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, (888) 711-5803. or visit www.mmc-compass.com . 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) 711-5803 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**Tier 1 Providers per Calendar Year:** Individual $0; Family $0 **Tier 2 Providers per Calendar Year:** Individual $1,000; Family $2,500 **Tier 3 Providers per Calendar Year:** Individual: 2,500; Family $7,500	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?	**Yes.** Physician visits, urgent care visits, preventive care, rehab services, and prescription drugs are covered before you meet the deductible.	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?	**Tier 1 Providers per Calendar Year:** Individual $1,000; Family $4,000 **Tier 2 Providers per Calendar Year:** Individual $5,000; Family $8,000 **Tier 3 Providers per Calendar Year**: Individual $17,500; Family $17,500 per covered person **Prescription Drugs have a separate out-of-pocket limit:** Individual $1,500, Family $4,500 (Tiers 1 & only)	The out-of-pocket limit is the most you could pay in a calendar year for covered services. If you have other family members on this plan, they have to meet their own out-of-pocket limits. Prescription drugs accrue to a separate prescription out-of-pocket limit.

Important Questions	Answers	Why This Matters:
What is not included in the out-of-pocket limit?	Premiums, balance billing charges, health care this plan doesn't cover, prescriptions, and cost containment penalties for failure to obtain preauthorization when required.	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.** Visit www.blueshieldca.com or call (888) 711-5803 for a list of Tier 2 network providers.	You pay the least if you use a Marshall Medical Center provider (Tier 1). You pay more if you use a network provider other than Marshall Medical Center (Tier 2). You will pay the most if you use a non-network provider (Tier 3) and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing).
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
		Tier 1: Community Medical Center Providers (You will pay the least)	Tier 2: All Other Network Providers (You will pay more)	Tier 3: Non-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	$10 copay	$50 copay	45% after deductible	Copay is applied before the deductible is met. Deductible does not apply to office visit only.
	Specialist visit	$20 copay	$75 copay		
	Preventive care/screening/ immunization	No charge.		45% after deductible	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)	Facility - $20 copay Professional - 10% coinsurance	Facility - 25% coinsurance Professional - 20% coinsurance	45% after deductible	None.

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1: Community Medical Center Providers (You will pay the least)	Tier 2: All Other Network Providers (You will pay more)	Tier 3: Non-Network Provider (You will pay the most)	
	Imaging (CT/PET scans, MRIs)	$150 facility copay 10% professional coinsurance	25% facility coinsurance 20% professional coinsurance	45% after deductible, limited to $800 maximum per test	Preauthorization may be required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at RxHelp@rxbenefits.com	Generic drugs	$10 copay/prescription		Not covered	Retail and Mail order supply up to 90 days for two copayments. No copay for all formulary generic antihypertensives, antihyperlipidemic and antihyperglycemic agents.
	Preferred brand drugs	$40 copay/prescription.		Not covered	
	Non-preferred brand drugs	Not Covered		Not covered.	
	Specialty drugs Generic drugs	20% up to $100		Not covered.	Preauthorization is required.
	Specialty drugs Preferred brand drugs	20% up to $100		Not covered.	Preauthorization is required.
	Specialty drugs Non-preferred brand drugs	20% up to $100		Not covered	Preauthorization is required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	25% coinsurance	45% coinsurance	Preauthorization may be required.
	Physician/surgeon fees	10% coinsurance	20% coinsurance	45% coinsurance	None.
If you need immediate medical attention	Emergency room care	$200 copay + 10% coinsurance			Copay waived if admitted.
	Emergency medical transportation	25% coinsurance			Non-emergent transport is not covered.
	Urgent care	0	$75 copay	45% coinsurance	None.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1: Community Medical Center Providers (You will pay the least)	Tier 2: All Other Network Providers (You will pay more)	Tier 3: Non-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	$250 copay, then 25% coinsurance	$2,000 copay then 45% coinsurance.	Preauthorization is required.
	Physician/surgeon fees	10% coinsurance	20% coinsurance	45% coinsurance	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	20% coinsurance	45% coinsurance	None.
	Inpatient services	10% coinsurance	$250 copay, then 25% coinsurance	$2,000 copay then 45% coinsurance	Preauthorization is required.
If you are pregnant	Office visits	$10 copay/visit	$50 copay/visit	45% coinsurance	None. All services are subject to deductible, except Tier 1 office visits.
	Childbirth/delivery professional services	$20 copay	25% coinsurance	45% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1: Community Medical Center Providers (You will pay the least)	Tier 2: All Other Network Providers (You will pay more)	Tier 3: Non-Network Provider (You will pay the most)	
	Childbirth/delivery facility services	10% coinsurance	$250 copay, then 25% coinsurance	$2,000 copay, then 45% coinsurance	Preauthorization is only required for a stay exceeding 48 hours after normal delivery or 96 hours after C-section.
If you need help recovering or have other special health needs	Home health care	10% coinsurance	20% coinsurance	45% coinsurance	Limited to 100 visits per calendar year.
	Rehabilitation services	10% coinsurance	20% coinsurance	45% coinsurance to $25 maximum payment	Tier 3 limited to $25 max per visit
	Habilitation services	10% coinsurance	20% coinsurance	45% coinsurance to $25 maximum payment	Tier 3 limited to $25 max per visit
	Skilled nursing care	10% coinsurance	$250 copay, then 25% coinsurance	$2000 copay, then 45% coinsurance	Limited to 100 days per calendar year.
	Durable medical equipment	50% coinsurance			
	Hospice services	No Charge		45%	None.
If your child needs dental or eye care	Children's eye exam	Not covered except as required by the Affordable Care Act (ACA) under essential health benefits.			None.
	Children's glasses				None.
	Children's dental check-up				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.)

- Cosmetic Surgery
- Dental Care (adult)
- Infertility
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Orthognathic Surgery
- Private-duty nursing
- 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.)

- Bariatric surgery
- Acupuncture (maximum 12 visits per year)
- Chiropractic Care (maximum 15 visits per year)
- Hearing aids (limited to 1 per year per 36 months)

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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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: Compass Health Administrators at (888) 711-5803 or visit www.compasshealthadministrators.com.

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 888-711-5803.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 888-711-5803.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 888-711-5803.

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-711-5803.

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 *copay*** **$20**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **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	**$35,025**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$20
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$1,000**

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

- **The plan's overall deductible** **$1,000**
- **Specialist *copay*** **$20**
- **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)*

Total Example Cost	**$745**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$745
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$745**

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

- **The plan's overall deductible** **$0**
- **Specialist copay** **$20**
- **ER (facility) coinsurance + copay** **$200+10%**
- **Other coinsurance** **10%**

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	**$6,020**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$200
Coinsurance	$582
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$782**

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