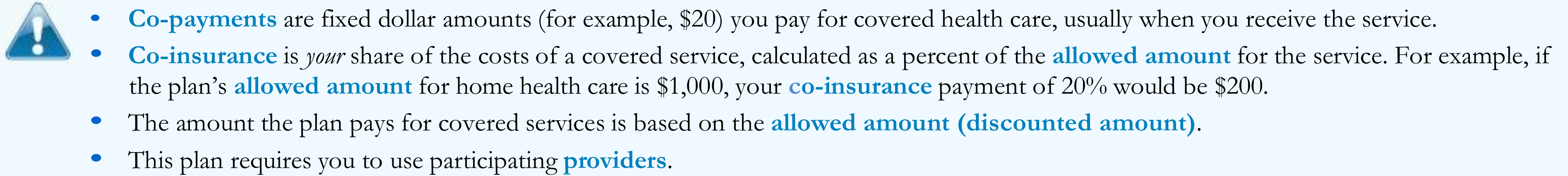
Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 11/01/2014 – 10/31/2015

Coverage for: TEAM Employees&Dependents|PlanType: GOLD

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.healthcomp.com . For network searches: www.blueshieldca.com for CA or www.bcbs.com for all other states ("Find a Health Care Professional Box")

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0** person **/** **$0** family Doesn't apply to preventive care	Not Applicable, you do NOT have a deductible on this medical plan.
Are there other deductibles for specific medical services?	No. There are no other specific **deductibles**.	Not Applicable, you do NOT have a deductible on this medical plan.
Is there an out–of–pocket limit on my expenses?	Yes. For participating **Blue Shield** providers. **$6,000** person **/ $12,000** family	The **out-of-pocket limit** is the most you could pay during a calendar year (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. Prescriptions are not included in the out-of-pocket max.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, RX and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. www.blueshieldca.com (CA) **or** www.bcbs.com (all other states) for a list of participating providers.	You must use a **Blue Shield/BCBS** in-network doctor or other health care **provider** in order to receive coverage for some or all of the costs of covered services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays. *THERE IS NO COVERAGE if you go to providers outside of this Blue Shield network for non-emergent care!* *Life threatening emergencies covered worldwide.*
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan as long as the providers are inside the Blue Shield/BCBS network.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.



- **Co-payments** are fixed dollar amounts (for example, $20) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for home health care is $1,000, your **co-insurance** payment of 20% would be $200.
- The amount the plan pays for covered services is based on the **allowed amount (discounted amount)**.
- This plan requires you to use participating **providers**.

Common Medical Event	Services You May Need	Your cost if you use a Participating Blue Shield Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 co-pay/visit	NOT COVERED	———none———
	Specialist visit	$20 co-pay/visit	NOT COVERED	———none———
	Other practitioner office visit	$30 co-pay/visit for chiropractor and acupuncture	NOT COVERED	Limited to 24 visits per calendar year (additional visits if medically necessary)
	Preventive care/screening/immunization	No charge!	NOT COVERED	
If you have a test	Diagnostic test (x-ray, blood work)	20% (non- preventative care)	NOT COVERED	———none———
	Imaging (CT/PET scans, MRIs)	20%	NOT COVERED	———none———

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.usscript.com**	Generic drugs	$10 co-pay/ RX (30 day retail); $30 co-pay / RX (90 day retail); $20 co-pay / RX (mail order)	NOT COVERED	––––––––none––––––––
	Preferred brand drugs	$40 co-pay/ RX (30 day retail); $120 co-pay / RX (90 day retail); $80 co-pay / RX (mail order)	NOT COVERED	––––––––none––––––––
	Non-preferred brand drugs	$100 co-pay/ RX (30 day retail); $300 co-pay /RX (90 day retail); $200 co-pay /RX mail order	NOT COVERED	––––––––none––––––––
	Specialty drugs	50% co-insurance (30 day supply only)	NOT COVERED	––––––––none––––––––
If you have outpatient surgery	Facility fee (e.g., ambulatory surgical center)	$500 co-pay	NOT COVERED	If admitted to hospital 20%
	Physician/surgeon fees	No Charge	NOT COVERED	––––––––none––––––––
If you need immediate medical attention	Emergency room services	$500 co-pay		$500 waived if admitted to hospital
	Emergency medical transportation/Ambulance	$100 co-pay then 20%		
	Urgent care	$25 co-pay	NOT COVERED	
If you have a hospital stay	Facility fee (e.g., hospital room)	20%	NOT COVERED	––––––––none––––––––
	Physician/surgeon fee	20%	NOT COVERED	––––––––none––––––––

Common Medical Event	Services You May Need	Your cost if you use a Blue Shield Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 co-pay	NOT COVERED	———none———
	Mental/Behavioral health inpatient services	20%	NOT COVERED	———none———
	Substance use disorder outpatient services	$20 co-pay	NOT COVERED	———none———
	Substance use disorder inpatient services	20%	NOT COVERED	———none———
If you are pregnant	Prenatal and postnatal care	$0 co-pay	NOT COVERED	———none———
	Delivery and all inpatient services	20%	NOT COVERED	———none———
If you need help recovering or have other special health needs	Rehabilitation services (substance abuse)	$20 co-pay	NOT COVERED	———none———
	Habilitation services (physical, occupational, speech)	$30 co-pay	NOT COVERED	Limited to 24 visits per calendar year. More visits available if medically necessary.
	Durable medical equipment	20% (max benefit $5,000 per year)	NOT COVERED	Additional benefit if medically necessary must be a designated DME network
	Disposable Medical Supplies	20% (max benefit $2,000 per year)	NOT COVERED	
	Hospice service (at home only)	20%	NOT COVERED	———none———
	Home Health Care	20%	NOT COVERED	Limited to 40 visits per calendar year. 4 hours/day = 1 visit

VISION (Reimbursement Plan)	Eye Exams	$50 every 12 months	NOTE: Unlike medical care which must be received at in-network providers only, vision care can be received at any licensed eye provider, even those outside of the Blue Shield network. The benefits are reimbursed through Healthcomp, our benefits administrator: www.healthcomp.com
	Frames	$100 every 24 months	
	Lenses	$100 every 24 months	
	Contacts in lieu of eyeglasses	$100 every 24 months	
DENTAL (Reimbursement Plan)	Calendar Year Maximum (per person)	$1,500	NOTE 1: Unlike medical care which must be received at in-network providers only, dental care can be received at any licensed dental provider, even those outside of the Blue Shield network. The benefits are reimbursed through Healthcomp, our benefits administrator: www.healthcomp.com • NOTE 2: Benefits are payable up to the "Allowed Amount". Patients are balanced billed for the amounts above this.
	Calendar Year Deductible	$50 Single/ $150 Family Max	
	Preventative Care	100% - No Deductible	
	Basic Care	80% - After Deductible	
	Mayor Care	50% - After Deductible	
	Ortho (Adult and Children)	50% up to $1,500 Lifetime Max	

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Bariatric surgery
- Private-duty nursing
- Routine foot care
- Hearing Aids

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

* Acupuncture
* **Weight Loss Programs**
* Chiropractic

Your Rights to Continue Coverage:

**** Group health coverage sample –**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan administrator at 1-866-363-6270. 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."

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Health Scope our administrator at **www.healthcomp.com** .

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,040
- **Patient pays** $1,500

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Co-pays ($500/day up to $1500 max)	$1500
Co-insurance	$0
Limits or exclusions	$0
Total	**$1,500**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $4,100
- **Plan pays** $3,620
- **Patient pays** $ 480 in Rx co-pays

Sample care costs:

Prescriptions	$1,500
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$730
Education	$290
Laboratory tests	$140
Vaccines, other preventive	$140
Total	**$4,100**

Patient pays:

Deductibles	$0
Co-pays (1 Generic/1 Brand/mo.)	$480
Co-insurance (assume no admission)	$0
Limits or exclusions	$0
Total	**$480**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. *If the care was non-emergent and received out of network, the services would NOT be covered.*

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**.