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, visit www.bac4cabenefits.org . 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/~~dol.gov/ebsa/healthreform~~ or call 626-646-1080 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$250 per person in-network (PPO) and $250 per person out-of-network (Non-PPO).	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Prescription drug and hearing aids are covered (additional copays may apply) before the overall deductible is met.	This plan covers some items and services even if you haven't met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	Yes. $50 deductible for hearing aids. 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?	$2,000 individual / $6,000 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?	Premiums, balance-billed charges, and health care that this plan does not 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 http://providerlookup.healthsmart.com or call 1-866-511-4757 for a list of network providers within the Healthsmart Preferred network.	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	20% coinsurance	40% coinsurance	——————none——————
	Specialist visit	20% coinsurance	40% coinsurance	——————none——————
	Preventive care/screening/ immunization	20% coinsurance	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed 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	——————none——————
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com	Generic drugs	Retail: $10/prescription Mail: $15/prescription	Not Covered	Covers up to a 30-day supply (retail); 31-90 day supply (mail order). Your copay will be higher if you elect to have a brand name drug when a generic drug is available. In this case, your copay would be $15 plus the difference in cost between the brand and generic drug. Requires pre-admission review for specialty drugs.
	Preferred brand drugs	Retail: $20/prescription Mail: $30/prescription	Not Covered	
	Non-preferred brand drugs	Retail: 20% coinsurance Mail: $45/prescription	Not Covered	
	Specialty drugs	20% coinsurance for injectables, see above for other specialty drugs	40% coinsurance for injectables, see above for other specialty drugs	——————none——————
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	——————none——————
	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	20% coinsurance	40% coinsurance	——————none——————

[* For more information about limitations and exceptions, see the plan or policy document at www.bac4cabenefits.org .]

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 a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Not to exceed the hospital's average charge for semi-private room accommodations. Requires pre-admission review.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	——————none——————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	——————none——————
	Inpatient services	20% coinsurance	40% coinsurance	Not to exceed the hospital's average charge for semi-private room accommodations. Requires pre-admission review.
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Pregnancy benefits for dependent children are limited to complications of pregnancy.
	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	——————none——————
	Rehabilitation services	20% coinsurance	40% coinsurance	Non-PPO Provider payment limited to $35 per visit. Physical therapy, chiropractic, and acupuncture services limited to 20 combined visits per year.
	Habilitation services	20% coinsurance	40% coinsurance	——————none——————
	Skilled nursing care	20% coinsurance	40% coinsurance	Must commence within seven days after a period of at least five days confinement in a hospital. Custodial care not included.
	Durable medical equipment	20% coinsurance	40% coinsurance	Limited to specific devices. Refer to SPD.
	Hospice services	20% coinsurance	40% coinsurance	——————none——————
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Covered under separate vision benefit.
	Children's glasses	Not Covered	Not Covered	Covered under separate vision benefit.
	Children's dental check-up	Not Covered	Not Covered	Covered under separate dental benefit.

[* For more information about limitations and exceptions, see the plan or policy document at www.bac4cabenefits.org .]

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 (Adult)
- Infertility treatment
- Long term care
- Non-emergency care while traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Weight loss program

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

- Acupuncture
- Chiropractic care
- Hearing aids
- Routine foot care

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. You may contact the plan at 626-646-1080. You may also contact your state insurance department, 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 on how 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 Trust Administration Office at 626-646-1080, Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA(3272) or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-696-6775.

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 626-646-1080.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag 626-646-1080.]

[Chinese (中文): 如果需要中帮文的助, 请拨打这个号码 626-646-1080.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 626-646-1080.]

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.bac4cabenefits.org .]

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	$250
Specialist *coinsurance*	20%
Hospital *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	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$250
Copayments	$0
Coinsurance	$1,800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$2,060

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

The plan's overall deductible	$250
Specialist *coinsurance*	20%
Hospital *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	$250
Copayments	$100
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$1,370

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

The plan's overall deductible	$250
Specialist *coinsurance*	20%
Hospital *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	$250
Copayments	$10
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$760

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