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?	In-network--- Single Plan: $1,500 employee Family Plan: $1,500 person/$3,000 family Out-of-network--- Single Plan: $2,000 employee Family Plan: $2,000 person/$5,000 family	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?	Yes. In-network preventive services, physician office visits and routine vision exams are some of the services 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 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?	In-network--- Single Plan: $3,000 employee Family Plan: $3,000 person/$6,000 family Out-of-network--- 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?	Preauthorization penalties, 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
		In-Network Provider (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	Level 1*: $50 copay/visit; deductible waived	30% coinsurance	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	Level 2*: $65 copay/visit; deductible waived		
	Preventive care/screening/Immunizations	No charge; deductible waived		
*Two levels of copays apply to most outpatient services (other copays may also apply). Level 1 applies to Primary Care Physician, obstetrician, gynecologist, nurse practitioner who bills independently, certified midwife, chiropractor, applied behavior analysis, early intervention, mental health & substance abuse rehabilitation & routine eye exams. Level 2 applies to outpatient services not specifically listed as Level 1. However, if Provider is both Level 1 Provider & Specialist, Level 1 copays will apply.				
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)			
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	Not covered	Deductible waived. 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)	20% coinsurance	30% coinsurance	None
	Physician/surgeon fees	20% coinsurance	30% coinsurance	

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
		In-Network Provider (You pay the least)	Out-of-Network Provider (You pay the most)	
If you need immediate medical attention	Emergency room care	$150 copay/visit; deductible waived		Copay waived if admitted
	Emergency medical transportation	20% coinsurance after In-network deductible		None
	Urgent care—Doctor on Demand, CVS Minute Clinics, Stand Alone Urgent Care Centers	$5 copay/visit; deductible waived		None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance	Preauthorization required or you pay $500 more
	Physician/Surgeon fees	20% coinsurance	30% coinsurance	
If you need mental health, behavioral health, substance abuse services	Outpatient services—Office visit	$50 copay/visit; deductible waived	30% coinsurance	Preauthorization required for Intensive outpatient treatment
	Outpatient services—Intensive outpatient treatment	No charge; deductible waived		
	Inpatient services	20% coinsurance	30% coinsurance	Preauthorization required or you pay $500 more.
If you are pregnant	Office visits	No charge; deductible waived	30% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Requires preauthorization for stays over 48 hrs (normal delivery) or 96 hrs (caesarean) or you pay $500 more.
	Childbirth/delivery professional services			
	Childbirth/delivery facility services	20% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	30% coinsurance	Preauthorization required
	Rehabilitation services—Inpatient	20% coinsurance	30% coinsurance	60 days/yr. Preauthorization required for Inpatient (or you pay $500 more) & Speech therapy. 40 visits/yr combined for Physical & Occupational therapies. Limits do not apply to children under age of 3 if Medically Necessary.
	Rehabilitation services—Outpatient	$20 copay/visit; deductible waived	30% coinsurance	
	Habilitation services—Early Intervention	No charge; deductible waived	30% coinsurance	to age 3.
	Habilitation services—Developmental Delay	$20 copay/visit; deductible waived	30% coinsurance	Preauthorization & visit limits based on services provided.
	Skilled nursing care	20% coinsurance	30% coinsurance	100 days/yr. Preauthorization required or you pay $500 more

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
		In-Network Provider (You pay the least)	Out-of-Network Provider (You pay the most)	
If you need help recovering or have other special health needs (continued)	Durable medical equipment— Oxygen & respiratory equipment, blood glucose monitors, infusion devices & insulin pumps/supplies	20% coinsurance No charge; deductible waived	30% coinsurance No charge; deductible waived	Preauthorization required for rental over 3 months, TENS units & equipment over $1,000.
	Hospice services	20% coinsurance	30% coinsurance	Preauthorization required.
If your child needs dental or eye care	Children's eye exam	$50 copay/visit; deductible waived	30% coinsurance	1 exam/yr
	Children's glasses	Not covered	Not covered	n/a
	Children's dental check-up--- Office Visit Hospital Outpatient Department	$50 copay/visit; deductible waived 20% coinsurance	30% coinsurance 30% coinsurance	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*** **$1,500**
- **Specialist *copayment*** **$65**
- **Hospital (facility) *coinsurance*** **20%**
- **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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$10
Coinsurance	$1,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,060**

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

- **The plan's overall *deductible*** **$1,500**
- **Specialist *copayment*** **$65**
- **Hospital (facility) *coinsurance*** **20%**
- **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	$100
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$720**

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

- **The plan's overall *deductible*** **$1,500**
- **Specialist *copayment*** **$65**
- **Hospital (facility) *coinsurance*** **20%**
- **Other *copayment*** **$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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,300
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,700**

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