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, go to www.bseny.com or call 1-800-888-1238. 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 http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-888-249-2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Does not apply,	Does not apply.
Are there services covered before you meet your deductible?	Does not apply,	Does not apply.
Are there other deductibles for specific services?	Does not apply.	Does not apply,
What is the out-of-pocket limit for this plan?	For network providers $1,980 individual / $3,960 family.	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, 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.bseny.com com or call 1-800-888-1238 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 in-network specialist you choose without permission from this plan.

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
		Network Provider (You will pay the least)	Out-of-Network 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	Not applicable	Not applicable	This is a prescription drug only plan
	Specialist visit	Not applicable	Not applicable	This is a prescription drug only plan
	Preventive care/screening/ immunization	Not applicable	Not applicable	This is a prescription drug only plan
If you have a test	Diagnostic test (x-ray, blood work)	Not applicable	Not applicable	This is a prescription drug only plan
	Imaging (CT/PET scans, MRIs)	Not applicable	Not applicable	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bsneny.com	Generic drugs (Tier 1)	$10 co-pay/prescription	Not covered	$20 co-pay per 90 day supply for mail order. $60 co-pay per 90 day supply for mail order. $100 co-pay per 90 day supply for mail order. Specialty drugs could be generic, preferred brand, or non-preferred brand. For Member Service related to prescriptions call 1-866-591-3878.
	Preferred brand drugs (Tier 2)	$30 co-pay/prescription	Not covered	
	Non-preferred brand drugs (Tier 3)	$50 co-pay/prescription	Not covered	
	Specialty drugs (Tier 4)	See Limitations and Exceptions	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not applicable	Not applicable	This is a prescription drug only plan
	Physician/surgeon fees	Not applicable	Not applicable	This is a prescription drug only plan
If you need immediate medical attention	Emergency room care	Not applicable	Not applicable	This is a prescription drug only plan
	Emergency medical transportation	Not applicable	Not applicable	
	Urgent care	Not applicable	Not applicable	
If you have a hospital stay	Facility fee (e.g., hospital room)	Not applicable	Not applicable	This is a prescription drug only plan
	Physician/surgeon fees	Not applicable	Not applicable	This is a prescription drug only plan

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 mental health, behavioral health, or substance abuse services	Outpatient services	Not applicable	Not applicable	This is a prescription drug only plan
	Inpatient services	Not applicable	Not applicable	This is a prescription drug only plan
If you are pregnant	Office visits	Not applicable	Not applicable	This is a prescription drug only plan
	Childbirth/delivery professional services	Not applicable	Not applicable	This is a prescription drug only plan
	Childbirth/delivery facility services	Not applicable	Not applicable	This is a prescription drug only plan
If you need help recovering or have other special health needs	Home health care	Not applicable	Not applicable	This is a prescription drug only plan
	Rehabilitation services	Not applicable	Not applicable	This is a prescription drug only plan
	Habilitation services	Not applicable	Not applicable	This is a prescription drug only plan
	Skilled nursing care	Not applicable	Not applicable	This is a prescription drug only plan
	Durable medical equipment	Not applicable	Not applicable	This is a prescription drug only plan
	Hospice services	Not applicable	Not applicable	This is a prescription drug only plan
If your child needs dental or eye care	Children's eye exam	Not applicable	Not applicable	This is a prescription drug only plan
	Children's glasses	Not applicable	Not applicable	This is a prescription drug only plan
	Children's dental check-up	Not applicable	Not applicable	This is a prescription drug only plan

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
- Long Term Care
- Weight Loss Programs
- Cosmetic surgery
- Custodial Care
- Private Duty Nursing
- Dental (Adult)
- Hearing Aids
- Routine Foot Care

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

- Bariatric Surgery Bariatric Surgery
- Infertility treatment
- Chiropractic Care
- Routine Eye Care (Adult)
- Elective Abortion
- 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 are the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, 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: 1-888-249-2583.

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 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 1-888-249-2583.
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-249-2583.
[Chinese (中文): 如果需要中文的帮助， **请拨打这个号码**1-888-249-2583.
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-249-2583.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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** **$**
- **Specialist cost share** **$**
- **Hospital (facility) cost share** **0%**
- **Other cost share** **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	**$7,540**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$7,530
The total Peg would pay is	**$7,540**

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

- **The plan's overall deductible** **$**
- **Specialist cost share** **$**
- **Hospital (facility) cost share** **0%**
- **Other cost share** **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	**$5,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$0
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$5,300
The total Joe would pay is	**$5,400**

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

- **The plan's overall deductible** **$**
- **Specialist cost share** **$**
- **Hospital (facility) cost share** **%**
- **Other cost share** **%**

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*	$0
Copayments	$85
Coinsurance	$0
What isn't covered	
Limits or exclusions	$1,840
The total Mia would pay is	**$1,925**

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 www.bseny.com or call 1-800-888-1238. *Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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