




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](http://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](http://www.benecardpbf.com) or call 1-877-723-6005 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	No.	You will have to meet the <a href="#">deductible</a> before the <a href="#">plan</a> pays for any services.
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$1,600 individual / \$3,200 family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a calendar 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.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Premiums 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> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.benecardpbf.com">www.benecardpbf.com</a> 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 <a href="http://www.benecardpbf.com">www.benecardpbf.com</a> . Please note you may be reimbursed less than what you actually paid at a non-participating pharmacy.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	Not applicable.	Not applicable.	
	<a href="#">Specialist</a> visit	Not applicable.	Not applicable.	
	<a href="#">Preventive care/screening/immunization</a>	Not applicable.	Not applicable.	
If you have a test	<a href="#">Diagnostic test</a> (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 More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.benecardpbf.com">www.benecardpbf.com</a>	Generic drugs	\$5 <a href="#">copay</a> /prescription (retail) \$10 <a href="#">copay</a> /prescription (mail order)	100%	Retail: 1 - 30 days (1 copay), 31 - 60 days (2 copays), 61 - 90 days (3 co-pays). Mail Order: Up to a 90-day supply.
	Preferred brand drugs	\$10 <a href="#">copay</a> /prescription (retail) \$20 <a href="#">copay</a> /prescription (mail order)	100%	Retail: 1 - 30 days (1 copay), 31 - 60 days (2 copays), 61 - 90 days (3 co-pays). Mail Order: Up to a 90-day supply.
	Non-preferred brand drugs	\$10 <a href="#">copay</a> /prescription (retail) \$20 <a href="#">copay</a> /prescription (mail order)	100%	Retail: 1 - 30 days (1 copay), 31 - 60 days (2 copays), 61 - 90 days (3 co-pays). Mail Order: Up to a 90-day supply.
	<a href="#">Specialty drugs</a>	\$10 <a href="#">copay</a> / for Generic prescription \$20 <a href="#">copay</a> / for Brand prescription (retail & mail order)	100%	Mail Order only: 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	<a href="#">Emergency room care</a>	Not applicable.	Not applicable.	
	<a href="#">Emergency medical transportation</a>	Not applicable.	Not applicable.	
	<a href="#">Urgent care</a>	Not applicable.	Not applicable.	

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)	Not applicable.	Not applicable.	
	Physician/surgeon fees	Not applicable.	Not applicable.	
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	<a href="#">Home health care</a>	Not applicable.	Not applicable.	
	<a href="#">Rehabilitation services</a>	Not applicable.	Not applicable.	
	<a href="#">Habilitation services</a>	Not applicable.	Not applicable.	
	<a href="#">Skilled nursing care</a>	Not applicable.	Not applicable.	
	<a href="#">Durable medical equipment</a>	Not applicable.	Not applicable.	
	<a href="#">Hospice services</a>	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](#).)

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| <ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Allergy Serum</li> <li>• Alternative Medications</li> <li>• Bariatric Surgery</li> <li>• Biologicals</li> <li>• Blood And Blood Plasma</li> <li>• Chiropractic Care</li> <li>• Cosmetic Surgery</li> <li>• Dental Care</li> <li>• Diagnostic Non Diabetic</li> </ul> | <ul style="list-style-type: none"> <li>• Hair Loss Medications</li> <li>• Hearing Aids</li> <li>• Homeopathic</li> <li>• Implant</li> <li>• Infertility Treatment</li> <li>• IV Medications</li> <li>• Long-term Care</li> <li>• Medical Supplies and Devices</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>• Nutritional and Dietary</li> <li>• Over-The-Counter Medications</li> <li>• Physician Administered Medications</li> <li>• Private-duty Nursing</li> <li>• Research</li> <li>• Rhogam</li> <li>• Routine Eye Care</li> <li>• Routine Foot Care</li> <li>• Vaccines</li> <li>• Weight Loss Programs</li> </ul> |
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**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 Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). 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 [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, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272), or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

**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, kwijigo holne' 1-877-723-6005.

-----*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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist</a> [ <i>cost sharing</i> ]	\$N/A
■ Hospital (facility) [ <i>cost sharing</i> ]	N/A%
■ Other [ <i>cost sharing</i> ]	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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$20
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$12,760
The total Peg would pay is	\$12,780

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist</a> [ <i>cost sharing</i> ]	\$N/A
■ Hospital (facility) [ <i>cost sharing</i> ]	N/A%
■ Other [ <i>cost sharing</i> ]	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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$400
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$1,400
The total Joe would pay is	\$1,800

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist</a> [ <i>cost sharing</i> ]	\$N/A
■ Hospital (facility) [ <i>cost sharing</i> ]	N/A%
■ Other [ <i>cost sharing</i> ]	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
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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