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.BASHealth.com or by calling 1-800-843-3831. 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.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-866-444-EBSA (3272) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$2,000** 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?	Deductible does not apply to: · Preventive Care services · Prescription drug · Services with a copayment (unless otherwise indicated)	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: 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?	**$8,150** Individual / **$16,300** 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 failing to follow the pre-certification procedures premiums, balance-billed 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.	This plan does not use a provider network. You can receive covered services from any provider.
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
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$40 Co-Pay/Visit	None
	Specialist visit	$80 Co-Pay/Visit	None
	Preventive care/screening/ immunization	No Charge	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. Deductible does not apply.
If you have a test	Diagnostic test (x-ray, blood work)	20% Co-Insurance	Lab Card Provider – No Charge
	Imaging (CT/PET scans, MRIs)	20% Co-Insurance	US Imaging Provider – No Charge
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.BASHealth.com.	Generic drugs	$20 Co-pay 30 days Retail $60 Co-pay 90 days Retail $40 Co-pay 90 days Mail Order	Prescriptions are subject to the Medical Out-of-Pocket limit. Co-pay applies per prescription. Generic FDA approved forms of contraceptives for women and certain cancer preventive drugs, as required under the ACA Prevent Care services – No Charge. Specialty Drugs Requires Precertification.
	Preferred brand drugs	$40 Co-pay 30 days Retail $120 Co-pay 90 days Retail $80 Co-pay 90 days Mail Order	
	Non-preferred brand drugs	$100 Co-pay 30 days Retail $300 Co-pay 90 days Retail $200 Co-pay 90 days Mail Order	
	Specialty drugs	50% for 30 day supply Retail (medical deductible applies) Mail Order is Not Applicable.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Co-Insurance	Non-compliance penalty; benefits may be reduced by 50%
	Physician/surgeon fees	20% Co-Insurance	None
If you need immediate medical attention	Emergency room care	20% Co-Insurance	None
	Emergency medical transportation	$100 Co-pay; then Deductible and 20% Coinsurance	Co-pay applies per trip.
	Urgent care	$50 Co-Pay/Visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Co-Insurance	Non-compliance penalty; benefits may be reduced by 50%
	Physician/surgeon fees	20% Co-Insurance	None

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Same as any other Illness	None
	Inpatient services	Same as any other Illness	Non-compliance penalty; benefit may be reduced by 50%
If you are pregnant	Office visits	Prenatal and postnatal care as defined by PPACA – No Charge	Cost sharing doesn't apply to preventive care services. Depending on the type of service, a copay, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Non-compliance penalty; benefit may be reduced by 50%
	Childbirth/delivery professional services	20% Co-Insurance	
	Childbirth/delivery facility services	20% Co-Insurance	
If you need help recovering or have other special health needs	Home health care	20% Co-Insurance	Calendar Year Maximum 40 visits. 1 visit = 4 hours.
	Rehabilitation services	$40 Co-Pay/Visit	Calendar Year Maximum 24 visits per each Therapy; Physical, Occupational, Speech and Respiratory Therapy.
	Habilitation services	20% Co-Insurance	None
	Skilled nursing care	20% Co-Insurance	Calendar Year Maximum 100 days. Non-compliance penalty; benefit may be reduced by 50%.
	Durable medical equipment	20% Co-Insurance	Non-compliance penalty; benefit may be reduced by 50%.
	Hospice services	20% Co-Insurance	Non-compliance penalty; benefits may be reduced by 50%. Bereavement Counseling is limited to services within six (6) months of the patient's death.
If your child needs dental or eye care	Children's eye exam	See Limitations & Exceptions	Coverage limited to $50 per eye exam, per covered person every 12 months. Must enroll in separate Vision Plan. *See the Vision Care Benefits section in the Plan Document
	Children's glasses	See Limitations & Exceptions	Coverage limited to $100 for Frame-type lenses per pair every 24 months; $100 for Frames per pair every 24 months; $100 for Contact Lenses (in lieu of glasses) every 24 months. Limits apply per covered person. Must enroll in separate Vision Plan.
	Children's dental check-up	No Charge	Must enroll in separate Dental Plan. *See the Dental Benefits section in the Plan Document.

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
- Chiropractic Care
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-emergency Care when traveling outside the U.S.
- Routine Eye Care (Adult)
- 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.)

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: your state insurance department, the U.S. Department of Labor's Employee Benefits Security Administration at **1-866-444-EBSA (3272)** or www.dol.gov/ebsa/healthreform 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 at **1-800-843-3831** or your state insurance department or the U.S. 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 1-800-843-3831.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-843-3831.]

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-843-3831.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-843-3831.]

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.BASHealth.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 in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$2,000**
- **Specialist copayment** **$80**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Primary 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	$2,000
Copayments	$10
Coinsurance	$2,100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,170**

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** **$80**
- **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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,020
Copayments	$900
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,020**

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

- **The plan's overall deductible** **$2,000**
- **Specialist copayment** **$80**
- **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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,520
Copayments	$500
Coinsurance	$20
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,520**

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