




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 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)	
<b>If you visit a health care provider's office or clinic</b>	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.	
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	Not applicable.	Not applicable.	
	Imaging (CT/PET scans, MRIs)	Not applicable.	Not applicable.	
<b>If you need drugs to treat your illness or condition</b> 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)	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) \$20 <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) \$20 <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>	\$10 <a href="#">copay</a> / for Generic prescription \$20 <a href="#">copay</a> / for Brand prescription (retail & mail order)	Not Covered.	Mail Order only: Up to a 90-day supply.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	Not applicable.	Not applicable.	
	Physician/surgeon fees	Not applicable.	Not applicable.	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	Not applicable.	Not applicable.	
	<a href="#">Emergency medical</a>	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)	
	<a href="#">transportation</a>			
	<a href="#">Urgent care</a>	Not applicable.	Not applicable.	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	Not applicable.	Not applicable.	
	Physician/surgeon fees	Not applicable.	Not applicable.	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	Not applicable.	Not applicable.	
	Inpatient services	Not applicable.	Not applicable.	
<b>If you are pregnant</b>	Office visits	Not applicable.	Not applicable.	
	Childbirth/delivery professional services	Not applicable.	Not applicable.	
	Childbirth/delivery facility services	Not applicable.	Not applicable.	
<b>If you need help recovering or have other special health needs</b>	<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.	
<b>If your child needs dental or eye care</b>	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 <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> .)		
<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> </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> </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> </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](#).)**

- Chiropractic Care
- Cosmetic Surgery
- Dental Care
- Diagnostic Non Diabetic
- Long-term Care
- Medical Supplies and Devices
- Medications prescribed for cosmetic purposes
- Non-emergency care when traveling outside the U.S.
- 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 Riverside Board of Education at 856-461-1255, 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>	\$300
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$1,300
<b>The total Joe would pay is</b>	<b>\$1,600</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.