

 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 <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 deductible?	Yes. In-network <u>preventive services</u> , physician office visits and routine vision exams are some of the services covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. 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 a list of covered <u>preventive services</u> at healthcare.gov/coverage/preventive-care-benefits
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> 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 <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 out-of-pocket limit?	<u>Preauthorization</u> penalties, <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 network provider?	Yes. See HealthPlansInc.com/BMC or call 1-844-926-2262 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You pay less if you use a <u>provider</u> in the <u>plan's network</u> . You pay the most if you use an <u>out-of-network 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 referral to see a specialist?	No.	You may see a <u>specialist</u> you choose without a <u>referral</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
		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 <u>copay/visit</u> ; <u>deductible waived</u>	30% <u>coinsurance</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your provider if services are <u>preventive</u> . Then check what your <u>plan</u> will pay.
	<u>Specialist</u> visit	Level 2*: \$65 <u>copay/visit</u> ; <u>deductible waived</u>		
	<u>Preventive care/screening/Immunizations</u>	No charge; <u>deductible waived</u>		
*Two levels of <u>copays</u> apply to most outpatient services (other <u>copays</u> 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 <u>copays</u> will apply.				
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	30% <u>coinsurance</u>	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 Mail Order	\$5 <u>copay/prescription</u> \$10 <u>copay/prescription</u> \$20 <u>copay/prescription</u> \$40 <u>copay/prescription</u>	Not covered	<u>Deductible waived</u> . Covers up to 30-day supply (BMC Employee Pharmacy Retail and Express Scripts Retail); 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 Mail Order	\$10 <u>copay/prescription</u> \$20 <u>copay/prescription</u> \$40 <u>copay/prescription</u> \$80 <u>copay/prescription</u>		
	Non-preferred brand drugs— BMC Pharmacy (30-day supply) BMC Pharmacy (90-day supply) Retail Mail Order	\$20 <u>copay/prescription</u> \$60 <u>copay/prescription</u> \$80 <u>copay/prescription</u> \$240 <u>copay/prescription</u>		
	<u>Specialty drugs</u> -- BMC Pharmacy (30-day supply) BMC Pharmacy (90-day supply) Retail Mail Order	\$20 <u>copay/prescription</u> \$60 <u>copay/prescription</u> 20% <u>coinsurance</u> ; \$250 max 20% <u>coinsurance</u> ; \$750 max		
	Facility fee (e.g., ambulatory surgery center)			
If you have outpatient surgery	Physician/surgeon fees	20% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> required for all spine & joint surgeries and spine injections 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 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	\$7 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				
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	
	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	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.	
		Outpatient	\$20 copay/visit; deductible waived		
	Habilitation services—	Early Intervention	No charge; deductible waived	30% coinsurance	to age 3.
		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% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> required for rental over 3 months, equipment over \$1,000, neuromuscular stimulator equipment and implantable loop recorders & defibrillators
	Hospice services	No charge; <u>deductible</u> waived	No charge; <u>deductible</u> waived	
If your child needs dental or eye care	Children's eye exam	20% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> required.
	Children's glasses	\$50 <u>copay</u> /visit; <u>deductible</u> waived	30% <u>coinsurance</u>	1 exam/yr
	Children's dental check-up-- Office Visit Hospital Outpatient Department	Not covered \$50 <u>copay</u> /visit; <u>deductible</u> waived 20% <u>coinsurance</u>	Not covered 30% <u>coinsurance</u> 30% <u>coinsurance</u>	n/a 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
- Non-emergency care when traveling outside U.S.
- Weight loss programs
- Dental care (over age 13)
- Private Duty Nursing
- Long term care
- Routine foot care

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

- Acupuncture (16 visits/yr)
- Hearing aids (\$1,000/aid/ear/36 months)
- Bariatric Surgery
- Infertility treatment
- Chiropractic care (16 visits/yr)
- 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 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 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:

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$1,500
<i>What isn't covered</i>	
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:

<i>Cost Sharing</i>	
Deductibles	\$100
Copayments	\$600
Coinsurance	\$0
<i>What isn't covered</i>	
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:

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