mmary 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 r 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.dol.gov/ebsa/healthreform or call 1-800-236-7789 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$500** individual / **$1,000** family for Preferred and Non-Preferred providers. PPO and Non-PPO deductibles are mutually satisfying.	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. Preferred Provider preventive care services and child immunizations age 6 and under 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 and Non-Preferred providers	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-billed charges, ineligible charges, charges in excess of the Plan maximums/limitations, charges over the Usual and Customary and Reasonable fee, Rx 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.
Will you pay less if you use a network provider?	Yes. See **www.healtheos.com** or call **1-800-279-9776** 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
		PPO Provider (You will pay the least)	Non-PPO 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	10% coinsurance	20% coinsurance	——————none——————
	Specialist visit	10% coinsurance	20% coinsurance	——————none——————
	Preventive care/screening/ immunization	No charge	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.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	20% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	10% coinsurance	20% coinsurance	——————none——————
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.pti-nps.com**	Generic drugs	10% coinsurance (retail and mail order)	20% coinsurance (retail)	Covers up to a 90-day supply (retail and mail order prescription). Viagra is limited to 10 pills per 30-day period. Smoking cessation products require a physician's prescription. Preventive drugs are covered at no charge (generic and single source brand only).
	Preferred brand drugs	10% coinsurance (retail and mail order)	20% coinsurance (retail)	
	Non-preferred brand drugs	10% coinsurance (retail and mail order)	20% coinsurance (retail)	
	Specialty drugs	10% coinsurance (retail and mail order)	Not covered	Covers up to a 30-day supply (retail and mail order prescription); Please see Prescription Drug Benefit section within your Plan Document for details.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	20% coinsurance	——————none——————
	Physician/surgeon fees	10% coinsurance	20% coinsurance	——————none——————
If you need immediate medical attention	Emergency room care	$50/visit then 10% coinsurance after PPO deductible		Usual and Customary and Reasonable apply to the Non-Preferred Providers.
	Emergency medical transportation	10% coinsurance after PPO deductible		Usual and Customary and Reasonable apply to the Non-Preferred Providers.
	Urgent care	10% coinsurance	20% coinsurance	——————none——————
If you have a hospital	Facility fee (e.g., hospital	10% coinsurance	20% coinsurance	——————none——————

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

stay	room)			
	Physician/surgeon fees	10% coinsurance	20% coinsurance	————————none————————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	20% coinsurance	————————none————————
	Inpatient services	10% coinsurance	20% coinsurance	Pre-admission certification should be obtained.
If you are pregnant	Office visits	10% coinsurance	20% coinsurance	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	10% coinsurance	20% coinsurance	————————none————————
	Childbirth/delivery facility services	10% coinsurance	20% coinsurance	Pre-admission certification should be obtained for vaginal deliveries requiring more than a 48 hour stay and for cesarean section deliveries requiring more than a 96 hour stay.
If you need help recovering or have other special health needs	Home health care	10% coinsurance	20% coinsurance	Maximum of 4 hours/visit in any 24 hour period and limited to a maximum of 40 visits per calendar year.
	Rehabilitation services	10% coinsurance	20% coinsurance	————————none————————
	Habilitation services	Not covered	Not covered	Not covered.
	Skilled nursing care	10% coinsurance	20% coinsurance	Admission to nursing facility must be within 24 hours of discharge from a hospital and is limited to 120 days per confinement. Pre-admission certification should be obtained
	Durable medical equipment	10% coinsurance	20% coinsurance	Rental cannot exceed the purchase price.
	Hospice services	10% coinsurance	20% coinsurance	Limited to a life expectancy of six months or less. Pre-admission certification should be obtained
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.

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

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 (unless administered by MD or DO)
- Bariatric surgery (except for morbid obesity and disease etiology)
- Cosmetic surgery (except due to a covered surgical procedure, accident or birth defect)
- Dental care (Adult)
- Dental check-up (Child)
- Eye exam (Child)
- Glasses (Child) (except the initial pair following Cataract surgery
- Habilitative services
- Infertility treatment (except initial diagnosis and testing)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care (unless medically necessary)
- Weight loss programs (except for morbid obesity and disease etiology)

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

- Chiropractic care (18 visit maximum per calendar year)
- Hearing aids (1 hearing aid per ear once every 3 years under age 18 only)
- Private-duty nursing

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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or 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 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, 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**

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.

For more information about limitations and exceptions, see 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** **$500**
- **Specialist *copayment*** **$0**
- **Hospital (facility) *coinsurance*** **10%**
- **Other *coinsurance*** **10%**

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$0
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,560**

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

- **The plan's overall deductible** **$500**
- **Specialist *copayment*** **$0**
- **Hospital (facility) *coinsurance*** **10%**
- **Other *coinsurance*** **10%**

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$0
Coinsurance	$718
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,274**

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

- **The plan's overall deductible** **$500**
- **Specialist *copayment*** **$0**
- **Hospital (facility) *coinsurance*** **10%**
- **Other *coinsurance*** **10%**

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	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$0
Coinsurance	$193
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$693**