

 **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](http://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](http://www.healthcare.gov/sbc-glossary) or call 1-800-236-7789 to request a copy.

Important Questions	Answers	Why This Matters:
<p><b>What is the overall <a href="#">deductible</a>?</b></p>	<p><b>\$1,000</b> person / <b>\$2,000</b> family for Preferred Provider and Non-Preferred Provider</p>	<p>Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay.                      If you have other family members on the <a href="#">plan</a>, each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a>.</p>
<p><b>Are there services covered before you meet your <a href="#">deductible</a>?</b></p>	<p>Yes. Preferred Provider preventive care, chiropractic/spinal manipulation, pre-admission testing and prescription drugs are covered before you meet your <a href="#">deductible</a>.</p>	<p>This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a>. See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</p>
<p><b>Are there other <a href="#">deductibles</a> for specific services?</b></p>	<p>No.</p>	<p>You don't have to meet <a href="#">deductible</a> for specific services.</p>
<p><b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b></p>	<p><b>\$2,000</b> person / <b>\$4,000</b> family for Preferred Providers and <b>\$4,000</b> person / <b>\$8,000</b> family for Non-Preferred Provider.                      See Prescription Drug for Prescription Drug out-of-pocket limit.</p>	<p>The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a>, they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.</p>
<p><b>What is not included in the <a href="#">out-of-pocket limit</a>?</b></p>	<p>Premiums, balance-billed charges, pre-certification penalties, ineligible charges, charges in excess of the plan's maximum and limitations, prescription copays, Manufacturer Copay Assistance charges that exceed the Copay, prescription ancillary charges and health care this plan doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a>.</p>

<p><b>Will you pay less if you use a <a href="#">network provider</a>?</b></p>	<p>Yes. See <a href="http://www.the-alliance.org">www.the-alliance.org</a> or call 1-800-223-4139 or <a href="http://www.preferredone.com">www.preferredone.com</a> or call 1-800-451-9597 or <a href="http://www.phcs.com">www.phcs.com</a> or call 1-800-922-4362 or <a href="http://www.multiplan.com">www.multiplan.com</a> or call 1-800-546-3887 for a list of <a href="#">network providers</a>.</p>	<p>This <a href="#">plan</a> uses a provider <a href="#">network</a>. You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a>. You will pay the most if you use an <a href="#">out-of-network provider</a>, and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays (<a href="#">balance billing</a>).</p> <p>Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.</p>
<p><b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b></p>	<p>No.</p>	<p>You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a>.</p>

 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	30% coinsurance	—————none—————
	<a href="#">Specialist</a> visit	20% coinsurance	30% coinsurance	—————none—————
	<a href="#">Preventive care/screening/immunization</a>	No charge Deductible does not apply	30% coinsurance (under age 6); 30% coinsurance up to \$700 maximum benefit (age 6 and over)	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.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% coinsurance	30% coinsurance	—————none—————
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance	—————none—————

For more information about limitations and exceptions, see plan or policy document at [www.bpaco.com](http://www.bpaco.com).

<p><b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.serve-you-rx.com">www.serve-you-rx.com</a></p>	Generic drugs	30% coinsurance with a minimum of \$10/prescription (retail) \$25/prescription (mail order) Deductible does not apply	30% coinsurance with a minimum of \$10/prescription (retail)	One copay per 30-day supply, maximum 90-day supply (retail prescription); one copay per 90-day supply (mail order prescription).
	Preferred brand drugs	30% coinsurance (retail) \$75/prescription (mail order) Deductible does not apply	30% coinsurance (retail)	Affordable Care Act (ACA) Preventive prescription drugs (generic and single source brand only) covered at 100%. Contraceptives are NOT a covered benefit.
	Non-preferred brand drugs	30% coinsurance (retail) \$75/prescription (mail order) Deductible does not apply	30% coinsurance (retail)	<u>Prescription Out-of-Pocket Maximum</u> <b>\$1,000</b> individual / <b>\$3,000</b> family
	<a href="#">Specialty drugs</a>	Applicable copay 30% copay Deductible does not apply -IPC Copay Assistance Program	Not covered	Covers up to a maximum 90-day supply. IPC Copay covers up to a maximum 30-day supply. Please see Prescription Drug Benefit section within your Plan Document for details. IPC Copay Assistance Program-the program will cover most if not all of the copay amount. Any actual out of pocket costs at point of sale will apply to the maximum out of pocket as applicable.
<p><b>If you have outpatient surgery</b></p>	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance	_____none_____
	Physician/surgeon fees	20% coinsurance	30% coinsurance	_____none_____
<p><b>If you need immediate medical attention</b></p>	<a href="#">Emergency room care</a>	\$200/visit then 20% coinsurance after PPO deductible		Copay is waived if admitted on inpatient basis within 24 hours for the same condition.
	<a href="#">Emergency medical transportation</a>	20% coinsurance after PPO deductible		_____none_____
	<a href="#">Urgent care</a>	20% coinsurance after PPO deductible		_____none_____
<p><b>If you have a hospital stay</b></p>	Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance	Services must be pre-certified to avoid a penalty of eligible expenses being reduced by \$200.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	_____none_____

For more information about limitations and exceptions, see plan or policy document at [www.bpaco.com](http://www.bpaco.com).

<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	20% coinsurance	30% coinsurance	—————none—————
	Inpatient services	20% coinsurance	30% coinsurance	Services must be pre-certified to avoid a penalty of eligible expenses being reduced by \$200.
<b>If you are pregnant</b>	Office visits	20% coinsurance	30% coinsurance	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of service, a <a href="#">copayment</a> , <a href="#">coinsurance</a> , or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	30% coinsurance	—————none—————
	Childbirth/delivery facility services	20% coinsurance	30% coinsurance	Services must be pre-certified 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 \$200 penalty per occurrence.
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	20% coinsurance	30% coinsurance	Maximum of 4 hours/visit in any 24 hour period and limited to a maximum of 40 visits per calendar year.
	<a href="#">Rehabilitation services</a>	20% coinsurance	30% coinsurance	—————none—————
	<a href="#">Habilitation services</a>	Not covered	Not covered	Not covered.
	<a href="#">Skilled nursing care</a>	20% coinsurance	30% coinsurance	Limited to 30 days per confinement. Services must begin within 14 days after discharge from an inpatient confinement of at least 3 consecutive days. Services must be pre-certified to avoid a \$200 penalty per occurrence.
	<a href="#">Durable medical equipment</a>	20% coinsurance	30% coinsurance	Rental cannot exceed purchase price.
	<a href="#">Hospice services</a>	20% coinsurance	30% coinsurance	Patient's life expectancy 6 months or less.
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge Deductible does not apply	30% coinsurance	—————none—————
	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:**

For more information about limitations and exceptions, see plan or policy document at [www.bpaco.com](http://www.bpaco.com).

**Services Your [Plan](#) Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other [excluded services](#).)**

- Bariatric surgery
- Cosmetic surgery (except due to a covered surgical procedure, accident or birth defect)
- Dental care (Adult) (except for limited oral surgery - see plan document)
- Dental check-up (Child)
- Glasses (Child)
- Hearing aids (except if needed as a result of covered injury)
- Infertility treatment (except initial diagnosis and testing)
- Long-term care
- Private-duty nursing
- Routine foot care (unless medically necessary)
- Weight loss programs

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

- Acupuncture
- Chiropractic care (\$25 per visit max & \$2,000 per calendar year max and no coverage for routine and maintenance)
- Coverage provided outside the United States. See [www.bpaco.com](http://www.bpaco.com)
- Non-emergency care when traveling outside the U.S
- Routine eye care (Adult)

**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 U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). 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](http://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, contact the plan at 1-800-236-7789. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

**Does this plan provide Minimum Essential Coverage? Yes**

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,000
■ <a href="#">Specialist</a> <a href="#">coinsurance</a>	20%
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,000
Copayments	\$0
Coinsurance	\$1,000
What isn't covered	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$2,000</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,000
■ <a href="#">Specialist</a> <a href="#">coinsurance</a>	20%
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	20%

#### 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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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#### In this example, Joe would pay:

Cost Sharing	
Deductibles	\$1,000
Copayments	\$380
Coinsurance	\$620
What isn't covered	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$2,000</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,000
■ <a href="#">Specialist</a> <a href="#">coinsurance</a>	20%
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$1,925</b>
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#### In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,000
Copayments	\$200
Coinsurance	\$378
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,578</b>