



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](http://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/](http://www.healthcare.gov/sbc-glossary/) or call 888-379-3785 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	<b>In-Network</b> per Calendar Year: Individual \$1,750; Family \$3,500	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
	<b>Out-of-Network</b> per Calendar Year: Individual \$3,500; Family \$7,000	
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	<b>Yes.</b> Preventive care, physician office visits and generic <a href="#">prescription drug co-payments</a> from Participating <a href="#">Providers</a> .	For example, this <a href="#">plan</a> covers certain <a href="#">preventive care</a> services without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive care</a> services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	<b>No.</b>	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	<b>In-Network</b> per Calendar Year: Individual \$2,500; Family \$5,000  <b>Out-of-Network</b> per Calendar Year: Individual \$10,000; Family \$20,000/	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	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 <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	<b>Yes.</b> See <a href="http://www.blueshieldca.com/networkppo">www.blueshieldca.com/networkppo</a> or call 888-379-3785 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider</a> network. You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance-billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.

Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see a <a href="#">specialist</a> you choose without a <a href="#">referral</a> .
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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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Telehealth visit coverage included (treated same as a traditional office visit).
	<a href="#">Specialist</a> visit	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None.
	<a href="#">Preventive care/screening/</a> immunization	No charge.	Not covered.	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> 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	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None.
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. Failure to obtain <a href="#">preauthorization</a> 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)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.navitus.com">www.navitus.com</a> or call 1-844-268-9789.	Generic drugs (Tier 1)*	<b>Retail</b> \$10/prescription <b>Mail Order</b> \$20/prescription	Not covered.	<b>*Tier 1:</b> No charge at Costco Pharmacy after deductible is met  <b>Retail:</b> limited to 30-day supply.
	Preferred brand drugs (Tier 2)	<b>Retail</b> \$20/prescription <b>Mail Order</b> \$40/prescription	Not covered.	<b>Mail Order:</b> limited to 90-day supply. Costco Pharmacy provides mail order services. Register online at <a href="http://www.pharmacy.costco.com">www.pharmacy.costco.com</a> . <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)	<b>Retail</b> \$50/prescription <b>Mail Order</b> \$100/prescription	Not covered.	
	<a href="#">Specialty drugs</a> (Tier 4)	30% <a href="#">coinsurance</a>	Not covered.	<a href="#">Specialty drugs</a> taken for chronic illnesses or complex diseases <u>must</u> be ordered through Luminera Health Services. Call their Patient Care Specialists at 1-855-847-3553 to fill these prescriptions. Limited to 30-day supply.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	<b>Ambulatory Surgical Center</b> 10% <a href="#">coinsurance</a> <b>Other Facilities</b> 20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a> up to \$350 maximum/day, plus 100% of additional charges	<a href="#">Preauthorization</a> is required. Failure to obtain <a href="#">preauthorization</a> when required may result in non-payment of benefits.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	20% <a href="#">coinsurance</a>		None.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>		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)	
	<a href="#">Urgent care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a> up to \$600/day, then 100%	<a href="#">Preauthorization</a> is required. Failure to obtain <a href="#">preauthorization</a> may result in non-payment of benefits.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<b>Other Services:</b> Includes Intensive Outpatient Program.
	Inpatient services	20% <a href="#">coinsurance</a>	Residential Care 40% <a href="#">coinsurance</a> up to \$600/admission, then 100%	<a href="#">Preauthorization</a> is required. Failure to obtain <a href="#">preauthorization</a> may result in non-payment of benefits.
			Partial Hospitalization 40% <a href="#">coinsurance</a> up to \$350/day, then 100%	
If you are pregnant	Office visits	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Cost-sharing does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None.
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a> up to \$600/day, then 100%	<a href="#">Preauthorization</a> 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	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	Not covered.	Limited to 100 visits per Calendar Year.
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Out-of-network provider</a> subject to a maximum allowable amount of \$350/day.
	<a href="#">Habilitation services</a>			
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	Freestanding Skilled Nursing Facility 40% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. Failure to obtain <a href="#">preauthorization</a> may result in non-payment of benefits.
			Hospital-based Facility 40% <a href="#">coinsurance</a> up to \$600/day, then 100%	

\*For more information about limitations and exceptions, see the plan or policy document at [www.coh-compass.com](http://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	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. Failure to obtain <a href="#">preauthorization</a> may result in non-payment of benefits.
	<a href="#">Hospice services</a>	No charge.	Not covered.	<a href="#">Preauthorization</a> is required. Failure to obtain <a href="#">preauthorization</a> 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"> <li>• Cosmetic surgery</li> <li>• Dental care (Adult)</li> <li>• Dental check-up (Child)</li> <li>• Eye exam (Child)</li> </ul>	<ul style="list-style-type: none"> <li>• Glasses (Child)</li> <li>• Hearing aids</li> <li>• Infertility treatment</li> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Private duty nursing (not related to hospice care)</li> <li>• Routine eye care (Adult)</li> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul>
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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"> <li>• Acupuncture (up to 20 visits per calendar year)</li> </ul>	<ul style="list-style-type: none"> <li>• Bariatric Surgery</li> </ul>	<ul style="list-style-type: none"> <li>• Chiropractic Care (up to 20 visits per calendar year)</li> </ul>
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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](http://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](http://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](http://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](http://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](http://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.

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*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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,750
■ <a href="#">Specialist coinsurance</a>	20%
■ <a href="#">Hospital(facility) coinsurance</a>	20%
■ Other (generic prescription drug) <a href="#">copay</a>	\$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*)

<b>Total Example Cost</b>	<b>\$12,840</b>
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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
<b>The total Peg would pay is</b>	<b>\$3,300</b>

### Managing Joe's type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,750
■ <a href="#">Specialist coinsurance</a>	20%
■ <a href="#">Hospital(facility) coinsurance</a>	20%
■ Other (brand prescription drug) <a href="#">copay</a>	\$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*)

<b>Total Example Cost</b>	<b>\$7,460</b>
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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
<b>The total Joe would pay is</b>	<b>\$1,940</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$1,750
■ <a href="#">Specialist coinsurance</a>	20%
■ Hospital (ER) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$2,010</b>
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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
<b>The total Mia would pay is</b>	<b>\$2,060</b>

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