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, visit www.cok-compass.com or call 1-888-435-3695. 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.healthcare.gov/sbc-glossary/ or call 1-888-435-3695 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers $250/person and $500/family per Calendar Year. For out-of-network providers $450/person and $900 family per calendar year.	See the Common Medical Events chart below for your costs for services this plan covers. 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, some benefits subject to a co-pay, and prescription drug expenses.	This plan covers some items and services even if you haven't met the deductible amount. But a copayment or coinsurance may apply.
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?	For in-network providers $2,500/person and $5,000/family per Calendar Year. For out-of-network providers $5,000/person and $10,000 family per calendar year.	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?	Prescription drug co-pays and coinsurance, premiums, balance-billed charges, 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/fad/home or call **888-435-3695** for a list of in-network providers. For MH/SA network providers, see https://halcyonbehavioral.com/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 that 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 visit to treat an injury or illness	$20/visit. Deductible does not apply.	50% coinsurance	None
	Specialist visit	$20/visit. Deductible does not apply.	50% coinsurance	None
	Other practitioner office visit	$10/visit. Deductible does not apply.	$10/visit. Deductible does not apply.	Applicable to chiropractic services and limited to 30 visits/ calendar year.
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	Precertification required.*
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	None
	Physician/surgeon fees	20% coinsurance	50% coinsurance	Precertification required for some services.*
If you need immediate medical attention	Emergency room care	20% coinsurance after $75 copay/visit.	20% coinsurance after $75 copay/visit.	Limited to treatment of a medical emergency. The co-pay is waived if admitted within 24 hours. The in-network deductible and out-of-pocket amounts apply to the out-of-network benefit.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Limited to transport during a medical emergency when medically necessary. The in-network deductible and out-of-pocket amounts apply to the out-of-network benefit.
	Urgent care center	20% coinsurance	50% coinsurance	The office visit benefit will apply to urgent care services provided in a physician office visit setting.

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 have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance after $500 co-pay/admission	Precertification required.*
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15/visit. Deductible does not apply.	50% coinsurance	Network and Utilization Management are handled by Halcyon Behavioral. Certain behavioral health services are not covered.
	Inpatient services	20% coinsurance	50% coinsurance after $500 co-pay/admission	Network and Utilization Management are handled by Halcyon Behavioral. Certain behavioral health services are not covered. Precertification required. *
If you are pregnant	Office visits	20% coinsurance	50% coinsurance	
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	None
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance after $500 co-pay/admission	None
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Limited to 100 visits/calendar year (4 hours = 1 visit).
	Rehabilitation services	20% coinsurance	50% coinsurance	Includes physical, speech, occupational, and other rehabilitative therapies. Physical and occupational therapies are limited to a combined maximum of 30 outpatient visits/calendar year. Speech therapy is limited to 20 outpatient visits/calendar year.
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	20% coinsurance	50% coinsurance	Precertification required.* Limited to 100 days/calendar year.
	Durable medical equipment	20% coinsurance	50% coinsurance	Precertification required.*
	Hospice services	20% coinsurance	50% coinsurance	Precertification required.*
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

* Precertification is required before certain medical services. Emergency admissions must be certified within 48 hours following the admission. To precertify services, call the phone number indicated on your ID card. **Failure to precertify out-of-network services may result in a penalty.**

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		COSTCO Preferred Retail Pharmacy (31 day supply)	Other Retail Pharmacy (31 day supply)	COSTCO Mail Order and COSTCO Retail Extended Day Supply (90 day supply):	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.navitus.com	Individual Out-of-Pocket Limit	$2,500			Includes prescription drug co-pays and coinsurance. The out-of-pocket limit is the most you could pay during a calendar year for your share of the cost of covered expenses. When an individual or family reaches the annual limit, the Plan pays 100% of additional covered expenses for the rest of the calendar year. Balance-billed charges and penalties do not apply to the out-of-pocket amount.
	Family Out-of-Pocket Limit	$5,000			
	Generic drugs	$5/prescription. Deductible does not apply.	$15/prescription. Deductible does not apply.	$15/prescription. Deductible does not apply.	Certain medications considered preventive care under ACA are payable at no cost-share to the member. The Prescription Drug Plan will pay up to the generic price, less the generic co-pay, whenever a generic drug is dispensed. If a preferred or non-preferred brand name drug is dispensed, and a generic equivalent is available, the covered person must pay the difference between the cost of the preferred or non-preferred brand name drug and the generic equivalent, plus the generic co-pay unless the *physician* specifies "Dispense as Written".
	Preferred brand drugs	$20/prescription. Deductible does not apply.	$30/prescription. Deductible does not apply.	$35/prescription. Deductible does not apply.	
	Non-preferred brand drugs	$30/prescription. Deductible does not apply.	$45/prescription. Deductible does not apply.	$65/prescription. Deductible does not apply.	
	Specialty drugs (up to a 30 day supply)/ Specialty Pharmacy	Not applicable	20% coinsurance up to $150 maximum/ prescription. Deductible does not apply.	Not applicable	

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
- Cosmetic surgery
- Dental care (adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (adult)
- Routine foot care
- 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
- Chiropractic care
- Inpatient private duty nursing

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 Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, www.cms.gov/cciio 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: Compass Health Administrators, 1-888-435-3695, www.cok-compass.com.

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 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 1-888-435-3695.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-435-3695.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-888-435-3695.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-435-3695.

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	$250
Specialist copayment	$20
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$250
Copayments	$20
Coinsurance	$2,160
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,490**

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	$20
Hospital (facility) coinsurance	20%
Other coinsurance	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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$120
Copayments	$510
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$650**

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

The plan's overall deductible	$250
Specialist copayment	$20
Hospital (facility) 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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$250
Copayments	$75
Coinsurance	$390
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$715**

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