



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> ?	\$1,430 individual / \$2,860 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.
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.
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 office</a> 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	\$3 <a href="#">copay</a> /prescription (retail) \$5 <a href="#">copay</a> /prescription (mail order)	Not Covered.	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) \$15 <a href="#">copay</a> /prescription (mail order)	Not Covered.	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) \$15 <a href="#">copay</a> /prescription (mail order)	Not Covered.	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>	\$3 <a href="#">copay</a> / for Generic prescription \$10 <a href="#">copay</a> / for Brand prescription (retail) \$5 <a href="#">copay</a> / for Generic prescription \$15 <a href="#">copay</a> / for Brand prescription (mail order)	Not Covered.	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.
If you have outpatient	Facility fee (e.g., ambulatory)	Not applicable.	Not applicable.	

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.benecardpbf.com](http://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)	
surgery	surgery center)			
	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.	
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.	
If your child needs dental or eye care	<a href="#">Hospice services</a>	Not applicable.	Not applicable.	
	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:**

<b>Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy 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>• Allergy Serum</li> </ul>	<ul style="list-style-type: none"> <li>• Growth Hormones</li> <li>• Hair Loss Medications</li> </ul>	<ul style="list-style-type: none"> <li>• Nutritional and Dietary</li> <li>• Over-The-Counter Medications</li> </ul>

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

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

- |   |  |   |
|---|--|---|
| <ul style="list-style-type: none"><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>• 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>• Physician Administered Medications</li><li>• Prescription Medications with OTC Equivalent</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> |
|---|--|---|

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

**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 Lumberton Township Board of Education at 609-267-1406, 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](http://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](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 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 Benecard at 1-877-723-6005.

**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 1-877-723-6005.]

[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.*

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## 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*)

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

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$12,690
<b>The total Peg would pay is</b>	<b>\$12,700</b>

### 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*)

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

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$1,300
<b>The total Joe would pay is</b>	<b>\$1,500</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$N/A
- [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*)

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

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

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