



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 may view the Glossary at healthcare.gov/sbc-glossary or call 1-844-926-2262 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	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 <u>plan</u> covers. Tier 3---Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u>?	Tiers 1 & 2---Not applicable Tier 3---Yes. <u>Preventive services</u> , physician office visits and routine eye exams are some of the services covered before you meet your <u>deductible</u> .	Tiers 1 & 2---Not applicable. Tier 3---This <u>plan</u> covers some items & services even if you haven't yet met <u>deductible</u> . But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See list of covered <u>preventive services</u> at www.healthcare.gov/coverage/preventive-care-benefits .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	Single Plan: \$3,000 employee Family Plan: \$3,000 person/\$6,000 family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> is met.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>balance-billing</u> charges and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. See HealthPlansInc.com/BMC or call 1-844-926-2262 for a list of <u>network providers</u> .	You pay the least if you use a Tier 1 <u>provider</u> . You may pay more if you use a Tier 2 <u>provider</u> . You pay the most if you use a Tier 3 <u>provider</u> and you might receive a bill from a <u>provider</u> for difference between <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance-billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	Yes.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .



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	Tier 2 Most HPHC Providers	Tier 3 High Cost HPHC Providers	
		(You pay the least)	(You may pay more)	(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 <u>copay</u> /visit	\$20 <u>copay</u> /visit	\$50 <u>copay</u> /visit; <u>deductible</u> waived	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if services are <u>preventive</u> . Then check what your <u>plan</u> will pay.
	<u>Specialist</u> visit (referral required)	\$5 <u>copay</u> /visit	\$25 <u>copay</u> /visit	\$65 <u>copay</u> /visit; <u>deductible</u> waived	
	<u>Preventive care/screening/</u> Immunization	No charge		\$50 <u>copay</u> /visit; <u>deductible</u> waived	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge	No charge	No charge; <u>deductible</u> waived	None
	Imaging (CT/PET scans, MRIs)— Hospital based Non-Hospital based	No charge No charge	\$100 <u>copay</u> /visit \$50 <u>copay</u> /visit	\$250 <u>copay</u> /visit \$250 <u>copay</u> /visit	None



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		Tier 1 BMC, BU, HealthNet Community Health Center Providers	Tier 2 Most HPHC Providers	Tier 3 High Cost HPHC Providers	
		(You pay the least)	(You may pay more)	(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 <u>copay</u> /prescription \$10 <u>copay</u> /prescription \$20 <u>copay</u> /prescription \$40 <u>copay</u> /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 <u>copay</u> /prescription \$20 <u>copay</u> /prescription \$40 <u>copay</u> /prescription \$80 <u>copay</u> /prescription			
	Non-preferred brand drugs— BMC Pharmacy (30-day supply) BMC Pharmacy (90-day supply) Retail Card Program Mail Order	\$20 <u>copay</u> /prescription \$60 <u>copay</u> /prescription \$80 <u>copay</u> /prescription \$240 <u>copay</u> /prescription			
	<u>Specialty</u> drugs— BMC Pharmacy (30-day supply) BMC Pharmacy (90-day supply) Retail Card Program Mail Order	\$20 <u>copay</u> /prescription \$60 <u>copay</u> /prescription 20% <u>coinsurance</u> (\$250 max/prescription) 20% <u>coinsurance</u> (\$750 max/prescription)			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	\$100 <u>copay</u> /admission	\$250 <u>copay</u> /admission	<u>Preauthorization</u> required. <u>Referral</u> required for Surgeon.
	Physician/surgeon fees	No charge	No charge	No charge; deductible waived	



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		Tier 1 BMC, BU, HealthNet Community Health Center Providers	Tier 2 Most HPHC Providers	Tier 3 High Cost HPHC Providers	
		(You pay the least)	(You may pay more)	(You pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	\$150 <u>copay</u> /visit	\$150 <u>copay</u> /visit	\$150 <u>copay</u> /visit; <u>deductible</u> waived	<u>Copay</u> waived if admitted
	<u>Emergency medical transportation</u>	No charge	No charge	No charge; <u>deductible</u> waived	None
	<u>Urgent care</u> —Doctor on Demand, CVS Minute Clinics, Stand Alone Urgent Care Centers	\$5 <u>copay</u> /visit	\$5 <u>copay</u> /visit	\$5 <u>copay</u> /visit; <u>deductible</u> waived	None
If you have a hospital stay	Facility fee (hospital room)	No charge	\$250 <u>copay</u> /admission	\$450 <u>copay</u> /admission	<u>Preauthorization</u> required
	Physician/surgeon fees	No charge	No charge	No charge; <u>deductible</u> waived	
If you need mental health, behavioral health, substance abuse services	Outpatient services— Office visit	\$5 <u>copay</u> /visit	\$5 <u>copay</u> /visit	\$5 <u>copay</u> /visit; <u>deductible</u> waived	<u>Preauthorization</u> required for Intensive Outpatient Treatment & Inpatient Services
	Intensive Outpatient Treatment	No charge	No charge	No charge; <u>deductible</u> waived	
	Inpatient services	No charge	No charge	No charge; <u>deductible</u> waived	
If you are pregnant	Office visits	No charge	No charge	No charge; <u>deductible</u> waived	Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). <u>Preauthorization</u> required for stays over 48 hrs (normal delivery) or 96 hrs (caesarean).
	Childbirth/delivery professional services				
	Childbirth/delivery facility services	No charge	\$100 <u>copay</u> /admission	\$250 <u>copay</u> /admission	



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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	Tier 2 Most HPHC Providers	Tier 3 High Cost HPHC Providers	
		(You pay the least)	(You may pay more)	(You pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	No charge	No charge; <u>deductible</u> waived	<u>Preauthorization</u> required
	<u>Rehabilitation services</u> — Inpatient	No charge	No charge	No charge; <u>deductible</u> waived	60 days/yr. Requires <u>preauthorization</u> for Inpatient & 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 <u>copay</u> /visit	\$20 <u>copay</u> /visit	\$20 <u>copay</u> /visit; <u>deductible</u> waived	
	<u>Habilitation services</u> — Early Intervention	No charge	No charge	No charge; <u>deductible</u> waived	\$5,200/yr; \$15,600/lifetime to age 3. <u>Referral</u> required from HPHC <u>provider</u> only. <u>Preauthorization</u> & visit limits based on services provided.
	Developmental Delay	\$5 <u>copay</u> /visit	\$20 <u>copay</u> /visit	\$20 <u>copay</u> /visit; <u>deductible</u> waived	
	<u>Skilled nursing care</u>	No charge	No charge	No charge; <u>deductible</u> waived	100 days/yr. <u>Preauthorization</u> required
	<u>Durable medical equipment</u> — Oxygen & respiratory equipment	20% <u>coinsurance</u> No charge	20% <u>coinsurance</u> No charge	20% <u>coinsurance</u> ; <u>deductible</u> waived No charge; <u>deductible</u> waived	<u>Preauthorization</u> required for rental over 3 months, TENS units & equipment over \$1,000.
	<u>Hospice services</u>	No charge	No charge	No charge; <u>deductible</u> waived	<u>Preauthorization</u> required
If your child needs dental or eye care	Children's eye exam	\$5 <u>copay</u> /visit	\$5 <u>copay</u> /visit	\$5 <u>copay</u> /visit; <u>deductible</u> waived	1 exam/yr
	Children's glasses	Not covered	Not covered	Not covered	n/a
	Children's dental check-up	\$5 <u>copay</u> /visit	\$5 <u>copay</u> /visit	\$5 <u>copay</u> /visit; <u>deductible</u> waived	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.)

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|--|-----------------------------|---------------------|
| • 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.)

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|--|-------------------------|--------------------------------------|
| • Acupuncture (16 visits/yr) | • Bariatric Surgery | • Chiropractic care (16 visits/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.

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 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 assistência 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 <u>deductible</u>	\$0
■ Specialist <u>copayment</u>	\$5
■ Hospital (facility) <u>no charge</u>	
■ Other <u>no charge</u>	

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
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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 <u>deductible</u>	\$0
■ Specialist <u>copayment</u>	\$5
■ Hospital (facility) <u>no charge</u>	
■ Other <u>coinsurance</u>	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	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$200
Coinsurance	\$200
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$420

Mia's Simple Fracture

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

■ The plan's overall <u>deductible</u>	\$0
■ Specialist <u>copayment</u>	\$5
■ Hospital (facility) <u>no charge</u>	
■ Other <u>copayment</u>	\$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	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$200
Coinsurance	\$60
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$260