



BMW Northwest – Gold Plan

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
Coastal Administrative Services: Medical Plan

Coverage Period: 10/01/2026 – 09/30/2027
Coverage for: EE/EE+SP/EE+CH(n)/FAM | **Plan Type:** RBP



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 CAS at 855-373-8232. 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.casbenefits.com or call 1-855-373-8232 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$375 Individual / \$1,125 Family	Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> , office visits, office surgery, outpatient diagnostic services, and prescription drugs are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$6,350 Individual / \$12,700 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billed charges</u> , and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	No. For questions on provider access, see www.casbenefits.com or call 855-373-8232.	This <u>plan</u> does not use a provider <u>network</u> . You can receive covered services from any licensed provider.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No, you do not need a referral to see a specialist.	You can see the <u>specialist</u> you choose without permission from this plan.



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
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness		\$20 <u>copay</u> /visit <u>deductible</u> waived		
	<u>Specialist</u> visit		\$20 <u>copay</u> /visit <u>deductible</u> waived		
	<u>Preventive care/screening/immunization</u>		No charge		You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (blood work) & <u>Imaging</u> (CT/PET scans, MRIs and X-rays)		10% <u>coinsurance</u> , <u>deductible</u> waived		<u>Preauthorization</u> is required for CT/PET scans, MRIs. No charge for diagnostic tests (blood work and X-rays) done at an office visit.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.liviniti.com	Generic drugs (Tier 1)		\$15 <u>copay</u> /prescription, deductible waived (retail); \$30 <u>copay</u> /prescription, then deductible waived (mail order)	\$15 <u>copay</u> /prescription, 40% <u>coinsurance</u> deductible waived (retail); Not Covered (mail order)	Covers up to a <u>30-day supply</u> (<u>retail</u> subscription); <u>90 day supply</u> and must be purchased through Southern Scripts Mail order (<u>mail order</u> prescription). <u>Cost sharing</u> does not apply to certain <u>preventive care drugs</u> . Specialty Drugs are limited to a 30-day supply. If you are using a specialty drug that costs \$5,000 or more, you may be eligible for an alternate program to help reduce cost.
	Formulary drugs (Tier 2)		\$35 <u>copay</u> /prescription, deductible waived (retail); \$70 <u>copay</u> /prescription, deductible waived (mail order)	\$35 <u>copay</u> /prescription, 40% <u>coinsurance</u> deductible waived (retail); Not Covered (mail order)	
	Non-Formulary brand drugs (Tier 3)		\$35 <u>copay</u> /prescription, deductible waived (retail); \$70 <u>copay</u> /prescription, deductible waived (mail order)	\$35 <u>copay</u> /prescription, 40% <u>coinsurance</u> deductible waived (retail); Not Covered (mail order)	
	Specialty drugs (Tier 4)	Drugs costing up to \$5,000	\$75 copay, deductible waived	Not Covered	
		Drugs costing \$5,000 or more	20% <u>coinsurance</u> up to \$500 copay, deductible waived	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)		10% <u>coinsurance</u> after <u>deductible</u>		<u>Preauthorization</u> is required for surgeries.
	Physician/surgeon fees		10% <u>coinsurance</u> after <u>deductible</u>		Anesthesia: 10% <u>coinsurance</u> after deductible

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you need immediate medical attention	<u>Emergency room care</u>	\$100 <u>copay</u> , then 10% <u>coinsurance</u> after <u>deductible</u>	Copay waived if directly admitted
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u> after <u>deductible</u>	
	<u>Urgent care</u>	\$20 <u>copay</u> /visit <u>deductible</u> waived	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u> after <u>deductible</u>	<u>Preauthorization</u> is required for inpatient hospital stays
	Physician/surgeon fees	10% <u>coinsurance</u> after <u>deductible</u>	Anesthesia: 10% <u>coinsurance</u> after <u>deductible</u>
If you need mental health, behavioral health, or substance abuse services	Inpatient/Outpatient Facility	10% <u>coinsurance</u> after <u>deductible</u>	<u>Preauthorization</u> is required for inpatient services.
	Inpatient Physician	10% <u>coinsurance</u> after <u>deductible</u>	
	Outpatient Physician	\$20 <u>copay</u> /visit <u>deductible</u> waived	
If you are pregnant	Office visits	\$20 <u>copay</u> / visit <u>deductible</u> waived	Some prenatal services are covered <u>preventive care services</u> and available to all covered persons. <u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Only employees and spouses are covered for all other maternity services. Depending on the type of services, <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% <u>coinsurance</u> after <u>deductible</u>	
	Childbirth/delivery facility services	10% <u>coinsurance</u> after <u>deductible</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u> after <u>deductible</u>	130 visits/Calendar Year
	<u>Rehabilitation services</u>	Inpatient: 10% <u>coinsurance</u> after <u>deductible</u>	Inpatient: Limited to 30 days per Calendar Year. Combined with Occupational, Physical & Speech Therapy
		Outpatient: \$20 <u>copay</u> /visit <u>deductible</u> waived	Outpatient: Limited to 45 visits per Calendar year. Combined with Massage, Occupational, Physical & Speech Therapy

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
	<u>Habilitation services</u>	Inpatient: 10% <u>coinsurance</u> after <u>deductible</u>	Inpatient: Limited to 30 days per Calendar Year. Combined with Occupational, Physical & Speech Therapy
		Outpatient: \$20 <u>copay</u> /visit <u>deductible waived</u>	Outpatient: Limited to 45 visits per Calendar year. Combined with Neurodevelopmental (<i>children under age 7</i>), Occupational, Physical & Speech Therapy
	<u>Skilled nursing care</u>	10% <u>coinsurance</u> after <u>deductible</u>	60 visits/calendar year
	<u>Durable medical equipment</u>	10% <u>coinsurance</u> after <u>deductible</u>	
	<u>Hospice services</u>	10% <u>coinsurance</u> after <u>deductible</u>	Limited to 6 months of care/lifetime, including 10 Inpatient days. <u>Preauthorization</u> is required for hospice services.
If your child needs dental or eye care	Children's eye exam	Not Covered	Please see vision benefit.
	Children's glasses	Not Covered	Please see vision benefit.
	Children's dental check-up	Not Covered	Please see dental benefit.

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 • Bariatric Surgery • Weight Loss Programs	• Long Term Care • Private Duty Nursing • Non-emergent care when traveling outside the U.S.	• Routine Foot Care • Infertility Treatment
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture • Hearing Aids	• Chiropractic Care	• Routine Eye Care (Adult)

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: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or <https://www.dol.gov/ebsa/healthreform>. 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: 1-855-373-8232

Does this plan provide Minimum Essential Coverage? Yes.

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 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 1-855-373-8232

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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 pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$375
■ <u>Specialist</u> copayment	\$20
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	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	\$12,800
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In this example, Peg would pay:

Cost Sharing	
Deductibles*	\$375
Copayments	\$180
Coinsurance	\$1,225
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$1,840

Managing Joe's type 2 Diabetes

(a year of routine care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$375
■ <u>Specialist</u> copayment	\$20
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	10%

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*	\$375
Copayments	\$240
Coinsurance	\$679
What isn't covered	
Limits or exclusions	\$60
The total Joe would pay is	\$1,354

Mia's Simple Fracture

(emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$375
■ Emergency Room <u>copayment</u>	\$100
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	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	\$6,900
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In this example, Mia would pay:

Cost Sharing	
Deductibles*	\$375
Copayments	\$100
Coinsurance	\$642
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,117