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?	For in-network providers: **$2,000**/individual or **$4,000**/family For out-of-networks providers: **$4,000**/individual or **$8,000**/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. In-network preventive care & immunizations, out-of-network immunizations through age 1, office visits, generic prescription drugs, urgent care facility visits 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. There are no other specific deductibles.	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 in-network providers **$4,000**/individual or **$8,000** family For out-of-network providers **$6,000**/individual or **$12,000**/family Combined medical/behavioral and pharmacy out-of-pocket limit.	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?	Yes. 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 specialists 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** **Deductible does not apply	40% coinsurance	None
	Specialist visit	$50 copay/visit** **Deductible does not apply	40% coinsurance	None
	Preventive care/screening/ immunization	No charge	Not Covered	Covered Services must be rendered by a Network Provider in that Provider's setting. 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	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Benefit payment reduced by $250 for no precertification.
If you need drugs to treat your illness or condition 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) $20 copay/prescription (90- day supply Mail Order)	Not covered	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. 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. 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) $70 copay/prescription (90-day supply Mail Order)	Not covered	
	Non-preferred brand drugs (Tier 3)	50% copay/ prescription up to a $100 maximum (30-day supply pharmacy) 50% copay/ prescription up to a $200 maximum (90- day supply Mail Order)	Not covered	
	Specialty drugs (Tier 4)	35% copay up to a $300 maximum (30-day supply pharmacy)	Not covered	
If you have outpatient	Facility fee (e.g., ambulatory	20% coinsurance	40% coinsurance	Benefit payment reduced by $250 for

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)	
surgery	surgery center)			no precertification.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None.
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	$150 copay/visit**, **Deductible does not apply	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Benefit payment reduced by $250 for no precertification.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/office visit** 20% coinsurance/all other services **Deductible does not apply	40% coinsurance/office visit 40% coinsurance/all other services	None.
	Inpatient services	20% coinsurance	40% coinsurance	Benefit payment reduced by $250 for no precertification.
If you are pregnant	Office visits	$25 copay ** **Deductible does not apply	40% coinsurance	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	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Benefit payment reduced by $250 for no precertification. Coverage is limited to 100 visits annual max. Network and Out-of-network visits are combined. 4-hours is considered as one visit.
	Rehabilitation services	20% coinsurance	40% coinsurance	Coverage is limited to annual max of: 30 days for Chiropractic care services;
	Habilitation services	Not Covered	Not Covered	Not covered
	Skilled nursing care	20% coinsurance	40% coinsurance	Benefit payment reduced by $250 for no precertification. Coverage is limited

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)	
				to 100 days annual max. Network and Out-of-network visits are combined.
	Durable medical equipment	20% coinsurance	40% coinsurance	Benefit payment reduced by $250 for no precertification of scooters or wheelchairs and pneumatic compression devices.
	Hospice services	20% coinsurance/	40% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No Charge	Not covered	One exam per 12-month period
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	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	$2,000
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	$2,000
Copayments	$350
Coinsurance	$1,650
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,060**

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

The plan's overall deductible	$2,000
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*	$1,489
Copayments	$1,065
Coinsurance	$372
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$2,981**

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

The plan's overall deductible	$2,000
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*	$1,305
Copayments	$150
Coinsurance	$326
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,781**

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.