**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 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?** | Not applicable | Not applicable |
| **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: $2,500 employee<br>Family Plan: $2,500 person/$5,000 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 HealthPlansInc.com/BMC or call 1-844-926-2262 for a list of network providers. | This plan uses a provider network. You pay less if you use a provider in the plan's network. You pay the most if you use an out-of-network 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?** | No. | You may see a 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 |
|---|---|---|---|---|
| | | BMC, HealthNet, Community Health Center & BMC Affiliated Providers (You pay the least) | Out-of-Network Provider (You pay the most) | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $7 copay/visit | Not covered | 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 | $7 copay/visit | Not covered | |
| | Preventive care/screening/Immunizations | No charge | Not covered | |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No charge | No charge | None |
| | Imaging (CT/PET scans, MRIs) | No charge | Not covered | None |
| **If you need drugs to treat your illness or condition.** More information about **prescription drug coverage** available at HealthPlansInc.com/BMC | Generic drugs--BMC Pharmacy (30-day supply)<br>BMC Pharmacy (90-day supply)<br>Retail Card Program<br>Mail Order | $5 copay/prescription<br>$10 copay/prescription<br>$20 copay/prescription<br>$40 copay/prescription | Not covered | 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—<br>BMC Pharmacy (30-day supply)<br>BMC Pharmacy (90-day supply)<br>Retail Card Program<br>Mail Order | <br>$10 copay/prescription<br>$20 copay/prescription<br>$40 copay/prescription<br>$80 copay/prescription | Not covered | |
| | Non-preferred brand drugs—<br>BMC Pharmacy (30-day supply)<br>BMC Pharmacy (90-day supply)<br>Retail Card Program<br>Mail Order | <br>$20 copay/prescription<br>$60 copay/prescription<br>$80 copay/prescription<br>$240 copay/prescription | Not covered | |
| | Specialty drugs-BMC Pharmacy (30-day supply)<br>BMC Pharmacy (90-day supply)<br>Retail Card Program<br>Mail Order | $20 copay/prescription<br>$60 copay/prescription<br>20% coinsurance ($250 max/prescription)<br>20% coinsurance ($750 max/prescription) | Not covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | No charge | Not covered | None |
| | Physician/surgeon fees | No charge | Not covered | |

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 |
|---|---|---|---|---|
| | | BMC, HealthNet, Community Health Center & BMC Affiliated Providers (You pay the least) | Out-of-Network Provider (You pay the most) | |
| **If you need immediate medical attention** | Emergency room care | $150 copay/visit | | Copay waived if admitted |
| | Emergency medical transportation | No charge | | None |
| | Urgent care—Doctor on Demand, CVS Minute Clinics, Stand Alone Urgent Care Centers | $5 copay/visit | | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | No charge | Not covered | Preauthorization required |
| | Physician/Surgeon fees | No charge | Not covered | |
| **If you need mental health, behavioral health, substance abuse services** | Outpatient services— Office visit | $5 copay/visit | Not covered | Preauthorization required for Intensive outpatient treatment & Inpatient services. |
| | Outpatient services— Intensive outpatient treatment | No charge | Not covered | |
| | Inpatient services | No charge | Not covered | |
| **If you are pregnant** | Office visits | No charge | Not covered | Maternity care may include tests & services described elsewhere in SBC (i.e. ultrasound). Preauthorization required for stays over 48 hrs (normal delivery) or 96 hrs (caesarean). |
| | Childbirth/delivery professional services | | | |
| | Childbirth/delivery facility services | No charge | Not covered | |
| **If you need help recovering or have other special health needs** | Home health care | No charge | Not covered | Preauthorization required |
| | Rehabilitation services— Inpatient | No charge | Not covered | 60 days/yr. Preauthorization required 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. |
| | Rehabilitation services— Outpatient | $5 copay/visit | Not covered | |
| | Habilitation services— Early Intervention | No charge | Not covered | to age 3 |
| | Habilitation services— Developmental Delay | $5 copay/visit | Not covered | Preauthorization & visit limits based on services provided. |
| | Skilled nursing care | No charge | Not covered | 100 days/yr. Preauthorization required |
| | Durable medical equipment— | 20% coinsurance | Not covered | Preauthorization required for rental over 3 months, TENS units & equipment over $1,000. |
| | Oxygen & respiratory equipment, blood glucose monitors, infusion devices & insulin pumps/supplies | No charge | Not covered | |
| | Hospice services | No charge | Not covered | Preauthorization required. |

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 |
|---|---|---|---|---|
| | | BMC, HealthNet, Community Health Center & BMC Affiliated Providers (You pay the least) | Out-of-Network Provider (You pay the most) | |
| **If your child needs dental or eye care** | Children's eye exam | $7 copay/visit | $7 copay/visit | 1 exam/yr |
| | Children's glasses | Not covered | Not covered | n/a |
| | Children's dental check-up | $5 copay/visit | Not covered | 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.)**

- 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.)**

- 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 1-800-318-2596.

**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 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 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*** **$7**
- **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*** **$7**
- **Hospital (facility) *no charge***
- **Other *no charge***

**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 | $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 *deductible*** **$0**
- **Specialist *copayment*** **$7**
- **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** | **$2,800** |
|---|---|

**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** |