



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 888-379-3785 or coh-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.healthcare.gov/sbc-glossary/ or call 888-379-3785 to request a copy.

Important Questions	Answers	Why This Matters:
<u>What is the overall deductible?</u>	<u>In-Network</u> per Calendar Year: Individual \$1,750; Family \$3,500	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 .
	<u>Out-of-Network</u> per Calendar Year: Individual \$3,500; Family \$7,000	
<u>Are there services covered before you meet your deductible?</u>	Yes. Preventive care, physician office visits and generic prescription drug co-payments from Participating Providers .	For example, this plan covers certain preventive care services without cost-sharing and before you meet your deductible . See a list of covered preventive care services at https://www.healthcare.gov/coverage/preventive-care-benefits/
<u>Are there other deductibles for specific services?</u>	No.	You don't have to meet deductibles for specific services.
<u>What is the out-of-pocket limit for this plan?</u>	<u>In-Network</u> per Calendar Year: Individual \$2,500; Family \$5,000	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 have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
	<u>Out-of-Network</u> per Calendar Year: Individual \$10,000; Family \$20,000/	
<u>What is not included in the out-of-pocket limit?</u>	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 .
<u>Will you pay less if you use a network provider?</u>	Yes. See www.blueshieldca.com/networkppo or call 888-379-3785 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.	You can see a specialist you choose without a referral .
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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
		In-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	20% coinsurance	40% coinsurance	Telehealth visit coverage included (treated same as a traditional office visit).
	Specialist visit	20% coinsurance	40% coinsurance	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.
	Telemedicine through Teladoc	No charge.	Not covered.	Applies to general physician telemedicine visits through the Plan's designated vendor for such services. Telephone consultations with other physicians will be paid under the appropriate benefit category (e.g. physician office visit) for the service.
	Hanford Employee Health Center	\$10 fee until deductible is met, then covered at 100%.	Not covered.	None.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-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.navitus.com or call 1-844-268-9789.	Generic drugs (Tier 1)*	Retail \$10/prescription Mail Order \$20/prescription	Not covered.	*Tier 1: No charge at Costco Pharmacy after deductible is met Retail: limited to 30-day supply.
	Preferred brand drugs (Tier 2)	Retail \$20/prescription Mail Order \$40/prescription	Not covered.	Mail Order: limited to 90-day supply. Costco Pharmacy provides mail order services. Register online at www.pharmacy.costco.com . <i>You do not need to be a Costco member to use Costco Pharmacy.</i> Generic contraceptive drugs: No charge.
	Non-preferred brand drugs (Tier 3)	Retail \$50/prescription Mail Order \$100/prescription	Not covered.	
	Specialty drugs (Tier 4)	30% coinsurance	Not covered.	Specialty drugs taken for chronic illnesses or complex diseases <u>must</u> be ordered through Lumicera Health Services. Call their Patient Care Specialists at 1-855-847-3553 to fill these prescriptions. Limited to 30-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory Surgical Center 10% coinsurance Other Facilities 20% coinsurance	40% coinsurance up to \$350 maximum/day, plus 100% of additional charges	Preauthorization is required. Failure to obtain preauthorization when required may result in non-payment of benefits.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None.
If you need immediate medical attention	Emergency room care	20% coinsurance		None.
	Emergency medical transportation	20% coinsurance		Non-emergency transport is not covered by this plan.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Urgent care	20% coinsurance	40% coinsurance	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance up to \$600/day, then 100%	Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	Other Services: Includes Intensive Outpatient Program.
	Inpatient services	20% coinsurance	Residential Care 40% coinsurance up to \$600/admission, then 100%	Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits.
			Partial Hospitalization 40% coinsurance up to \$350/day, then 100%	
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Cost-sharing does not apply to certain preventive services . Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	None.
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance up to \$600/day, then 100%	Preauthorization is only required for 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	20% coinsurance	Not covered.	Limited to 100 visits per Calendar Year.
	Rehabilitation services	20% coinsurance	40% coinsurance	Out-of-network provider subject to a maximum allowable amount of \$350/day.
	Habilitation services			
	Skilled nursing care	20% coinsurance	Freestanding Skilled Nursing Facility 40% coinsurance	Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits.
			Hospital-based Facility 40% coinsurance up to \$600/day, then 100%	

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-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	Durable medical equipment	20% coinsurance	40% coinsurance	Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits.
	Hospice services	No charge.	Not covered.	Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits.
If your child needs dental or eye care	Children's eye exam		Not covered.	None.
	Children's glasses		Not covered.	None.
	Children's dental check-up		Not covered.	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](#).)

<ul style="list-style-type: none"> • Cosmetic surgery • Dental care (Adult) • Dental check-up (Child) • Eye exam (Child) 	<ul style="list-style-type: none"> • Glasses (Child) • Hearing aids • Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> • Private duty nursing (not related to hospice care) • Routine eye care (Adult) • Routine foot care • Weight loss programs
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

<ul style="list-style-type: none"> • Acupuncture (up to 20 visits per calendar year) 	<ul style="list-style-type: none"> • Bariatric Surgery 	<ul style="list-style-type: none"> • Chiropractic Care (up to 20 visits per calendar year)
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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 1-877-696-6775 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 1-888-379-3785. 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 1-877-696-6775 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 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 1-866-684-1628.

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-379-3785.

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-379-3785.

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-379-3785.

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

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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	\$1,750
■ Specialist coinsurance	20%
■ Hospital(facility) coinsurance	20%
■ Other (generic prescription drug) copay	\$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	\$12,840
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,750
Copayments	\$10
Coinsurance	\$1,480
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$3,300

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$1,750
■ Specialist coinsurance	20%
■ Hospital(facility) coinsurance	20%
■ Other (brand prescription drug) copay	\$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	\$7,460
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$1,750
Copayments	\$20
Coinsurance	\$110
What isn't covered	
Limits or exclusions	\$60
The total Joe would pay is	\$1,940

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$1,750
■ Specialist coinsurance	20%
■ Hospital (ER) coinsurance	20%
■ 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	\$2,010
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,750
Copayments	\$0
Coinsurance	\$310
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,060

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.