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, visit www.bpaco.com or call 1-800-236-7789. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call1-800-236-7789 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1,500** individual / **$3,000** family for Preferred Provider and Non-Preferred Provider.	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, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preferred Provider preventive care services are 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 https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductible for specific services.
What is the out-of-pocket limit for this plan?	**$1,500** individual / **$3,000** family for Preferred Provider and **$1,750** individual / **$3,500** family for Non-Preferred Provider.	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, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance billing charges, charges over the maximum allowable charge, ineligible charges, charges in excess of the plan maximums/limitations, pre-certification penalties, prescription ancillary 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.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See **www.preferredone.com** or call **1-800-451-9597 or www.phcs.com** or call **1-800-922-4362 or www.multiplan.com** or call **1-800-546-3887** for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the 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 can see the 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
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% coinsurance	20% coinsurance	——————none——————
	Specialist visit	0% coinsurance	20% coinsurance	——————none——————
	Preventive care/screening/ immunization	No charge; Deductible does not apply	20% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Immunizations for the purpose of travel are not considered preventive care services.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	20% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	0% coinsurance	20% coinsurance	——————none——————

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.caremark.com**	Generic drugs	0% coinsurance (retail and mail order)	20% coinsurance (retail)	Covers up to a 90-day supply (retail and mail order prescription). Affordable Care Act (ACA) preventive drugs are covered at no charge (Generic and single source Brand only). See Plan Document for non-use of generic drug penalty.
	Preferred brand drugs	0% coinsurance (retail and mail order)	20% coinsurance (retail)	
	Non-preferred brand drugs	0% coinsurance (retail and mail order)	20% coinsurance (retail)	
	Specialty drugs	Contact Caremark Specialty Pharmacy, your pharmacy vendor, for applicable cost.	Not covered	Covers up to a 30-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	20% coinsurance	——————none——————
	Physician/surgeon fees	0% coinsurance	20% coinsurance	——————none——————
If you need immediate medical attention	Emergency room care	0% coinsurance	0% coinsurance	——————none——————
	Emergency medical transportation	0% coinsurance	0% coinsurance	——————none——————
	Urgent care	0% coinsurance	0% coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	20% coinsurance	Pre-certification is required in order to avoid a 25% reduction of benefits up to a maximum of $250 penalty per occurrence.
	Physician/surgeon fees	0% coinsurance	20% coinsurance	——————none——————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance	20% coinsurance	——————none——————
	Inpatient services	0% coinsurance	20% coinsurance	Pre-certification is required in order to avoid a 25% reduction of benefits up to a maximum of $250 penalty per occurrence.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
If you are pregnant	Office visits	0% coinsurance	20% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of service, a coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	0% coinsurance	20% coinsurance	——————none——————
	Childbirth/delivery facility services	0% coinsurance	20% coinsurance	Pre-certification is required for vaginal deliveries requiring more than a 48 hour stay and for cesarean section deliveries requiring more than a 96 hour stay in order to avoid a 25% reduction of benefits up to $250 per occurrence.
If you need help recovering or have other special health needs	Home health care	0% coinsurance	20% coinsurance	Maximum of 4 hours/visit in any 24-hour period and a maximum of 40 visits per plan year (excluding autism spectrum disorder therapies).
	Rehabilitation services	0% coinsurance	20% coinsurance	Maximum of 20 visits each for Occupational, Physical, and Speech therapies per plan year (excluding autism spectrum disorder therapies).
	Habilitation services	Not covered	Not covered	Not covered.
	Skilled nursing care	0% coinsurance	20% coinsurance	Maximum of 60 days per confinement. Pre-certification is required in order to avoid a 25% reduction of benefits up to $250 penalty per occurrence.
	Durable medical equipment	0% coinsurance	20% coinsurance	——————none——————
	Hospice services	0% coinsurance	20% coinsurance	Limited to 6 months from date of acceptance or the death of the covered person, whichever is the earliest.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered.
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered.

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.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery (except due to surgical procedure, accident, or birth defect)
- Dental care (except oral surgery, refer to your plan document for details)
- Dental check-up (Adult and Child)
- Glasses (except due to surgical procedures, refer to your plan document for details)
- Habilitative services
- Infertility treatment (except initial diagnosis and testing)
- Long-term care
- Private duty nursing
- Routine eye care (Adult and Child)
- Routine foot care (except if medically necessary)
- Weight loss programs (except morbid obesity)

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

- Chiropractic care
- Coverage provided outside the United States. See www.bpaco.com.
- Hearing aids (one aid per ear every 36 months for age 18 and under)
- Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact the plan at 1-800-236-7789. You may also contact your state insurance department, the Department of Labor's 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 on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the plan at 1-800-236-7789. You may also contact your state insurance department, the Department of Labor's 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 the 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.

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*	**$0**
Hospital (facility) *coinsurance*	**0%**
Other *coinsurance*	**0%**

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	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$1,500**

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*	**$0**
Hospital (facility) *coinsurance*	**0%**
Other *coinsurance*	**0%**

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	$1,500
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,500**

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

The plan's overall deductible	**$1,500**
Specialist *copayment*	**$0**
Hospital (facility) *coinsurance*	**0%**
Other *coinsurance*	**0%**

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	$1,500
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,500**

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