



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) 379-3785. 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 or call (888) 379-3785 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$0	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 ?	Not applicable.	This plan has no deductible . But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	No.	You don't have to meet deductible for specific services.
What is the out-of-pocket limit for this plan ?	\$2,500 individual /\$5,000 family for In-Network providers	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 are required to meet their individual out-of-pocket limit 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, 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 out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes. See www.blueshieldca.com/networkppo or call 1-888-379-3785 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 specialist you choose without a referral .

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	\$15/visit	Not Covered	None
	Specialist visit	\$25/visit	Not Covered	None
	Preventive care/screening/immunization	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	Diagnostic test (x-ray, blood work, ultrasounds)	\$25 copay/x-ray \$ 15 copay/lab	Not Covered	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not Covered	Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits.

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>If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.navitus.com or call 1-844-268-9789.</p>	Generic drugs*	Retail: \$15 copayment /prescription (31-90 Day Supply) Mail Order: \$30 copayment /prescription	Not Covered	*No charge at Costco Pharmacy
	Formulary brand drugs	Retail: \$20 copayment /prescription (31-90 Day Supply) Mail Order: \$40 copayment /prescription	Not Covered	Mail Order: limited to 90-day supply. Costco Pharmacy provides mail order services. Register online at www.pharmacy.costco.com . <i>You do <u>not</u> need to be a Costco member to use Costco Pharmacy.</i>
	Non-Formulary brand drugs	Retail: \$40 copayment /prescription (31-90 Day Supply) Mail Order: \$80 copayment /prescription	Not Covered	Generic contraceptive drugs: No charge.
	Specialty drugs	Retail: 30% coinsurance	Not Covered	Specialty drugs taken for chronic illnesses or complex diseases <u>must</u> be ordered through Lumicera Health Services. Call their Patient Care Specialists at 1-855-847-3553 to fill these prescriptions. Specialty Drugs: Covers up to a 30-day supply

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 outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surgical Center 10% coinsurance	Not Covered	Preauthorization is required. Failure to obtain preauthorization when required may result in non-payment of benefits.
		Other Facilities 20% coinsurance		
	Physician/surgeon fees	20% coinsurance	Not Covered	None
If you need immediate medical attention	Emergency room care	\$150 copayment		Copayment waived if admitted.
	Emergency medical transportation	\$150 copayment		Non-emergency transport is not covered by this plan.
	Urgent care	\$50/visit	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$100 copay + 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
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$50 copay + 20% coinsurance	Not Covered	
	Inpatient services	20% coinsurance	Not Covered	Pre-admission certification must be obtained in order to avoid a 50% reduction of benefits.
If you are pregnant	Office visits	\$25/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 more than a 96 hour stay in order to avoid a 50% reduction of benefits.

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	Home health care	20% coinsurance	Not Covered	Limited to 100 visits per calendar year
	Rehabilitation services	\$15/visit	Not Covered	None
	Habilitation services	20% coinsurance	Not Covered	None
	Skilled nursing care	20% coinsurance	Not Covered	Limited to 100 days per calendar year
	Durable medical equipment	20% coinsurance	Not Covered	Rental is covered up to the cost of purchase.
	Hospice services	20% coinsurance	Not Covered	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not Covered	Not covered under the medical plan. Refer to vision plan.
	Children's eye exam	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"> Hearing Aids Infertility Treatment Cosmetic surgery (except due to accidental injury, birth defect or illness or mastectomy) 	<ul style="list-style-type: none"> Dental care Long-term care Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> Routine eye care (Adult) Routine foot care Weight loss programs Private-duty nursing
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none"> Acupuncture (up to 20 visits per calendar year) 	<ul style="list-style-type: none"> Chiropractic care (up to 20 visits per calendar year) 	<ul style="list-style-type: none"> Bariatric Surgery

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, Employee Benefits Security Administration at 1-866-444-3272 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 (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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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 1-888-379-3785.

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-379-3785.

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-379-3785.

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-379-3785.

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

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For more information about limitations and exceptions, see the plan or policy document at coh-compass.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	\$0
■ Specialist copayment	\$25
■ Hospital (facility) coinsurance	20%
■ Other (generic prescription drug) copay	\$10

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	\$14,800
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$2,000
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	\$0
■ Specialist copayment	\$25
■ Hospital (facility) coinsurance	20%
■ Other (brand prescription drug) copay	\$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
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In this example, Joe would pay:

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

Mia's Emergency Room Visit

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$0
■ Specialist copayment	\$25
■ Hospital (ER) 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	\$1,925
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In this example, Mia would pay:

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