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.healthcare.gov/sbc-glossary or call 1-866-444-EBSA (3272) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network providers **$1,500** Individual / **$3,000** Family. Non-Network providers **$3,000** Individual / **$6,000** 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: · Network Preventive Care · Prescription drug with a Co-payment benefit · Services with a Co-payment (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 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?	Network providers **$6,350** Individual / **$12,700** Family. Non-Network providers **$12,700** Individual / **$25,400** 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 pre-certification procedures, Amounts in excess of the reasonable and customary limit/maximum allowed amount, Expenses not covered under the plan, 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?	Yes. See www.BASHealth.com or call 1-800-843-3831 for a list of in-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 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
		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 Co-Pay/Visit - Includes Online visits	40% Co-Insurance	Chiropractic Calendar Year Maximum Visits 26.
	Specialist visit	$50 Co-Pay/Visit	40% Co-Insurance	---none---
	Preventive care/screening/ immunization	No Charge	40% Co-Insurance; Immunizations, for children under age 6: 100% No Deductible	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) Including Independent Lab, Radiologist, & Pathologist	$25 Co-Pay or a $50 Co-Pay	40% Co-Insurance	Lab card is preferred provider
	Diagnostic Mammograms including 3D	No Charge	40% Co-Insurance	---none---
	Imaging (CT/PET scans, MRIs)	20% Co-Insurance	40% Co-Insurance	---none---
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.BASHealth.com.	Generic drugs	$12.00 Co-Pay Retail/ $30.00 Co-Pay Mail Order/Prescription	$12.00 Co-Pay Retail/ $30.00 Co-Pay Mail Order/Prescription	Prescription drug costs are subject to the Medical Out of Pocket limit. If a generic drug is available and you choose to purchase the brand drug, you pay the cost difference between the brand and generic plus the co-pay, unless script is marked dispensed as written (DAW)
	Preferred brand drugs	$30.00 Co-Pay Retail/ $75.00 Co-Pay Mail Order/Prescription	$30.00 Co-Pay Retail/ $75.00 Co-Pay Mail Order/Prescription	
	Non-preferred brand drugs	$60.00 Co-Pay Retail/ $150.00 Co-Pay Mail Order/ Prescription	60.00 Co-Pay Retail/ $150.00 Co-Pay Mail Order/ Prescription	

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)	
	Specialty drugs	Prior authorization required, then applicable Co-Pay applies Retail and Mail/Order Prescription	Prior authorization required, then applicable Co-Pay applies Retail and Mail/Order Prescription	See above Limitations
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Co-Insurance	40% Co-Insurance	Non-compliance penalty of $500 per occurrence.
	Physician/surgeon fees	20% Co-Insurance	40% Co-Insurance	---none---
If you need immediate medical attention	Emergency room care	**Emergency:** $250 Co-Pay/Visit **Non-Emergency:** Not Covered	**Emergency:** $250 Co-Pay/Visit **Non-Emergency:** Not Covered	Co-Pay/Visit waived if admitted
	Emergency medical transportation	20% Co-Insurance	20% Co-Insurance Network level benefit	---none---
	Urgent care	$40 Co-Pay/Visit	40% Co-Insurance	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Co-Insurance	40% Co-Insurance	Non-compliance penalty of $500 per occurrence.
	Physician/surgeon fees	20% Co-Insurance	40% Co-Insurance	---none---
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 Co-Pay/ office visit	40% Co-Insurance	---none---
	Inpatient services	20% Co-Insurance	40% Co-Insurance	Non-compliance penalty of $500 per occurrence
If you are pregnant	Office visits	$25 Co-Pay/Visit - Includes Online visits	40% Co-Insurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC
	Childbirth/delivery professional services	20% Co-Insurance	40% Co-Insurance	
	Childbirth/delivery facility services	20% Co-Insurance	40% Co-Insurance	Non-compliance penalty of $500 per occurrence.
If you need help recovering or have other special health needs	Home health care	20% Co-Insurance	40% Co-Insurance	Calendar Year Maximum 100 visits.
	Rehabilitation services	$25 Co-pay/Visit or 20% Co-Insurance Physical medicine & Rehabilitation Calendar year maximum 60 days	40% Co-Insurance	Calendar Year Maximum - Physical Therapy; 20 visits. Occupational Therapy; 20 visits. Speech Therapy; No Maximum. Non-compliance penalty of $500 per occurrence

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

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 help recovering or have other special health needs	Habilitation services	$25 Co-pay/Visit or 20% Co-Insurance Physical medicine & Rehabilitation Calendar year maximum 60 days	40% Co-Insurance	See Rehabilitation services above.
	Skilled nursing care	20% Co-Insurance	40% Co-Insurance	Calendar Year Maximum 90 days. Non-compliance penalty of $500 per occurrence.
	Durable medical equipment	20% Co-Insurance	40% Co-Insurance	---none---
	Hospice services	No Charge	No Charge	Includes Bereavement Counseling
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	---none---
	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.)

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Infertility Treatment
- Long-Term Care
- Non-emergency Care when traveling outside the U.S.
- Routine Eye Care (Adult)
- 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
- Hearing Aids
- Private-duty Nursing- Covered only when provided through Home Health Care Services

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**.

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

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. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and www.cciio.cms.gov/programs/consumer/capgrants/index.html.

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 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** **$1,500**
- **Specialist copayment** **$50**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **100%**

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$40
Coinsurance	$2,180
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$3,730**

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

- **The plan's overall deductible** **$1,500**
- **Specialist copayment** **$50**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **100%**

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	$1,500
Copayments	$900
Coinsurance	$140
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,600**

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

- **The plan's overall deductible** **$1,500**
- **Specialist copayment** **$50**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **100%**

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	**$1,930**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,180
Copayments	$350
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,530**

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