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, call (888) 205-2688. 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 call 1-800-558-7798 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers $1,000 individual / $2,000 family; For out- of-network $2,500 individual / $5,000 family	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. Preventive care and primary 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 must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For network providers $3,500 individual / $7,000 family; For out-of-network $7,000 individual / $14,000 family	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?	Penalties for non-compliance with plan provisions, Copayments for certain services, premiums, balance-billing 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.
What is the co-insurance?	network providers 20% out- of-network 50%	Up to the out-of-pocket limit
Will you pay less if you use a network provider?	Yes. Contact your concierge service 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	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay	50% coinsurance after deductible.	None
	Specialist visit	$40 copay	50% coinsurance after deductible.	Chiropractor Care: 25 visits/year
	Telemedicine	$0 copay	N/A	
	Preventive care/screening/ immunization	No charge	N/A	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)	100% covered with Quest	50% coinsurance after deductible.	Labs performed during network office visit are included in office visit copay.
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible.	50% coinsurance after deductible.	Preauthorization is required or $500 reduction in benefits
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bmr-inc.com	Generic drugs (Tier 1)	$0 copay	N/A	Benefits may vary if more than a 30 day supply is needed.
	Preferred brand drugs (Tier 2)	$35 copay or 25% Whichever is greater	N/A	
	Non-preferred brand drugs (Tier 3)	$75 copay or 45% Whichever is greater	N/A	
	Specialty drugs (Tier 4)	$200 copay or 30% Whichever is greater	N/A	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible.	50% coinsurance after deductible.	Preauthorization is required or $500 reduction in benefits
	Physician/surgeon fees	20% coinsurance after deductible.	50% coinsurance after deductible.	

[* For more information about limitations and exceptions, see the plan or policy document by logging into your member portal]

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$300 copay	$300 copay	$500 applies if used for non-urgent services.
	Emergency medical transportation	20% coinsurance after deductible.	50% coinsurance after deductible.	
	Urgent care	$40 copay	$40 copay	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible.	50% coinsurance after deductible.	Preauthorization is required or $500 reduction in benefits
	Physician/surgeon fees	20% coinsurance after deductible.	50% coinsurance after deductible.	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay office visit All other services 20% coinsurance after deductible.	50% coinsurance after deductible.	Behavioral health and mental wellness services that are rendered by a licensed professional in an office visit setting are subject to the same payments as primary care.
	Inpatient services	20% coinsurance after deductible.	50% coinsurance after deductible.	
If you are pregnant	Office visits	$40 copay (First Visit Only)	50% coinsurance after deductible.	
	Childbirth/delivery professional services	20% coinsurance after deductible.	50% coinsurance after deductible.	
	Childbirth/delivery facility services	20% coinsurance after deductible.	50% coinsurance after deductible.	
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible.	50% coinsurance after deductible.	Home Health Care max 60 days/yr. Physical, speech, occupational, cardiac rehabilitation:35 visits/year, combined Preauthorization is required. Benefits may be reduced $500. Skilled Nursing 25 days/year. Hospice 15 visits/days per lifetime.
	Rehabilitation services	20% coinsurance after deductible.	50% coinsurance after deductible.	
	Habilitation services	20% coinsurance after deductible.	50% coinsurance after deductible.	
	Skilled nursing care	20% coinsurance after deductible.	50% coinsurance after deductible.	
	Durable medical equipment	20% coinsurance after deductible.	50% coinsurance after deductible.	
	Hospice services	20% coinsurance after deductible.	50% coinsurance after deductible.	
If your child needs dental or eye care	Children's eye exam	No Charge	No Benefit	Coverage limited to one exam/year.
	Children's glasses	No Benefit	No Benefit	None
	Children's dental check-up	No Benefit	No Benefit	None

[* For more information about limitations and exceptions, see the plan or policy document by logging into your member portal]

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 (if prescribed for rehabilitation purposes)
- Cosmetic Surgery
- Dental Care
- Infertility Treatment
- Hearing Aids
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Routine eye care (Adult)
- Routine Foot Care
- Weight Loss Programs
- Bariatric Surgery

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

- Birth Control
- Colonoscopy
- Diagnostic Services
- Sterilization for Women
- Transplants (inpatient only)

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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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: [insert applicable contact information from instructions].

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.

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-800-674-9363]

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 by logging into your member portal]

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	$1000
Specialist copayment	$40
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	**$10,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$40
Coinsurance	$2,720
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,820**

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

The plan's overall deductible	$1000
Specialist copayment	$40
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	**$7,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$1,000
Copayments	$40
Coinsurance	$1,170
What isn't covered	
Limits or exclusions	$637
The total Joe would pay is	**$2,847**

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

The plan's overall deductible	$1000
Specialist copayment	$40
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	**$5,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$1,000
Copayments	$40
Coinsurance	$578
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,618**

The plan would be responsible for the other costs of these EXAMPLE covered services. Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: NOT APPLICABLE *Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.