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 1-844-926-2262. 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.healthcare.gov/sbc-glossary or call 1-844-926-2262 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Tiers 1 & 2---$0 Tier 3---Single Plan: $500 employee Family Plan: $500 person/$1,000 family	Tiers 1 & 2---See the Common Medical Events chart below for your costs for services this plan covers. Tier 3---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 plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Tiers 1 & 2---Not applicable Tier 3---Yes. Preventive services, physician office visits and routine eye exams are some of the services covered before you meet your deductible.	Tiers 1 & 2---Not applicable. Tier 3---This plan covers some items & services even if you haven't yet met deductible. 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 list of covered preventive services at 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?	Single Plan: $3,000 employee Family Plan: $3,000 person/$6,000 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 is met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges 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.healthplansinc.com/bmc or call 1-844-926-2262 for a list of network providers.	You pay the least if you use a Tier 1 provider. You pay more if you use a Tier 2 provider. You pay the most if you use a Tier 3 provider and you might receive a bill from a provider for difference between 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?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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
		Tier 1 BMC, BU, HealthNet Community Health Center Providers (You pay the least)	Tier 2 Most HPHC Providers (You pay more)	Tier 3 High Cost HPHC Providers (You pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$5 copay/visit	$20 copay/visit	$50 copay/visit; deductible does not apply	You may have to pay for services that aren't preventive. Ask your provider if services are preventive. Then check what your plan will pay.
	Specialist visit (referral required)	$5 copay/visit	$25 copay/visit	$65 copay/visit; deductible does not apply	
	Preventive care/screening/ Immunization	No charge		$50 copay/visit; deductible does not apply	
If you have a test	Diagnostic test (x-ray, blood work)	No charge	No charge	No charge; deductible does not apply	None
	Imaging (CT/PET scans, MRIs)— Hospital based Non-Hospital based	No charge No charge	$100 copay/visit $50 copay/visit	$250 copay/visit $250 copay/visit	None

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
		Tier 1 BMC, BU, HealthNet Community Health Center Providers (You pay the least)	Tier 2 Most HPHC Providers (You pay more)	Tier 3 High Cost HPHC Providers (You pay the most)	
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at healthplansinc.com/bmc	Generic drugs— BMC Pharmacy (30-day supply) BMC Pharmacy (90-day supply) Retail Card Program Mail Order	$5 copay/prescription $10 copay/prescription $20 copay/prescription $40 copay/prescription			Covers up to 30-day supply (BMC Employee Pharmacy Retail Card Program and Express Scripts Retail Card Program); 90-day supply (BMC Employee Pharmacy and Express Scripts Mail Order Pharmacy).
	Preferred brand drugs— BMC Pharmacy (30-day supply) BMC Pharmacy (90-day supply) Retail Card Program Mail Order	$10 copay/prescription $20 copay/prescription $40 copay/prescription $80 copay/prescription			
	Non-preferred brand drugs— BMC Pharmacy (30-day supply) BMC Pharmacy (90-day supply) Retail Card Program Mail Order	$20 copay/prescription $60 copay/prescription $80 copay/prescription $240 copay/prescription			
	Specialty drugs— BMC Pharmacy (30-day supply) BMC Pharmacy (90-day supply) Retail Card Program Mail Order	$20 copay/prescription $60 copay/prescription 20% coinsurance ($250 max/prescription) 20% coinsurance ($750 max/prescription)			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	$50 copay/admission	$250 copay/admission	Preauthorization required. Referral required for Surgeon.
	Physician/surgeon fees	No charge	No charge	No charge; deductible does not apply	
If you need immediate medical attention	Emergency room care	$125 copay/visit	$125 copay/visit	$125 copay/visit; deductible does not apply	Copay waived if admitted to hospital
	Emergency medical transportation	No charge	No charge	No charge; deductible does not apply	None
	Urgent care	$5 copay/visit	$5 copay/visit	$5 copay/visit; deductible does not apply	None

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
		Tier 1 BMC, BU, HealthNet Community Health Center Providers (You pay the least)	Tier 2 Most HPHC Providers (You pay more)	Tier 3 High Cost HPHC Providers (You pay the most)	
If you have a hospital stay	Facility fee (hospital room)	No charge	$200 copay/admission	$450 copay/admission	Preauthorization required
	Physician/surgeon fees	No charge	No charge	No charge; deductible does not apply	
If you need mental health, behavioral health, substance abuse services	Outpatient services— Office visit	$5 copay/visit	$5 copay/visit	$5 copay/visit; deductible does not apply	Preauthorization required for Intensive Outpatient Treatment & Inpatient Services
	Intensive Outpatient Treatment	No charge	No charge	No charge; deductible does not apply	
	Inpatient services	No charge	No charge	No charge; deductible does not apply	
If you are pregnant	Office visits Childbirth/delivery professional services	No charge	No charge	No charge; deductible does not apply	Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Preauthorization required for stays over 48 hrs (normal delivery) or 96 hrs (caesarean).
	Childbirth/delivery facility services	No charge	$100 copay/admission	$250 copay/admission	
If you need help recovering or have other special health needs	Home health care	No charge	No charge	No charge; deductible does not apply	Preauthorization required
	Rehabilitation services— Inpatient	No charge	No charge	No charge; deductible does not apply	60 days/yr. Requires preauthorization for Inpatient rehab & Speech therapy. 60 visits/yr combined for Physical & Occupational therapies. Limits do not apply to children under age of 3 if Medically Necessary
	Outpatient	$5 copay/visit	$20 copay/visit	$20 copay/visit; deductible does not apply	

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
		Tier 1 BMC, BU, HealthNet Community Health Center Providers (You pay the least)	Tier 2 Most HPHC Providers (You pay more)	Tier 3 High Cost HPHC Providers (You pay the most)	
If you need help recovering or have other special health needs (continued)	Habilitation services—				
	Early Intervention	No charge	No charge	No charge; deductible does not apply	$5,200/yr; $15,600/lifetime to age 3. Referral required from HPHC provider only. Preauthorization & visit limits based on services provided.
	Developmental Delay	$5 copay/visit	$20 copay/visit	$20 copay/visit; deductible does not apply	
	Skilled nursing care	No charge	No charge	No charge; deductible does not apply	100 days/yr. Preauthorization required
	Durable medical equipment—	20% coinsurance	20% coinsurance	20% coinsurance; deductible does not apply	Preauthorization required for rental over 3 months, TENS units & equipment over $1,000.
	Oxygen & respiratory equipment	No charge	No charge	No charge; deductible does not apply	
	Hospice services	No charge	No charge	No charge; deductible does not apply	Preauthorization required
If your child needs dental or eye care	Children's eye exam	$5 copay/visit	$5 copay/visit	$5 copay/visit; deductible does not apply	1 exam/yr
	Children's glasses	Not covered	Not covered	Not covered	n/a
	Children's dental check-up	$5 copay/visit	$5 copay/visit	$5 copay/visit; deductible does not apply	2 exams/yr to age 13

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.)

- Acupuncture
- Cosmetic surgery
- Dental care (over age 13)
- Long term care
- Non-emergency care when traveling outside U.S.
- Private Duty Nursing
- Routine foot care
- Weight loss programs

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

- Bariatric Surgery
- Chiropractic care ($500/yr)
- Hearing aids ($1,000/aid/ear/36 months)
- Infertility treatment
- Routine eye care (adult-1 exam/yr)

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 the U.S. Department of Labor, Employee Benefits Security Administration, at 1-866-444-EBSA (3272) or 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 1-844-926-2262.

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 to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, you can contact the plan at 1-844-926-2262. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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 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 1-844-926-2262
Portuguese (Português): De assistència em Português, ligue 1-844-926-2262
Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** 1-844-926-2262

[————————————*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 plan's overall *deductible*** **$0**
- **Specialist *copayment*** **$5**
- **Hospital (facility) *no charge***
- **Other *no charge***

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	$60
The total Peg would pay is	**$70**

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 *copayment*** **$5**
- **Hospital (facility) *no charge***
- **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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$340
Coinsurance	$350
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$750**

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

- **The plan's overall *deductible*** **$0**
- **Specialist *copayment*** **$5**
- **Hospital (facility) *no charge***
- **Other *copayment*** **$5**

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	**$1,930**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$160
Coinsurance	$10
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$170**

See Notice about Nondiscrimination and Accessibility next page

Language Assistance Services

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-800-532-7575 (TTY: 711).

Español (Spanish) ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están a su disposición. Llame al 1-800-532-7575 (TTY: 711).

Português (Portuguese) ATENÇÃO: Se você fala português, encontram-se disponíveis serviços linguísticos gratuitos. Ligue para 1-800-532-7575 (TTY: 711).

Kreyòl Ayisyen (French Creole) ATANSYON: Si nou palé Kreyòl Ayisyen, gen asistans pou sèvis ki disponib nan lang nou pou gratis. Rele 1-800-532-7575 (TTY: 711).

繁體中文 (Traditional Chinese) 注意：如果**您使用繁體中文，您可以免費獲得語言援助服務**。請致電 1-800-532-7575（TTY：711）。

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu quí vị nói Tiếng Việt, dịch vụ thông dịch của chúng tôi sẵn sàng phục vụ quí vị miễn phí. Gọi số 1-800-532-7575 (TTY: 711).

Русский (Russian) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-532-7575 (телетайп: 711).

العربية (Arabic)
إنتباه: إذا أنت تتكلم أللُّغةِ **العربية** ، خَدَمات ألمُساعَدة أللُّغَوية مُتَوفرة لك مَجاناً. **إتصل على 1-800-532-7575 (TTY: 711)**

ខ្មែរ (Cambodian) ប្រសិនជាអ្នកនិយាយភាសាខ្មែរ, យើងមានសេវាកម្មបកប្រែ ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ ចូរ ទូរស័ព្ទ 1-800-532-7575 (TTY: 711)។

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-532-7575 (ATS: 711).

Italiano (Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-532-7575 (TTY: 711).

한국어 (Korean) '알림': 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-532-7575 (TTY: 711) 번으로 전화해 주십시오.

ελληνικά (Greek) ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, υπάρχουν στη διάθεσή σας δωρεάν υπηρεσίες γλωσσικής υποστήριξης. Καλέστε 1-800-532-7575 (TTY: 711).

Polski (Polish) UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-532-7575 (TTY: 711).

हिंदी (Hindi) ध्यान दीजिए: अगर आप हिंदी बोलते हैं तो आपके लिये भाषाकी सहायता मुफ्त में उपलब्ध है. जानकारी के लिये फोन करे. 1-800-532-7575 (TTY: 711)

ગુજરાતી (Gujarati) ધ્યાન આપો : જો તમે ગુજરાતી બોલતા હો તો આપને માટે ભાષાકીય સહાય તદ્દન મફત ઉપલબ્ધ છે. વિશેષ માહિતી માટે ફોન કરો. 1-800-532-7575 (TTY: 711)

(Continued)

Notice about Nondiscrimination and Accessibility

Your employer complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Your employer does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Your employer:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, other formats)
- Provides free language services to people whose primary language is not English, such as qualified interpreters.

If you need these services, contact your employer's Civil Rights Compliance Officer or call 800-532-7575.

If you believe that your employer has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance. For contact information for your employer's Grievance Coordinator, please go to https://www.**healthplansinc.com**/, click on *Log in to My Plan*, then click on the link to Important Non-Discrimination Information. If you have no internet access, you may call 800-532-7575 for help. You can file a grievance with your employer in person or by mail, fax or email. If you need help filing a grievance, the Grievance Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
(800) 368-1019, (800) 537-7697 (TTY)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.