Bronze Limited Network Plan

Coverage Period: 01/01/2025-12/31/2025

Summary of Benefits and Coverage: What This Plan Covers & What it Costs | Coverage for: Individual/Family | Plan Type: EPO

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 the Member Services number listed on the back of your ID card or visit us at compassgroup.bswift.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 https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/uniform-glossary-final.pdf or call Member Services to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$4,000** person/**$8,000** family for in-network;	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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes, the deductible is waived for **preventive care, screenings, and immunizations**	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?	**$8,000** person/**$16,000** family for in-network; **$1,000** person/**$2,000** family for prescription drugs.	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, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	**Premiums** (deductions), balanced-billed charges, health care this plan doesn't cover, and penalties for failure to obtain pre-certification for services. Prescription drugs have a separate out-of-pocket limit. Lifestyle medications will not apply towards the prescription drug annual out-of-pocket maximum.	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. Call the Member Services number listed on the back of your ID card or visit us at compassgroup.bswift.com 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

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		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.

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
		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	40% **Co-insurance**, after **deductible**	Not Covered	None
	Specialist visit	40% **Co-insurance**, after **deductible**	Not Covered	None
	Preventive care/screening/ immunization	No Charge, **deductible** waived	Not Covered	Limits may apply
If you have a test	Diagnostic test (x-ray, blood work)	40% **Co-insurance**, after **deductible**	Not Covered	None
	Imaging (CT/PET scans, MRIs)	40% **Co-insurance**, after **deductible**	Not Covered	Prior authorization required or services will not be covered.

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		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 www.caremark.com	Generic drugs	$12.50 **copay** (retail) $25 **copay** (mail order)	Not Covered	Coverage is limited up to a 30 day supply (retail) and up to a 90 day supply (mail order). Members are required to fill maintenance medications through the Maintenance Choice program. Other limitations, including prior authorization, may apply.
	Preferred brand drugs	50% **Co-insurance**, min $50, max $100 out-of-pocket (retail) 50% **Co-insurance**, min $100, max $200 out-of-pocket (mail order)	Not Covered	Coverage is limited up to a 30 day supply (retail) and up to a 90 day supply (mail order). Additional costs to the member will apply when a generic is available, but the pharmacy dispenses the brand-name medication for any reason. Members are required to fill maintenance medications through the Maintenance Choice program. Other limitations, including prior authorization, may apply.
	Non-preferred brand drugs	50% **Co-insurance**, min $75, max $150 out-of-pocket (retail) 50% **Co-insurance**, min $150, max $300 out-of-pocket (mail order)	Not Covered	Coverage is limited up to a 30 day supply (retail) and up to a 90 day supply (mail order). Additional costs to the member will apply when a generic is available, but the pharmacy dispenses the brand-name medication for any reason. Members are required to fill maintenance medications through the Maintenance Choice program. Other limitations, including prior authorization, may apply.
	Specialty drugs	50% **Co-insurance**, min $100, max $200	Not Covered	Coverage is limited up to a 30 day supply.

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		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		out-of-pocket		$0.00 cost for eligible drugs if participating in the PrudentRx Copay Program.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% **Co-insurance**, after **deductible**	Not Covered	None
	Physician/surgeon fees	40% **Co-insurance**, after **deductible**	Not Covered	None
If you need immediate medical attention	Emergency room care	40% **Co-insurance**, after **deductible**	40% **Co-insurance**, after **deductible**	None
	Emergency medical transportation	40% **Co-insurance**, after **deductible**	40% **Co-insurance**, after **deductible**	None
	Urgent care	40% **Co-insurance**, after **deductible**	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	40% **Co-insurance**, after **deductible**	Not Covered	Precertification is required
	Physician/surgeon fees	40% **Co-insurance**, after **deductible**	Not Covered	None

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		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	40% **Co-insurance**, after **deductible**	Not Covered	Precertification may be required
	Inpatient services	40% **Co-insurance**, after **deductible**	Not Covered	Precertification is required
If you are pregnant	Office visits	40% **Co-insurance**, after **deductible**	Not Covered	None
	Childbirth/delivery professional services	40% **Co-insurance**, after **deductible**	Not Covered	None
	Childbirth/delivery facility services	40% **Co-insurance**, after **deductible**	Not Covered	None
If you need help recovering or have other special health needs	Home health care	40% **Co-insurance**, after **deductible**	Not Covered	100 days per calendar year. Prior authorization is required or services will not be covered.
	Rehabilitation services	40% **Co-insurance**, after **deductible**	Not Covered	Limits may apply
	Habilitation services	40% **Co-insurance**, after **deductible**	Not Covered	Limits may apply
	Skilled nursing care	40% **Co-insurance**, after **deductible**	Not Covered	120 days per calendar year. Precertification required
	Durable medical equipment	40% **Co-insurance**, after **deductible**	Not Covered	Prior authorization may be required. Limits may apply

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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)	
	Hospice services	40% **Co-insurance**, after **deductible**	Not Covered	Limits may apply
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Excluded
	Children's glasses	Not Covered	Not Covered	Excluded
	Children's dental check-up	Not Covered	Not Covered	Excluded

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.)

- Acupuncture
- Artificial insemination
- Benefits paid as a result of the injuries caused by another party may need to be repaid to the health plan or paid for by another party under certain circumstances
- Cosmetic Surgery
- Dental check- up
- Glasses or Routine eye care (adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Reverse sterilization
- 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 – may be covered with limitations
- Hearing aids – may be covered with limitations
- Orthotics
- Routine foot care – may be covered with limitations

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

- For more information on your rights to continue coverage, contact bswift at compassgroup.bswift.com or 1-877-311-4747
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/agencies/ebsa

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.

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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: [insert applicable contact information from instructions].

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 1-800-755-0790 (BCBS), 1-877-571-9862 (UHC), 866-238-1128 (Aetna).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-755-0790 (BCBS), 1-877-571-9862 (UHC), 866-238-1128 (Aetna).

Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-800-755-0790 (BCBS), 1-877-571-9862 (UHC), 866-238-1128 (Aetna).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-755-0790 (BCBS), 1-877-571-9862 (UHC), 866-238-1128 (Aetna).

Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-800-755-0790 (BCBS), 1-877-571-9862 (UHC), 866-238-1128 (Aetna) uff.

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-800-755-0790 (BCBS), 1-877-571-9862 (UHC), 866-238-1128 (Aetna).

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-755-0790 (BCBS), 1-877-571-9862 (UHC), 866-238-1128 (Aetna).

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 1-800-755-0790 (BCBS), 1-877-571-9862 (UHC), 866-238-1128 (Aetna).

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	$4,000
Specialist *[cost sharing]*	40%
Hospital (facility) *[cost sharing]*	40%
Other *[cost sharing]*	40%

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	**$12,687**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$4,000
Copayments	$11
Coinsurance	$3,427
What isn't covered	
Limits or exclusions	$61
The total Peg would pay is	**$7,498**

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

The plan's overall deductible	$4,000
Specialist *[cost sharing]*	40%
Hospital (facility) *[cost sharing]*	40%
Other *[cost sharing]*	40%

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	**$5,601**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,139
Copayments	$592
Coinsurance	$0
What isn't covered	
Limits or exclusions	$22
The total Joe would pay is	**$1,753**

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

The plan's overall deductible	$4,000
Specialist *[cost sharing]*	40%
Hospital (facility) *[cost sharing]*	40%
Other *[cost sharing]*	40%

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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,795
Copayments	$5
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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