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, visit **www.netbenefits.com** or call **1-866-476-8723**. 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.dol.gov/ebsa/healthreform** or **www.cciio.cms.gov** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1,600** person / **$3,200** family in-network medical and Rx combined **$3,200** person / **$6,400** family out-of-network medical True Family Aggregate Deductible	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
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?	**$3,600** person / **$7,200** family in-network medical and Rx combined **$7,200** person / **$14,400** family out-of-network medical Embedded Maximum Out of Pocket	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, balance-billed charges, and health care services 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, if you are enrolled with Horizon BCBS see www.horizonblue.com/pfizer and if you are enrolled with UnitedHealthcare see http://welcometouhc.com/pfizer for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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	$35 copay, after deductible	40% coinsurance, after deductible	Out of Network expenses are subject to Allowed Amounts for Out-of-Network (OON) services as determined by the Claims Administrator, refer to the Summary Plan Description for details.
	Specialist visit	$55 copay, after deductible	40% coinsurance, after deductible	Out of Network expenses are subject to Allowed Amounts for OON services as determined by the Claims Administrator, refer to the Summary Plan Description for details.
	Preventive care/screening/ immunization	No cost, covered in full	No cost, covered in full	Out of Network expenses are subject to Allowed Amounts for OON services as determined by the Claims Administrator, refer to the Summary Plan Description for details. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance, after deductible	40% coinsurance, after deductible	Out of Network expenses are subject to Allowed Amounts for OON services as determined by the Claims Administrator, refer to the Summary Plan Description for details.
	Imaging (CT/PET scans, MRIs)	20% coinsurance, after deductible	40% coinsurance, after deductible	Failure to obtain pre-authorization may result in non-coverage or reduced benefits. Out of Network expenses are subject to Allowed Amounts for OON services as determined by the Claims Administrator, refer to the Summary Plan Description for details.

[* For more information about limitations and exceptions, see the plan or policy document at **www.netbenefits.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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at 1-866-804-5881 or www.caremark.com	Generic drugs	$15 per 30 day supply $45 per 90 day retail $30 per 90 day mail-order or retail from CVS Pharmacy After deductible	In-network copayment plus any amount over the Caremark contracted rate. Paper claim required.	Deductible waived for preventive medications on the **HSA Copay Preventive Drug List**. Most Pfizer medications with no generic available covered in full (Deductible applies if not on **HSA Copay Preventive Drug List**). Pfizer medications with a generic equivalent available covered same as non-Pfizer medications, (Deductible applies if not on **HSA Copay Preventive Drug List**). Certain weight loss medications require enrollment in Pfizer's Healthy Weight Program, otherwise member pays the full cost of the medication. Increased out of pocket cost will apply when a non-Pfizer brand medication is requested and the prescriber has not ordered a "dispense as written" prescription. Must use CVS Specialty for specialty drugs.
	Preferred brand drugs Dispense as written (DAW) provisions apply	20% coinsurance, after deductible 30 day, Min $15, Max $80 90 day retail, Min $45, Max $240 90 day mail-order or retail from CVS Pharmacy, Min $30, Max $160	In-network cost share plus any amount over the Caremark contracted rate. Paper claim required.	
	Non-preferred brand drugs Dispense as written (DAW) provisions apply	20% coinsurance, after deductible 30 day, Min $15, Max $80 90 day retail, Min $45, Max $240 90 day mail-order or retail from CVS Pharmacy, Min $30, Max $160	In-network cost share plus any amount over the Caremark contracted rate. Paper claim required.	
	Specialty drugs Dispense as written (DAW) provisions apply	20% coinsurance, after deductible 30 day, Min $15, Max $80 90 day retail, Min $45, Max $240 90 day mail-order, Min $30, Max $160	Not Covered	

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 outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$450 copay, after deductible for outpatient facility services; $200 copay after deductible for ambulatory surgical services	40% coinsurance, after deductible	Out of Network expenses are subject to Allowed Amounts for OON services as determined by the Claims Administrator, refer to the Summary Plan Description for details.
	Physician/surgeon fees	$200 copay, after deductible	40% coinsurance, after deductible	Out of Network expenses are subject to Allowed Amounts for OON services as determined by the Claims Administrator, refer to the Summary Plan Description for details.
If you need immediate medical attention	Emergency room care	$450 copay, after deductible	$450 copay, after deductible	Out of Network expenses are subject to Allowed Amounts for OON services as determined by the Claims Administrator, refer to the Summary Plan Description for details.
	Emergency medical transportation	20% coinsurance, after deductible	40% coinsurance, after deductible	Out of Network expenses are subject to Allowed Amounts for OON services as determined by the Claims Administrator, refer to the Summary Plan Description for details.
	Urgent care	$75 copay, after deductible	40% coinsurance, after deductible	Out of Network expenses are subject to Allowed Amounts for OON services as determined by the Claims Administrator, refer to the Summary Plan Description for details.
If you have a hospital stay	Facility fee (e.g., hospital room)	$450 copay, after deductible	40% coinsurance, after deductible	365 days inpatient hospital care; requires pre-approval. Out of Network expenses are subject to Allowed Amounts for OON services as determined by the Claims Administrator, refer to the Summary Plan Description for details.
	Physician/surgeon fees	$200 copay, after deductible	40% coinsurance, after deductible	Out of Network expenses are subject to Allowed Amounts for OON services as determined by the Claims Administrator, refer to the Summary Plan Description for details.

[* For more information about limitations and exceptions, see the plan or policy document at **www.netbenefits.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. Claims administrator is Optum if you are enrolled with United Healthcare. For more information call 1-800-638-8010 or www.liveandworkwell.com Claims administrator is Horizon BCBS if you are enrolled with Horizon BCBS. For more information call 1-888-340-5001 or www.HorizonBlue.com/Pfizer	Outpatient services	$450 facility copay, after deductible $35 physician copay, after deductible	40% coinsurance, after deductible	Out of Network expenses are subject to Allowed Amounts for OON services as determined by the Claims Administrator, refer to the Summary Plan Description for details.
	Inpatient services	$450 facility copay, after deductible $35 physician copay, after deductible	40% coinsurance, after deductible	365 days inpatient hospital care; requires pre-approval. Out of Network expenses are subject to Allowed Amounts for OON services as determined by the Claims Administrator, refer to the Summary Plan Description for details.
If you are pregnant	Office visits	$55 copay, after deductible	40% coinsurance, after deductible	Prenatal and postnatal visits are included in the delivery charge.
	Childbirth/delivery professional services	$200 copay, after deductible	40% coinsurance, after deductible	365 days inpatient hospital care; requires pre-approval. Out of Network expenses are subject to Allowed Amounts for OON services as determined by the Claims Administrator, refer to the Summary Plan Description for details.
	Childbirth/delivery facility services	$450 copay, after deductible	40% coinsurance, after deductible	
If you need help recovering or have other special health needs	Home health care	20% coinsurance, after deductible	40% coinsurance, after deductible	Failure to obtain pre-authorization may result in non-coverage or reduced benefits.

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)	
	Rehabilitation services	$450 facility copay, after deductible $35 physician copay, after deductible	40% coinsurance, after deductible	Outpatient Physical, Speech, and Occupational therapy limited to a combined 120 annual visit maximum. Inpatient care requires pre-approval.
	Habilitation services	$450 facility copay, after deductible $35 physician copay, after deductible	40% coinsurance, after deductible	Outpatient Physical, Speech, and Occupational therapy limited to a combined 120 annual visit maximum. Inpatient care requires pre-approval.
	Skilled nursing care	$450 facility copay, after deductible $200 physician copay, after deductible	40% coinsurance, after deductible	120 days per benefit period, with direct admission; failure to obtain pre-authorization may result in non-coverage or reduced benefits.
	Durable medical equipment	20% coinsurance, after deductible	40% coinsurance, after deductible	Requires pre-approval for rentals or purchases over $1,000. Failure to obtain pre-authorization may result in non-coverage or reduced benefits.
	Hospice services	100% coinsurance, after deductible	40% coinsurance, after deductible	Requires pre-approval.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	

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.)

- Cosmetic surgery
- Dental care
- Long-term care
- Routine eye care
- Routine foot care
- Weight loss programs

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

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture • Bariatric surgery • Private-duty nursing	• Chiropractic Care • Hearing aids	• Infertility treatment • Non-emergency care when traveling outside the U.S.

[* For more information about limitations and exceptions, see the plan or policy document at **www.netbenefits.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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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 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 medical 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 Horizon BCBSNJ at 1-888-340-5001 or UnitedHealthcare at 1-800-638-8010. You may also contact the Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

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 1-888-340-5001 (Horizon) or 1-800-638-8010 (UnitedHealthcare).
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-340-5001 (Horizon) or 1-800-638-8010 (UnitedHealthcare).
[Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** 1-888-340-5001 (Horizon) or 1-800-638-8010 (UnitedHealthcare).
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-340-5001 (Horizon) or 1-800-638-8010 (UnitedHealthcare).

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.netbenefits.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	$1600
Specialist copayment	$55
Hospital (facility) copayment	$450
Other coinsurance	20%

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	**$12,660**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,600
Copayments	$900
Coinsurance	$300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,860**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1600
Specialist copayment	$55
Hospital (facility) copayment	$450
Other coinsurance	20%

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	**$5,620**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,600
Copayments	$300
Coinsurance	$600
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,520**

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

The plan's overall deductible	$1600
Specialist copayment	$55
Hospital (facility) copayment	$450
Other coinsurance	20%

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	**$2,770**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,600
Copayments	$400
Coinsurance	$70
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,070**

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