**`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, baslimited.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 www.healthcare.gov/sbc-glossy or call 1-800-748-8696 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | **$1,000**/individual or **$2,000**/family or 2 persons | 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 & 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 don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | **$3,000**/ individual or **$6,000** family or 2 persons | 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-authorization for service, 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?** | No. | There are no networks with this plan. |
| **Do you need a referral to see a specialist?** | No. | You can see the specialist you choose without a referral. |

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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 | $25 copay/visit<br>Deductible does not apply | N/A | Other Covered Services rendered in the provider's office will be subject to the coinsurance amount. |
| | Specialist visit | $50 copay/visit<br>Deductible does not apply | N/A | Other Covered Services rendered in the provider's office will be subject to the coinsurance amount. |
| | 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 you need are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% coinsurance | N/A | None |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | N/A | Benefit payment reduced by $250 for no precertification. |
| **If you need drugs to treat your illness or condition**<br>More information about **prescription drug coverage** is available at www.scriptcare.com or www.zip-scripts.com | Generic drugs (Tier 1) | $10 copay/prescription (30- day supply pharmacy)<br>$20 copay/prescription (90- day supply Mail Order) | N/A | Limited to a 30-day retail supply. Certain Prescription drugs may be subject to Prior Authorization, quantity limits, day limits and/or duration of use restrictions.<br><br>Limited to a 90-day maintenance supply. Certain drugs may be subject to Prior Authorization, quantity limits, day limits and/or duration of use restrictions.<br><br>The Plan requires pharmacies dispense Generic Drugs when available unless Physician specifically prescribes a Tier 2 or Tier 3 and marks prescription as "Dispense as Written" (DAW). |
| | Preferred brand drugs (Tier 2) | $35 copay/prescription (30-day supply pharmacy)<br>$70 copay/prescription (90-day supply Mail Order) | N/A | |
| | Non-preferred brand drugs (Tier 3) | 50% copay/ prescription up to a $100 maximum (30-day supply pharmacy)<br>50% copay/ prescription up to a $200 maximum (90- day supply Mail Order) | N/A | |
| | Specialty drugs (Tier 4) | 35% copay up to a $300 maximum (30-day supply pharmacy) | N/A | |

| 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 have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | N/A | Benefit payment reduced by $250 for no precertification. |
| | Physician/surgeon fees | 20% coinsurance | N/A | None. |
| **If you need immediate medical attention** | Emergency room care | 20% coinsurance | N/A | None |
| | Emergency medical transportation | 20% coinsurance | N/A | None |
| | Urgent care | $150 copay/visit, Deductible does not apply | N/A | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | N/A | Benefit payment reduced by $250 for no precertification. |
| | Physician/surgeon fees | 20% coinsurance | N/A | None. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $25 copay/office visit<br>20% coinsurance/all other services<br>Deductible does not apply | N/A | None. |
| | Inpatient services | 20% coinsurance | N/A | Benefit payment reduced by $250 for no precertification. |
| **If you are pregnant** | Office visits | $25 copay<br>Deductible does not apply | N/A | Primary Care or Specialist benefit levels apply for initial visit to confirm pregnancy. Depending on the type of services, 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 | N/A | |
| | Childbirth/delivery facility services | 20% coinsurance | N/A | |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | N/A | Benefit payment reduced by $250 for no precertification. Coverage is limited to 100 visits annual max. |
| | Rehabilitation services | 20% coinsurance | N/A | Coverage is limited to annual max of: 30 days for Chiropractic care services; |
| | Habilitation services | Not Covered | N/A | Not covered |
| | Skilled nursing care | 20% coinsurance | N/A | Benefit payment reduced by $250 for no precertification. Coverage is limited to 100 days annual max. |

| 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) | |
| | Durable medical equipment | 20% coinsurance | N/A | Benefit payment reduced by $250 for no precertification of scooters or wheelchairs and pneumatic compression devices. |
| | Hospice services | 20% coinsurance/ | N/A | None |
| **If your child needs dental or eye care** | Children's eye exam | No Charge | N/A | One exam per 12-month period |
| | Children's glasses | Not covered | N/A | None |
| | Children's dental check-up | Not covered | N/A | None |

## 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
- Dental Care
- Hearing aids
- Infertility Treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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**

- Acupuncture (combined with Chiropractic Care)
- Chiropractic Care (combined with Acupuncture Services)
- Routine eye care (Adult) one exam per 12-month period.
- Teledoc visit $10 copayment

**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: 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: the plan sponsor at 1-662-680-3148, the plan's Claims processor at 1-800-748-8696, or the U. S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

**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 1-800-748-8696.
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-748-8696.
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-748-8696.
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-748-8696.

*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 | $1,000 |
| Specialist copayment | $50 |
| 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** | **$12,800** |

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,000 |
| Copayments | $350 |
| Coinsurance | $1,650 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$3,060** |

### 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 copayment | $50 |
| 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** | **$7,400** |

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles* | $1,000 |
| Copayments | $1,065 |
| Coinsurance | $372 |
| *What isn't covered* | |
| Limits or exclusions | $55 |
| **The total Joe would pay is** | **$2,492** |

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

| | |
|---|---|
| The plan's overall deductible | $1,000 |
| Specialist copayment | $50 |
| 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** | **$1,900** |

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles* | $1,000 |
| Copayments | $150 |
| Coinsurance | $326 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,476** |

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: The Plan Administrator.
*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.