



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 call Compass Health Administrators at (888) 277-2912. 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/healthreform](http://www.dol.gov/ebsa/healthreform) or call (888) 858-6427 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$0	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	Not applicable.	This <a href="#">plan</a> has no <a href="#">deductible</a> . But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply.
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductible</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$2,000 individual /\$4,000 family for In-Network providers	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they are required to meet their individual <a href="#">out-of-pocket limit</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Premiums, balance-billed charges, out-of-network services, charges in excess of the usual and customary rates, pre-authorization penalties and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.blueshieldca.com/networkppo">www.blueshieldca.com/networkppo</a> or call (888) 858-6427 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services.

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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$15/visit	Not Covered	—————none—————
	<a href="#">Specialist</a> visit	\$15/visit	Not Covered	—————none—————
	<a href="#">Preventive care/screening/immunization</a>	No Charge	Not Covered	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	<a href="#">Diagnostic test</a> (x-ray, blood work, ultrasounds)	20% coinsurance	Not Covered	—————none—————
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not Covered	—————none—————

For more information about limitations and exceptions, see plan or policy document at [www.compasshealthadministrators.com](http://www.compasshealthadministrators.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)	
<p><b>If you need drugs to treat your illness or condition</b>            More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.optumrx.com">www.optumrx.com</a> or call 1-800-334-8134</p>	Generic drugs	Retail: \$10 <a href="#">copayment</a> /prescription Mail Order: \$20 <a href="#">copayment</a> /prescription	Not Covered	Retail: Covers up to a 30-day supply  Mail Order: Covers up to a 90-day supply
	Formulary brand drugs	Retail: \$20 <a href="#">copayment</a> /prescription Mail Order: \$40 <a href="#">copayment</a> /prescription	Not Covered	
	Non-Formulary brand drugs	Retail: 20% with \$75 maximum <a href="#">copayment</a> Mail Order: 20% with \$100 maximum <a href="#">copayment</a>	Not Covered	
	Injectable Drugs (non-specialty)	Retail: Generic - \$10 <a href="#">copayment</a> /prescription Formulary Brand – \$20 <a href="#">copayment</a> /prescription Non-Formulary Brand - 20% with \$50 maximum <a href="#">copayment</a> Mail Order: Not Available	Not Covered	
	<a href="#">Specialty drugs</a>	Retail: 20% with \$75 maximum <a href="#">copayment</a> Mail Order: 20% with \$150 maximum <a href="#">copayment</a>	Not Covered	

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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)	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not Covered	_____none_____
	Physician/surgeon fees	20% coinsurance	Not Covered	_____none_____
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$100 copayment, then 20% coinsurance	\$100 copayment, then 20% coinsurance	_____none_____
	<a href="#">Emergency medical transportation</a>	20% coinsurance	20% coinsurance (emergency) Not Covered (non-emergency)	_____none_____
	<a href="#">Urgent care</a>	\$15/visit	Not Covered	_____none_____
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% coinsurance	Not Covered	Pre-admission certification must be obtained in order to avoid a 50% reduction of benefits.
	Physician/surgeon fees	20% coinsurance/surgeon \$15 copayment/physician visit	Not Covered	_____none_____
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$15/visit	Not Covered	
	Inpatient services	20% coinsurance	Not Covered	Pre-admission certification must be obtained in order to avoid a 50% reduction of benefits.
<b>If you are pregnant</b>	Office visits	\$15/visit	Not Covered	_____none_____
	Childbirth/delivery professional services	20% coinsurance	Not Covered	_____none_____
	Childbirth/delivery facility services	20% coinsurance	Not Covered	Pre-admission certification must be obtained for vaginal deliveries requiring more than a 48 hour stay and for cesarean section deliveries requiring

For more information about limitations and exceptions, see plan or policy document at [www.compasshealthadministrators.com](http://www.compasshealthadministrators.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)	
				more than a 96 hour stay in order to avoid a 50% reduction of benefits.
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	20% coinsurance	Not Covered	Limited to 100 visits per calendar year
	<a href="#">Rehabilitation services</a>	\$15/visit	Not Covered	—————none—————
	<a href="#">Habilitation services</a>	20% coinsurance	Not Covered	—————none—————
	<a href="#">Skilled nursing care</a>	20% coinsurance	Not Covered	Limited to 100 days per calendar year
	<a href="#">Durable medical equipment</a>	20% coinsurance	Not Covered	Rental is covered up to the cost of purchase.
	<a href="#">Hospice services</a>	20% coinsurance	Not Covered	—————none—————
<b>If your child needs dental or eye care</b>	Children's eye exam	Not covered	Not covered	Not covered under the medical plan. Refer to vision plan.
	Children's glasses	Not covered	Not covered	Not covered under the medical plan. Refer to vision plan.
	Children's dental check-up	Not covered	Not covered	Not covered under the medical plan. Refer to dental plan.

**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](#).)**

- |  |   |   |
|--|---|---|
| <ul style="list-style-type: none"> <li>• Hearing Aids</li> <li>• Infertility Treatment</li> <li>• Cosmetic surgery (except due to accidental injury, birth defect or illness or mastectomy)</li> </ul> | <ul style="list-style-type: none"> <li>• Dental care</li> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>• Routine eye care (Adult)</li> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul> |
|--|---|---|

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

- |               |                     |                     |                        |
|---------------|---------------------|---------------------|------------------------|
| • Acupuncture | • Chiropractic care | • Bariatric Surgery | • Private-duty nursing |
|---------------|---------------------|---------------------|------------------------|

For more information about limitations and exceptions, see plan or policy document at [www.compasshealthadministrators.com](http://www.compasshealthadministrators.com).

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact the plan at (888) 277-2912. 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/healthreform](http://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](http://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](http://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 (888) 277-2912. 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/healthreform](http://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](http://www.cciio.cms.gov).

**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](#).

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*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

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**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](#) \$0
- [Specialist copayment](#) \$15
- 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*)

<b>Total Example Cost</b>	<b>\$14,800</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$2,000
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,060</b>

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$15
- 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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$410
Coinsurance	\$42
<i>What isn't covered</i>	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$507</b>

**Mia's Emergency Room Visit**  
(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$15
- Hospital (facility) [copayment/coinsurance](#) \$100/20%
- 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*)

<b>Total Example Cost</b>	<b>\$1,925</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$100
Coinsurance	\$365
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$465</b>