable. | Not applicable. | |
| | Children's glasses | Not applicable. | Not applicable. | |
| | Children's dental check-up | Not applicable. | Not applicable. | |

## Excluded Services & Other Covered Services:

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

- Acupuncture
- Allergy Serum
- Alternative Medications
- Bariatric Surgery
- Biologicals
- Blood And Blood Plasma
- Chiropractic Care
- Cosmetic Surgery
- Dental Care
- Diagnostic Non Diabetic
- Hair Loss Medications
- Hearing Aids
- Homeopathic
- Implant
- Infertility Treatment
- IV Medications
- Long-term Care
- Medical Supplies and Devices
- Non-emergency care when traveling outside the U.S.
- Nutritional and Dietary
- Over-The-Counter Medications
- Physician Administered Medications
- Private-duty Nursing
- Research
- Rhogam
- Routine Eye Care
- Routine Foot Care
- Vaccines
- Weight Loss Programs

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

[* For more information about limitations and exceptions, see the plan or policy document at www.benecardpbf.com.]

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 Washington Township Board of Education at 856-589-6644 the Department of Health and 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 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 Benecard at 1-877-723-6005.

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 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 1-877-723-6005.
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-723-6005.
[Chinese (中文): 如果需要中文的帮助， **请拨打这个号码**1-877-723-6005.
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-723-6005.

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

[* For more information about limitations and exceptions, see the plan or policy document at www.benecardpbf.com.]

## 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 *[cost sharing]* | $N/A |
| Hospital (facility) *[cost sharing]* | N/A% |
| Other *[cost sharing]* | N/A% |

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 | $40 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $12,760 |
| The total Peg would pay is | $12,800 |

### 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 *[cost sharing]* | $N/A |
| Hospital (facility) *[cost sharing]* | N/A% |
| Other *[cost sharing]* | N/A% |

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 | $1,200 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $1,500 |
| The total Joe would pay is | $2,700 |

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

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist *[cost sharing]* | $N/A |
| Hospital (facility) *[cost sharing]* | N/A% |
| Other *[cost sharing]* | N/A% |

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 | $N/A |
| Copayments | $N/A |
| Coinsurance | $N/A |
| *What isn't covered* | |
| Limits or exclusions | $N/A |
| The total Mia would pay is | $N/A |

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