



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 ? | \$1,411 individual / \$2,822 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 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. |
| 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 More information about prescription drug coverage is available at www.benecardpbf.com | Generic drugs | \$10 copay /prescription (retail) \$5 copay /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 | \$21 copay /prescription (retail) \$31 copay /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 | \$42 copay /prescription (retail) \$52 copay /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. |
| | Specialty drugs | \$10 copay / for Generic prescription \$21 copay / for Preferred Brand prescription \$42 copay / for Non-Preferred Brand prescription (retail) \$5 copay / for Generic prescription \$31 copay / for Preferred | 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. |

* 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) | |
| | | Brand prescription \$52 copay / for Non-Preferred Brand prescription (mail) | | |
| 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. | |
| 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. | |

* 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) | |
| | 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 .) | | | |
|--|---|--|--|
| <ul style="list-style-type: none"> • Acupuncture • Allergy Serum • Alternative Medications • Bariatric Surgery • Biologicals • Blood And Blood Plasma • Chiropractic Care • Cosmetic Surgery • Dental Care • Diagnostic Non Diabetic | <ul style="list-style-type: none"> • Growth Hormones • 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. | <ul style="list-style-type: none"> • Nutritional and Dietary • Over-The-Counter Medications • Physician Administered Medications • Prescription Medications with OTC Equivalent • 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.)

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. 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 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](#).

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

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.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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 | \$12,700 |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing | |
|-----------------------------------|-----------------|
| Deductibles | \$0 |
| Copayments | \$10 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$12,690 |
| The total Peg would pay is | \$12,700 |

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 | \$5,600 |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$0 |
| Copayments | \$500 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$1,300 |
| The total Joe would pay is | \$1,800 |

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*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$2,800 |
|---------------------------|----------------|

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.