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, www.coupehealth.com. 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 https://www.healthcare.gov/sbc-glossary or call 1-800-882-5158 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	N/A	N/A
Are there other deductibles for specific services?	Yes. $500/individual for nonpreferred provider prescription drugs. $300/individual for Specialty drugs. For BGC's custom preferred provider prescription drugs network, there is $0 deductible.	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?	Tier 1, Tier 2,or Tier 3 Preferred Provider: $5,000/individual or $10,000/family per benefit period. Tier 4 Nonpreferred Provider: Unlimited/individual or Unlimited/family per benefit period.	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 failure to obtain pre-certification for 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.
Will you pay less if you use a network provider?	Yes. See www.coupehealth.com or call 1-800-882-5158 for a list of network providers.	You pay the least if you use a tier 1 preferred provider. You pay more if you use a tier 2 or tier 3 preferred provider. You will pay the most if you use a tier 4 nonpreferred 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 tier 1 preferred provider, tier 2 preferred provider, or tier 3 preferred provider might use a tier 4 nonpreferred 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
		Tier 1 Preferred Provider (You will pay the least)	Tier 2 Preferred Provider (You will pay more)	Tier 3 Preferred Provider (You will pay more)	Tier 4 Nonpreferred 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	$50 copayment/visit	$65 copayment/visit	$105 copayment/visit	$130 copayment/visit	General Medical telemedicine services through MD Live: $10 copayment.
	Specialist visit	$75 copayment/visit	$100 copayment/visit	$165 copayment/visit	$200 copayment/visit	None.
	Preventive care/screening/ immunization	$0 copayment/visit	$0 copayment/visit	$0 copayment/visit	Not covered	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)	Basic labs: $0 copayment/visit Advanced diagnostic labs: $75 copayment/visit X-ray: $75 copayment/visit	Basic labs: $0 copayment/visit Advanced diagnostic labs: $100 copayment/visit X-ray: $100 copayment/visit	Basic labs: $0 copayment/visit Advanced diagnostic labs: $170 copayment/visit X-ray: $170 copayment/visit	Basic labs: $75 copayment/visit Advanced diagnostic labs: $205 copayment/visit X-ray: $205 copayment/visit	None.
	Imaging (CT/PET scans, MRIs)	$150 copayment/visit	$200 copayment/visit	$340 copayment/visit	$405 copayment/visit	None.

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Tier 1 Preferred Provider (You will pay the least)	Tier 2 Preferred Provider (You will pay more)	Tier 3 Preferred Provider (You will pay more)	Tier 4 Nonpreferred 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.myprime.com or call 1-855-457-0007.	Generic drugs	Retail: $10 copayment/ prescription (deductible does not apply) Mail order: Not covered	Retail: $10 copayment/ prescription (deductible does not apply) Mail order: Not covered	Retail: $10 copayment/ prescription (deductible does not apply) Mail order: Not covered	Retail: 50% coinsurance Mail order: Not covered	All Walgreens, Reasor's or BGC In-Store Pharmacies will have preferred provider benefits apply. Non-Walgreens, non-Reasor's or non-BGC In-Store Pharmacies will have nonpreferred provider benefits apply. Nonpreferred provider only: prescription drugs deductible: $500. Up to $250 maximum per prescription at preferred provider pharmacies for non-specialty drugs. 90-day supply allowed at any Walgreens, Reasor's, or BDC in-store Pharmacies. All other pharmacies limited to 30-day supply. ESN does not apply. mail order is not covered. Copay or coinsurance applies to a 30-day supply Retail and Copay does not apply to preventive drugs required by the Affordable Care Act. If you purchase a brand name drug when a generic drug is available, you must pay difference in cost. For nonpreferred provider pharmacy claims, partner must file a claim.
	Preferred drugs	Retail: 30% coinsurance up to $250 maximum (deductible does not apply) Mail order: Not covered	Retail: 30% coinsurance up to $250 maximum (deductible does not apply) Mail order: Not covered	Retail: 30% coinsurance up to $250 maximum (deductible does not apply) Mail order: Not covered	Retail: 50% coinsurance Mail order: Not covered	
	Non-preferred drugs	Retail: 50% coinsurance up to $250 maximum (deductible does not apply) Mail order: Not covered	Retail: 50% coinsurance up to $250 maximum (deductible does not apply) Mail order: Not covered	Retail: 50% coinsurance up to $250 maximum (deductible does not apply) Mail order: Not covered	Retail: 50% coinsurance Mail order: Not covered	

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Tier 1 Preferred Provider (You will pay the least)	Tier 2 Preferred Provider (You will pay more)	Tier 3 Preferred Provider (You will pay more)	Tier 4 Nonpreferred Provider (You will pay the most)	
	Specialty drugs	Retail: 50% coinsurance up to $700 maximum after $300 deductible Mail order: Not covered	Retail: 50% coinsurance up to $700 maximum after $300 deductible Mail order: Not covered	Retail: 50% coinsurance up to $700 maximum after $300 deductible Mail order: Not covered	Retail: Not covered Mail order: Not covered	Specialty drugs deductible: $300. Specialty drugs are available at any Walgreens, Reasor's, or BGC in-store pharmacy or through Prime Therapeutics/Accredo only. Up to $700 maximum per prescription. There is no specialty drugs benefits for nonpreferred provider pharmacies. Specialty drug retail limited to a 30-day supply and mail order is not covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$1,000 copayment/visit	$1,750 copayment/visit	$2,250 copayment/visit	$2,700 copayment/visit	None.
	Physician/surgeon fees	$0 copayment/visit	$0 copayment/visit	$0 copayment/visit	$0 copayment/visit	None.
If you need immediate medical attention	Emergency room care	$750 copayment/visit	$750 copayment/visit	$750 copayment/visit	$750 copayment/visit	Copay waived if admitted.
	Emergency medical transportation	$750 copayment	$750 copayment	$750 copayment	$750 copayment	None.
	Urgent care	$75 copayment/visit	$75 copayment/visit	$75 copayment/visit	$75 copayment/visit	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	$2,500 copayment/ admission	$3,325 copayment/ admission	$4,135 copayment/ admission	$4,965 copayment/ admission	Pre-certification is required. If pre-certification is not obtained, benefits are subject to a $250 penalty of the total cost of the service.
	Physician/surgeon fees	$0 copayment/ admission	$0 copayment/ admission	$0 copayment/ admission	$0 copayment/ admission	None.

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Tier 1 Preferred Provider (You will pay the least)	Tier 2 Preferred Provider (You will pay more)	Tier 3 Preferred Provider (You will pay more)	Tier 4 Nonpreferred Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visits: $50 copayment/visit Other Outpatient Services: $1,000 copayment/visit	Office visits: $65 copayment/visit Other Outpatient Services: $1,750 copayment/visit	Office visits: $105 copayment/visit Other Outpatient Services: $2,250 copayment/visit	Office visits: $130 copayment/visit Other Outpatient Services: $2,700 copayment/visit	None.
	Inpatient services	$2,500 copayment/ admission	$3,325 copayment/ admission	$4,135 copayment/ admission	$4,965 copayment/ admission	Pre-certification is required. If pre-certification is not obtained, benefits are subject to a $250 penalty of the total cost of the service.
If you are pregnant	Office visits	$50 copayment/visit	$65 copayment/visit	$105 copayment/visit	$130 copayment/visit	Dependent daughters are covered for this benefit. Copayment applies to first prenatal visit (per pregnancy). Cost sharing does not apply for preventive services. Depending on the type of services, a copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	0% copayment/ admission	0% copayment/ admission	0% copayment/ admission	0% copayment/ admission	
	Childbirth/delivery facility services	$2,500 copayment/ admission	$3,325 copayment/ admission	$4,135 copayment/ admission	$4,965 copayment/ admission	
If you need help recovering or have other special health needs	Home health care	$150 copayment/ admission	$200 copayment/ admission	$250 copayment/ admission	$400 copayment/ admission	Home health care visits limited to 60 visits per benefit period. Pre-certification is required. If pre-certification is not obtained, benefits are subject to a $250 penalty of the total cost of the service.
	Rehabilitation services	$75 copayment/visit	$100 copayment/visit	$165 copayment/visit	$200 copayment/visit	None.
	Habilitation services	$75 copayment/visit	$100 copayment/visit	$165 copayment/visit	$200 copayment/visit	None.

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

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Tier 1 Preferred Provider (You will pay the least)	Tier 2 Preferred Provider (You will pay more)	Tier 3 Preferred Provider (You will pay more)	Tier 4 Nonpreferred Provider (You will pay the most)	
	Skilled nursing care	$2,500 copayment/ admission	$3,325 copayment/ admission	$4,135 copayment/ admission	$4,965 copayment/ admission	Skilled nursing care limited to 25 days per benefit period. Pre-certification is required. If pre-certification is not obtained, benefits are subject to a $250 penalty of the total cost of the service.
	Durable medical equipment	$100 copayment	$135 copayment	$225 copayment	$270 copayment	None.
	Hospice services	$0 copayment/ admission	$0 copayment/ admission	$0 copayment/ admission	$400 copayment/ admission	Pre-certification is required. If pre-certification is not obtained, benefits are subject to a $250 penalty of the total cost of the service.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	Not covered	Not covered.
	Children's glasses	Not covered	Not covered	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	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.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care
- Routine foot care
- Weight loss programs

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

- Chiropractic care (limited to 35 visits per benefit period)
- Hearing aids

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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-882-5158.
Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-800-882-5158.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-882-5158.
Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-800-882-5158 uff.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-882-5158.
Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-800-882-5158.
Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-882-5158.
Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-800-882-5158.

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.coupehealth.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 preferred provider pre-natal care and a hospital delivery)

The plan's overall (Tier 1 preferred provider)	$0
Specialist copayment	$75
Hospital (facility) copayment	$2,500
Other copayment	$1,000

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*	$0
Copayments	$5,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$5,070**

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

The plan's overall (Tier 1 preferred provider)	$0
Specialist copayment	$75
Hospital (facility) copayment	$2,500
Other copayment	$1,000

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*	$0
Copayments	$1,300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$3,500
The total Joe would pay is	**$4,800**

Mia's Simple Fracture
(preferred provider emergency room visit and follow-up care)

The plan's overall (Tier 1 preferred provider)	$0
Specialist copayment	$75
Hospital (facility) copayment	$2,500
Other copayment	$1,000

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic tests (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$0
Copayments	$1,900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$1,910**

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