



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>?	In-network---Single Plan: \$1,700 employee Family Plan: \$3,400 family Out-of-Network---Single Plan: \$3,400 employee Family Plan: \$6,800 employee & 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> , the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
Are there services covered before you meet your <u>deductible</u>?	Yes. In-network <u>preventive services</u> are 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 <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>?	In-network--- Single Plan: \$5,500 employee Family Plan: \$5,500 person/\$11,000 family Out-of-network--- Single Plan: \$11,000 employee Family Plan: \$11,000 person/\$22,000 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>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 <u>network provider</u>?	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 <u>referral</u> to see a <u>specialist</u>?	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	30% <u>coinsurance</u>	50% <u>coinsurance</u>	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 <u>plan</u> will pay.
	<u>Specialist</u> visit	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
	<u>Preventive care/screening/Immunizations</u>	No charge; <u>deductible</u> waived	50% <u>coinsurance</u>	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required for non-BMC Imaging Providers
	Imaging (CT/PET scans, MRIs)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
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	\$12 <u>copay</u> /prescription \$24 <u>copay</u> /prescription \$20 <u>copay</u> /prescription \$40 <u>copay</u> /prescription	Not covered	<u>Deductible</u> applies except for certain <u>preventive care</u> drugs. 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). <u>Prescription drug</u> program requires certain <u>specialty</u> drugs be accessed through Accredo Health Group, an Express Scripts specialty pharmacy. Please call the number on your ID card for a list of such drugs
	Preferred brand drugs— BMC Pharmacy (30-day supply) BMC Pharmacy (90-day supply) Retail Mail Order	\$20 <u>copay</u> /prescription \$40 <u>copay</u> /prescription \$50 <u>copay</u> /prescription \$100 <u>copay</u> /prescription	Not covered	
	Non-preferred brand drugs— BMC Pharmacy (30-day supply) BMC Pharmacy (90-day supply) Retail Mail Order	\$30 <u>copay</u> /prescription \$85 <u>copay</u> /prescription \$90 <u>copay</u> /prescription \$270 <u>copay</u> /prescription	Not covered	
	<u>Specialty</u> drugs-- BMC Pharmacy (30-day supply) BMC Pharmacy (90-day supply) Retail Mail Order	\$35 <u>copay</u> /prescription \$105 <u>copay</u> /prescription 20% <u>coinsurance</u> ; \$250 max 20% <u>coinsurance</u> ; \$750 max	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required for all spine & joint surgeries and spine injections or you pay \$500 more
	Physician/surgeon fees	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need immediate medical attention	<u>Emergency room care</u>	30% <u>coinsurance</u> after In-network <u>deductible</u>		None
	<u>Emergency medical transportation</u>	30% <u>coinsurance</u> after In-network <u>deductible</u>		None
	<u>Urgent care</u> —Doctor on Demand, CVS Minute Clinics, Stand Alone Urgent Care Centers	30% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required or you pay \$500 more
	Physician/Surgeon fees	30% <u>coinsurance</u>	50% <u>coinsurance</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 need mental health, behavioral health, substance abuse services	Outpatient services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required for Intensive outpatient treatment
	Inpatient services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required or you pay \$500 more.
If you are pregnant	Office visits--- Prenatal Care Postnatal Care	No charge; <u>deductible</u> waived 30% <u>coinsurance</u>	50% <u>coinsurance</u>	Maternity care may include tests & services described elsewhere in SBC (i.e., ultrasound). Requires <u>preauthorization</u> for stays over 48 hrs (normal delivery) or 96 hrs (caesarean) or you pay \$500 more.
	Childbirth/delivery professional services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required
	<u>Rehabilitation services</u> — Inpatient	30% <u>coinsurance</u>	50% <u>coinsurance</u>	60 days/yr. <u>Preauthorization</u> 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	30% <u>coinsurance</u>	50% <u>coinsurance</u>	
	<u>Habilitation services</u> — Early Intervention Developmental Delay	30% <u>coinsurance</u> 30% <u>coinsurance</u>	50% <u>coinsurance</u> 50% <u>coinsurance</u>	to age 3. <u>Preauthorization</u> & visit limits based on services provided.
	<u>Skilled nursing care</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	100 days/yr. <u>Preauthorization</u> required or you pay \$500 more
	Durable medical equipment	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required for rental over 3 months, equipment over \$1,000, neuromuscular stimulator equipment and implantable loop recorders & defibrillators
	<u>Hospice services</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required.
If your child needs dental or eye care	Children's eye exam	30% <u>coinsurance</u>	50% <u>coinsurance</u>	1 exam/yr
	Children's glasses	Not covered	Not covered	n/a
	Children's dental check-up	No charge; <u>deductible</u> waived	50% <u>coinsurance</u>	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 1-800-318-2596.

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 <u>deductible</u>	\$1,700
■ Specialist <u>coinsurance</u>	30%
■ Hospital (facility) <u>coinsurance</u>	30%
■ Other <u>coinsurance</u>	30%

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	\$1,700
Copayments	\$10
Coinsurance	\$2,500
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$4,270

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>	\$1,700
■ Specialist <u>coinsurance</u>	30%
■ Hospital (facility) <u>coinsurance</u>	30%
■ Other <u>no charge</u>	

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	\$1,700
Copayments	\$200
Coinsurance	\$300
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$2,220

Mia's Simple Fracture

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

■ The plan's overall <u>deductible</u>	\$1,700
■ Specialist <u>coinsurance</u>	30%
■ Hospital (facility) <u>coinsurance</u>	30%
■ Other <u>coinsurance</u>	30%

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	\$1,700
Copayments	\$0
Coinsurance	\$200
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,900