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?	**$1,000** individual / **$2,000** 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, 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, pre-admission testing, chiropractic/spinal manipulation and 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?	**$2,000** individual / **$4,000** family for Preferred Provider and **$4,000** individual / **$8,000** family for Non-Preferred Provider. See Prescription Drug for Prescription Drug out-of-pocket limit.	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 copays, Manufacturer Copay Assistance coinsurance charges that exceed the plan specialty drug copay, prescription ancillary charges, and health care this plan doesn't	Even though you pay these expenses, they don't count toward the out–of–pocket limit.

Important Questions	Answers	Why This Matters:
	cover.	

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See **www.the-alliance.org** or call **1-800-223-4139 or https://www.mayoclinic.org/appointments/find-a-doctor** or **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 or http://directory.phx-online.com** or call **1-888-621-7900** 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	20% coinsurance	30% coinsurance	Office visit charge only.
	Specialist visit	20% coinsurance	30% coinsurance	Office visit charge only.
	Preventive care/screening/ immunization	No charge Deductible does not apply	30% 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)	20% coinsurance	30% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% 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.serve-you-rx.com**.	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); Deductible does not apply	One copy per 30-day supply, maximum 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). Contraceptives are NOT a covered benefit. Prescription Out-of-Pocket Maximum **$1,000** individual / **$3,000** family
	Preferred brand drugs	30% coinsurance (retail); $75/prescription (mail order); Deductible does not apply	30% coinsurance (retail); Deductible does not apply	
	Non-preferred brand drugs	30% coinsurance (retail); $75/prescription (mail order); Deductible does not apply	30% coinsurance (retail); Deductible does not apply	
	Specialty drugs	Applicable copay IPC Copay Assistant Program - 30% copay; Deductible does not apply	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 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.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance	——————none——————
	Physician/surgeon fees	20% coinsurance	30% 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 immediate medical attention	Emergency room care	$200/visit, then 20% coinsurance	$200/visit, then 20% coinsurance after Preferred Provider deductible	Copay waived if admitted on inpatient basis within 24 hours for the same condition.
	Emergency medical transportation	20% coinsurance	20% coinsurance after Preferred Provider deductible	——————none——————
	Urgent care	20% coinsurance	20% coinsurance after Preferred Provider deductible	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	30% coinsurance	Pre-certification is required in order to avoid a $200 reduction in benefits.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	——————none——————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	30% coinsurance	——————none——————
	Inpatient services	20% coinsurance	30% coinsurance	Pre-certification is required in order to avoid a $200 reduction in benefits.
If you are pregnant	Office visits	20% coinsurance	30% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of service, a copayment, coinsurance, or deductible 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	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 $200 reduction in benefits.

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 help recovering or have other special health needs	Home health care	20% coinsurance	30% coinsurance	Maximum of 4 hours/visit in any 24-hour period and a maximum of 40 visits per calendar year (*excluding autism spectrum disorder therapies*).
	Rehabilitation services	20% coinsurance	30% coinsurance	——————none——————
	Habilitation services	Not covered	Not covered	Not covered.
	Skilled nursing care	20% coinsurance	30% coinsurance	Maximum of 30 days per confinement. Services must begin within 14 days after discharge from an inpatient confinement of at least 3 consecutive days. Pre-certification is required in order to avoid a $200 reduction in benefits.
	Durable medical equipment	20% coinsurance	30% coinsurance	Rental cannot exceed purchase price.
	Hospice services	20% coinsurance	30% coinsurance	Patient's life expectancy 6 months or less.
If your child needs dental or eye care	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:

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) (except for limited oral surgery - see plan document)	• Glasses • Habilitation services • Infertility treatment (except for initial diagnosis and testing)	• Long-term care • Private duty nursing • 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 • Chiropractic care no coverage for routine and maintenance care)	• Coverage provided outside the United States. See www.bpaco.com. • Hearing aids – (Children under 18 years of age – one aid per ear every 36 months)	• 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. 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: visit www.bpaco.com or call 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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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	**$1,000**
Specialist coinsurance	**20%**
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:	
Cost Sharing	
Deductibles	$1,000
Copayments	$0
Coinsurance	$1,000
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	**$1,000**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**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)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$1,000
Copayments	$0
Coinsurance	$1,300
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,000**

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

The plan's overall deductible	**$1,000**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**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:	
Cost Sharing	
Deductibles	$1,000
Copayments	$200
Coinsurance	$300
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.