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:
What is the overall deductible?	**In-Network per Calendar Year:** Individual $250; Family $500 **Out-of-Network per Calendar Year:** Individual $3,000; Family $6,000	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.** 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/
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?	**In-Network per Calendar Year:** Individual $1,600; Family $3,200 **Out-of-Network per Calendar Year:** Individual $10,000; Family $20,000	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.
What is not included in the out-of-pocket limit?	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.
Will you pay less if you use a network provider?	**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 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
		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 or Specialist visit to treat an injury or illness	**Office Visit** $15 copay/visit **Other Office Services**: 20% coinsurance	40% coinsurance	Copay is applied before the deductible is met. Deductible does not apply to office visit only. Telehealth visit coverage included (treated same as a traditional office visit).
	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	No charge.	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.

*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 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 copay/prescription	**Retail** $10 copay/prescription then 25% coinsurance	***Tier 1:** No charge at Costco Pharmacy **Generic contraceptive drugs:** No charge. **Retail:** Limited to 30-day supply. **Mail Order:** Limited to 90-day supply. Costco Pharmacy provides mail order services. Register online at www.pharmacy.costco.com. *You do not need to be a Costco member to use Costco Pharmacy.*
		Mail Order: $20 copay/prescription	**Mail Order** Not covered.	
	Preferred brand drugs (Tier 2)	**Retail:** $25 copay/prescription	**Retail** $25 copay/prescription then 25% coinsurance	
		Mail Order: $50 copay/prescription	**Mail Order** Not covered.	
	Non-preferred brand drugs (Tier 3)	**Retail:** $40 copay/prescription	**Retail** $40 copay/prescription then 25% coinsurance	
		Mail Order: $80 copay/prescription	**Mail Order** Not covered.	
	Specialty drugs (Tier 4)	30% coinsurance/ prescription	Not covered.	Specialty drugs taken for chronic illnesses or complex diseases must be ordered through Lumicera Health Services. Call their Patient Care Specialists at 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	40% coinsurance up to $350, then 100%	Preauthorization is required. Failure to obtain preauthorization when required may result in non-payment of benefits.
		Other Facilities 20% coinsurance		
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None.
If you need immediate medical attention	Emergency room care	20% coinsurance		None.

*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)	
	Emergency medical transportation	20% coinsurance		Non-emergency transport is not covered by this plan.
	Urgent care	$15 copay/office visit + 20% coinsurance for all other services	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	**Office Visit** $15 copay/visit **All Other Services/ Facilities** 20% coinsurance	40% coinsurance	**Other Services:** Includes Intensive Outpatient Program.
	Inpatient services	**Residential Care and Partial Hospitalization** 20% coinsurance	**Residential Care** 40% coinsurance up to $600/day, then 100% **Partial Hospitalization** 40% coinsurance up to $350/day, then 100%	Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits.
If you are pregnant	Office visits	**Prenatal** No cost to Participant. **Postnatal** $15 copay/visit **Other Services** 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	$100 copay, then 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.

*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	Home health care	20% coinsurance	Not covered.	Limited to 100 visits per Calendar Year.
	Rehabilitation services	**Office Visit** $15 copay/visit	40% coinsurance	None.
	Habilitation services	**Other Office Services/ Outpatient Facility** 20% coinsurance		
	Skilled nursing care	20% coinsurance	**Freestanding Skilled Nursing Facility** 40% coinsurance **Hospital-based Facility** 40% coinsurance up to $600/day, then 100%	Preauthorization is required. Failure to obtain preauthorization may result in non-payment of benefits. Limited to 100 visits per Calendar Year.
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 cost to Participant.	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.)

- Cosmetic surgery (except due to accidental injury, birth defect or illness or mastectomy)
- Dental care
- Hearing Aids
- Infertility Treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

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

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture (up to 20 visits per calendar year)	• Bariatric surgery	• Chiropractic care (up to 20 visits/calendar year)

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.

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

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** **$250**
- **Specialist copayment** **$15**
- **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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$250
Copayments	$180
Coinsurance	$2,350
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$2,780**

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

- **The plan's overall deductible** **$250**
- **Specialist copayment** **$15**
- **Hospital(facility) coinsurance** **20%**
- **Other (brand prescription drug) copay** **$25**

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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$250
Copayments	$60
Coinsurance	$210
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$580**

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

- **The plan's overall deductible** **$250**
- **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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$250
Copayments	$0
Coinsurance	$373
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$623**

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