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 https://www.cms.gov/CCIIO/Resources/Forms or call (888) 379-3785 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0**	See the Common Medical Events chart below for your costs for services this plan covers.
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/HPNEPO or call (888) 277-2912 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.	This plan will pay some or all of the costs to see a specialist 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 provider's office or clinic	Primary care visit to treat an injury or illness	$30/visit	Not Covered	——————none——————
	Specialist visit	$50/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)	$20 copayment	Not Covered	——————none——————
	Imaging (CT/PET scans, MRIs)	Freestanding: $100 copayment Hospital: $250 copayment	Not Covered	——————none——————

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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://drexi.com/welcome or call 844-728-3479.	Generic drugs	Retail: $5 copayment /prescription Mail Order: $15 copayment /prescription	Not Covered	Retail: Covers up to a 30-day supply Mail Order: Covers up to a 90-day supply
	Formulary brand drugs	Retail: $30 copayment /prescription Mail Order: $90 copayment /prescription	Not Covered	
	Non-Formulary brand drugs	Retail: $50 copayment /prescription Mail Order: $150 copayment /prescription	Not Covered	
	Specialty drugs	Retail: 30% with $250 maximum copayment Mail Order: 30% with $250 maximum copayment	Not Covered	

For more information about limitations and exceptions, see plan or policy document at www.adept-compass.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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 copayment	Not Covered	——————none——————
	Physician/surgeon fees	$250 copayment	Not Covered	——————none——————
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Copayment waived if admitted.
	Emergency medical transportation	Ground: $100 copayment Air: 20% coinsurance	20% coinsurance (emergency) Not Covered (non-emergency)	——————none——————
	Urgent care	$30/visit	Not Covered	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay	Not Covered	Services must be preauthorized
	Physician/surgeon fees	$500 copay	Not Covered	——————none——————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visit: $30/visit Other services: 20%	Not Covered	
	Inpatient services	$500 copay	Not Covered	Services must be preauthorized
If you are pregnant	Office visits	$30/visit	Not Covered	——————none——————
	Childbirth/delivery professional services	20% coinsurance	Not Covered	——————none——————
	Childbirth/delivery facility services	$500 copay	Not Covered	

For more information about limitations and exceptions, see plan or policy document at www.adept-compass.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	Home health care	20% coinsurance	Not Covered	Limited to 100 visits per calendar year
	Rehabilitation services	$30/visit	Not Covered	60 visit limit per injury
	Habilitation services	20% coinsurance	Not Covered	——————none——————
	Skilled nursing care	Freestanding: no charge Hospital: 20% coinsurance	Not Covered	Limited to 100 days per calendar year
	Durable medical equipment	20% coinsurance	Not Covered	——————none——————
	Hospice services	No charge	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 vison 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.)

- Hearing Aids
- Infertility Treatment
- Cosmetic surgery (except due to accidental injury, birth defect or illness or mastectomy)
- Dental care
- 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.)

- Acupuncture
- Chiropractic care (60 visit max)
- Bariatric Surgery
- Private-duty nursing

For more information about limitations and exceptions, see plan or policy document at www.adept-compass.com.

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 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 888-379-3785.

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

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

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

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

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	$50
Hospital (facility) copay	$500
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	**$14,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$500
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,560**

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	$50
Hospital (facility) copay	$500
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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$150
Coinsurance	$70
What isn't covered	
Limits or exclusions	$17
The total Joe would pay is	**$237**

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

The plan's overall deductible	$0
Specialist copayment	$50
Hospital (facility) copay	$250
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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$250
Coinsurance	$46
What isn't covered	
Limits or exclusions	$40
The total Mia would pay is	**$346**

For more information about limitations and exceptions, see plan or policy document at www.adept-compass.com.