
 **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.myhnas.com](http://www.myhnas.com) or call 1-855-323-1131. 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.myhnas.com](http://www.myhnas.com) or call 1-855-323-1131 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	For in-network <a href="#">providers</a> \$4,000/person and \$8,000/family. For out-of-network <a href="#">providers</a> \$10,000/person and \$20,000/family.	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this plan 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> . The in-network and out-of-network deductibles are not combined.
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes, preventive care.	This <a href="#">plan</a> covers some items and services even if you haven't met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> 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>	No.	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>	For in-network <a href="#">providers</a> \$6,450/person and \$12,900/family. For out-of-network <a href="#">providers</a> \$12,900/person and \$25,800/family.	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. The in-network and out-of-network out-of-pocket amounts are separate and do not apply towards each other.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	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 <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://www.blueshield.com/networkPPO">www.blueshield.com/networkPPO</a> or call 1-800-541-6652 for a list of <a href="#">network providers</a> in CA; or 1-800-810-2583 outside of CA.	This <a href="#">plan</a> uses a <a href="#">provider network</a> . 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 <a href="#">provider's charge</a> and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware that 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.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	30% <a href="#">coinsurance</a> *	50% <a href="#">coinsurance</a> *	None
	<a href="#">Specialist</a> visit	30% <a href="#">coinsurance</a> *	50% <a href="#">coinsurance</a> *	None
	Teladoc	30% <a href="#">coinsurance</a> *	Not applicable	None
	Chiropractic visit	30% <a href="#">coinsurance</a> *	50% <a href="#">coinsurance</a> *	Limited to 60 visits per calendar year.
	Acupuncture visit	30% <a href="#">coinsurance</a> *	50% <a href="#">coinsurance</a> *	Limited to 12 visits per calendar year.
	<a href="#">Preventive care/screening/immunization</a>	No charge. <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a> *	Includes preventive services as mandated by ACA. You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	30% <a href="#">coinsurance</a> *	50% <a href="#">coinsurance</a> *	None
	Imaging (CT/PET scans, MRIs)	30% <a href="#">coinsurance</a> *	50% <a href="#">coinsurance</a> * to a max benefit of \$800/procedure	None
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	30% <a href="#">coinsurance</a> *	50% <a href="#">coinsurance</a> * to a max benefit of \$350/day	Precertification required for certain procedures.**
	Physician/surgeon fees	30% <a href="#">coinsurance</a> *	50% <a href="#">coinsurance</a> *	None
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$150 copay*	Paid as in-network	None
	<a href="#">Emergency medical transportation</a>	30% <a href="#">coinsurance</a> *	Paid as in-network	Precertification is required for non-emergent air ambulance and limited to \$50,000 for out-of-network transport. Out-of-network, non-emergent transport will be covered at 50% <a href="#">coinsurance</a> *.
	<a href="#">Urgent care</a>	30% <a href="#">coinsurance</a> *	50% <a href="#">coinsurance</a> *	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	30% <a href="#">coinsurance</a> *	50% <a href="#">coinsurance</a> * to a max benefit of \$1,000/day	Precertification required.**
	Physician/surgeon fees	30% <a href="#">coinsurance</a> *	50% <a href="#">coinsurance</a> *	None

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 mental health, behavioral health, or substance abuse services</b>	Outpatient services	30% <u>coinsurance</u> *	50% <u>coinsurance</u> *	None
	Inpatient services	30% <u>coinsurance</u> *	50% <u>coinsurance</u> * to a max benefit of \$1,000/day	Precertification required.**
<b>If you are pregnant</b>	Office visits	30% <u>coinsurance</u> *	50% <u>coinsurance</u> *	Cost-sharing does not apply for in-network routine prenatal services that are considered <u>preventive care</u> .
	Childbirth/delivery professional services	30% <u>coinsurance</u> *	50% <u>coinsurance</u> *	None
	Childbirth/delivery facility services	30% <u>coinsurance</u> *	50% <u>coinsurance</u> * to a max benefit of \$1,000/day	None
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	30% <u>coinsurance</u> *	50% <u>coinsurance</u> *	Precertification required.** Limited to 100 visits per calendar year.
	<a href="#">Rehabilitation services</a> – physical, speech & occupational & other rehabilitative therapies	30% <u>coinsurance</u> *	50% <u>coinsurance</u> *	None
	<a href="#">Habilitation services</a>	30% <u>coinsurance</u> *	50% <u>coinsurance</u> *	None
	<a href="#">Skilled nursing care</a>	30% <u>coinsurance</u> *	50% <u>coinsurance</u> *	Precertification required.** Limited to 100 days per calendar year.
	<a href="#">Durable medical equipment</a>	30% <u>coinsurance</u> *	50% <u>coinsurance</u> *	Precertification required for select items.** Wigs are limited to a maximum of \$500 per calendar year. Hearing aids are limited to 1 per ear per every 3-year period.
	<a href="#">Hospice services</a>	30% <u>coinsurance</u> *	50% <u>coinsurance</u> *	None
<b>If your child needs dental or eye care</b>	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

\* Deductible applies.

\*\* 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 reduction or denial of benefits.**

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Retail Pharmacy (30 day supply)	Mail Order Pharmacy (90 day supply)	
<p><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.medimpact.com">www.medimpact.com</a></p>	Generic drugs	\$20 copay*	\$40 copay*	<p>Certain medications considered <u>preventive care</u> under ACA are payable at no cost-share to the member.</p> <p>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 (but not more than 50% of the average cost for the drug), plus the generic co-pay unless the physician specifies "Dispense as Written".</p> <p>Impotence/sexual dysfunction drugs are limited to 6 pills or units per every 30 days.</p>
	Preferred brand drugs	\$30 copay*	\$60 copay*	
	Non-preferred brand drugs	\$60 copay*	\$120 copay*	
	<a href="#">Specialty drugs</a> **	30% <u>coinsurance</u> * to a maximum copay of \$150	30% <u>coinsurance</u> * to a maximum copay of \$300	
	<p>*Medical deductible applies            A 90-day supply is available at retail pharmacies with a triple copay.            Drugs obtained at a non-participating pharmacy will be a 50% <u>coinsurance</u>* of the prescription drug maximum allowed amount &amp; costs in excess of the prescription drug maximum allowed amount.            **Specialty drugs may only be obtained through the specialty pharmacy program.</p>			

## 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
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care
- Routine foot care, except for the treatment of diabetes
- Weight loss programs

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Acupuncture
- Bariatric surgery, limited to a lifetime maximum of \$30,000
- Chiropractic care
- Hearing aids

**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: HealthNow Administrative Services, 1-855-323-1131, [www.myhnas.com](http://www.myhnas.com); Department of Labor/Employee Benefits Security Administration, 1-866-444-EBSA (3272), [www.dol.gov/ebsa/healthreform](http://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](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: Department of Labor/Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

### 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 1-855-323-1131.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-323-1131.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-323-1131.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-323-1131.

————— *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](#) \$4000
- [Specialist](#) coinsurance 30%
- Hospital (facility) coinsurance 30%
- Other coinsurance 30%

**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>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$2000
Copayments	\$40
Coinsurance	\$2260
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$4360</b>

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

- The [plan's](#) overall [deductible](#) \$4000
- [Specialist](#) coinsurance 30%
- Hospital (facility) coinsurance 30%
- Other coinsurance 30%

**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>\$7,400</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$4000
Copayments	\$680
Coinsurance	\$130
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$4870</b>

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

- The [plan's](#) overall [deductible](#) \$4000
- [Specialist](#) coinsurance 30%
- Hospital (facility) coinsurance 30%
- Other coinsurance 30%

**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>\$1,900</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1920
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1920</b>