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?	**$2,000** individual / **$4,000** family for Preferred Provider and **$3,000** individual / **$6,000** family for 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, 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. Prescription drugs and Preferred Provider acupuncture, chiropractic/spinal manipulation, preventive care services, primary care office visits, specialist office visits, E-visits, walk-in/convenience care/retail health clinic and urgent care 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?	**$4,500** individual / **$9,000** family for Preferred Provider and **$8,000** individual / **$16,000** 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, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been 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.bpaco.com** or call **1-800-236-7789** 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	$30/visit; Deductible does not apply	50% coinsurance	Includes office visit charge only
	Specialist visit	$60/visit; Deductible does not apply	50% coinsurance	Includes office visit charge only
	Preventive care/screening/ immunization	0% coinsurance; Deductible does not apply	50% 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.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	50% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	0% coinsurance	50% coinsurance	——————none——————

Common Medical Event	Services You May Need	What You Will Pay Preferred Provider (You will pay the least)	What You Will Pay Non-Preferred Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **. www.primetherapeutics.com**	Generic drugs	$15/prescription (30-day supply retail and mail order); $38/prescription (31 to 90-day supply First Choice pharmacy retail and mail order); Deductible does not apply	Not covered	Covers up to a 90-day supply (retail); 90-day supply (mail order) Affordable Care Act (ACA) preventive drugs are covered at no charge (Generic and single source Brand only).
	Preferred brand drugs	$35/prescription (30-day supply retail and mail order); $88/prescription (31 to 90-day supply First Choice pharmacy retail and mail order); Deductible does not apply	Not covered	
	Non-preferred brand drugs	$75/prescription (30-day supply retail and mail order); $188/prescription (31 to 90-day supply First Choice pharmacy retail and mail order); Deductible does not apply	Not covered	
	Specialty drugs	Specialty Pharmaceutical Drugs are no longer included in your Major Medical Plan. Notwithstanding the foregoing, the Plan MAY cover the charges for a Specialty Pharmaceutical Drug for one 30 day period during a calendar year for each Specialty Pharmaceutical Drug when an urgent fill of medication is required, unless otherwise excluded elsewhere in the Plan		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	50% coinsurance	————————none————————
	Physician/surgeon fees	0% coinsurance	50% coinsurance	————————none————————

Common Medical Event	Services You May Need	What You Will Pay Preferred Provider (You will pay the least)	What You Will Pay Non-Preferred Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need immediate medical attention	Emergency room care	$300/visit – facility charge 0% coinsurance - physician fee and misc. hospital expenses	$300/visit after Preferred Provider deductible - facility charge 0% coinsurance after Preferred Provider deductible -- physician fee and misc. hospital expenses	——————none——————
	Emergency medical transportation	0% coinsurance	0% coinsurance after Preferred Provider deductible	——————none——————
	Urgent care	$100/visit; Deductible does not apply	50% coinsurance	Includes facility charge and Physician fee only. Emergency Services provided in an Urgent Care facility that is considered an independent Freestanding Emergency Department are paid as indicated in Emergency Room Care as stated above.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	50% coinsurance	Pre-certification is required in order to avoid a 50% reduction of benefits.
	Physician/surgeon fees	0% coinsurance	50% coinsurance	——————none——————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30/visit; Deductible does not apply 0% coinsurance; (intensive outpatient, partial hospitalization services, psychological testing and other therapies)	50% coinsurance	——————none——————
	Inpatient services	0% coinsurance	50% coinsurance	Pre-certification is required in order to avoid a 50% reduction of benefits.

Common Medical Event	Services You May Need	What You Will Pay Preferred Provider (You will pay the least)	What You Will Pay Non-Preferred Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you are pregnant	Office visits	$30/visit; Deductible does not apply	50% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of service, a copayment, coinsurance or a deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	0% coinsurance	50% coinsurance	——————none——————
	Childbirth/delivery facility services	0% coinsurance	50% 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 50% reduction of benefits.
If you need help recovering or have other special health needs	Home health care	0% coinsurance	50% coinsurance	Maximum of 4 hours/visit in any 24-hour period and a maximum of 30 visits per Calendar Year.
	Rehabilitation services	0% coinsurance	50% coinsurance	Maximum of 30 visits per Calendar Year (excluding autism spectrum disorder therapies) combined for physical, speech, occupational, pulmonary rehabilitation, cardiac rehabilitation, post-cochlear implant and cognitive rehabilitation therapy combined with habilitation. Maximum of 60 days per Calendar Year combined for skilled nursing facility and rehabilitation facility inpatient services. Pre-certification is required for inpatient rehab in order to avoid a 50% reduction of benefits.

Common Medical Event	Services You May Need	What You Will Pay Preferred Provider (You will pay the least)	What You Will Pay Non-Preferred Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Habilitation services	0% coinsurance	50% coinsurance	Maximum of 30 visits per Calendar Year (excluding autism spectrum disorder therapies) combined for physical, speech, occupational, pulmonary rehabilitation, cardiac rehabilitation, post-cochlear implant and cognitive rehabilitation therapy. Combined with rehabilitation.
	Skilled nursing care	0% coinsurance	50% coinsurance	Pre-certification is required in order to avoid a 50% reduction of benefits. Maximum of 60 days per Calendar Year combined for skilled nursing facility and rehabilitation facility inpatient services.
	Durable medical equipment	0% coinsurance	50% coinsurance	——————none——————
	Hospice services	0% coinsurance	50% coinsurance	——————none——————
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.)

- Bariatric surgery
- Cosmetic surgery (except due to a covered surgical procedure, accident or birth defect)
- Dental care (Adult and Child)
- Infertility treatment (except for 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 for morbid obesity)

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

- Acupuncture (maximum of 10 visits per Calendar Year)
- Chiropractic care (maximum of 20 visits per Calendar Year)
- Coverage provided outside the United States. See www.bpaco.com.
- Hearing aids (one aid per ear every 36 months)
- 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. The contact information for those agencies is: 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: 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.*

* For more information about limitations and exceptions, see the plan or policy document at www.bpaco.com.

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	**$2,000**
Specialist copayment	**$60**
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	$2,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$2,000**

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

The plan's overall deductible	**$2,000**
Specialist copayment	**$60**
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	$2,000
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,400**

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

The plan's overall deductible	**$2,000**
Specialist copayment	**$60**
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	$2,000
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,500**

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