

 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 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 or call 1-855-323-1131 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	For in-network providers \$1,500/person and \$3,000/family. For out-of-network providers \$3,000/person and \$6,000/family.	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 , the overall family deductible must be met before the plan begins to pay. The in-network and out-of-network deductibles are not combined.
Are there services covered before you meet your deductible ?	Yes, preventive care.	This plan covers some items and services even if you haven't met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive 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 ?	For in-network providers \$3,000/person and \$6,000/family. For out-of-network providers \$6,000/person and \$12,000/family.	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 , the overall family out-of-pocket must be met. The in-network out-of-pocket amounts do not apply to the out-of-network out-of-pocket amounts. However, the out-of-network out-of-pocket amounts do apply to the in-network out-of-pocket amounts.
What is not included in the out-of-pocket limit ?	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.blueshield.com/networkPPO or call 1-800-541-6652 for a list of network providers in CA; or 1-800-810-2583 outside of CA.	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	15% coinsurance *	50% coinsurance *	None
	Specialist visit	15% coinsurance *	50% coinsurance *	None
	Teladoc	15% coinsurance *	Not applicable	None
	Chiropractic visit	15% coinsurance *	50% coinsurance *	Limited to 24 visits per calendar year.
	Acupuncture visit	15% coinsurance *	50% coinsurance *	Limited to 24 visits per calendar year.
	Preventive care/screening/immunization	No charge. Deductible does not apply.	50% coinsurance *	Includes preventive services as mandated by ACA. 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)	15% coinsurance *	50% coinsurance *	None
	Imaging (CT/PET scans, MRIs)	15% coinsurance *	50% coinsurance *	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance *	50% coinsurance *	Precertification required for certain procedures.**
	Physician/surgeon fees	15% coinsurance *	50% coinsurance *	None
If you need immediate medical attention	Emergency room care	15% coinsurance *	Paid as in-network	None
	Emergency medical transportation	15% coinsurance *	Paid as in-network	None
	Urgent care	15% coinsurance *	50% coinsurance *	None
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance *	50% coinsurance *	Precertification required.**
	Physician/surgeon fees	15% coinsurance *	50% coinsurance *	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)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	15% <u>coinsurance</u> *	50% <u>coinsurance</u> *	None
	Inpatient services	15% <u>coinsurance</u> *	50% <u>coinsurance</u> *	Precertification required.**
If you are pregnant	Office visits	15% <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	15% <u>coinsurance</u> *	50% <u>coinsurance</u> *	None
	Childbirth/delivery facility services	15% <u>coinsurance</u> *	50% <u>coinsurance</u> *	None
If you need help recovering or have other special health needs	Home health care	15% <u>coinsurance</u> *	50% <u>coinsurance</u> *	Precertification required.**
	Rehabilitation services – physical, speech & occupational & other rehabilitative therapies	15% <u>coinsurance</u> *	50% <u>coinsurance</u> *	Limited to 60 visits per therapy per calendar year.
	Rehabilitation services – cardio rehabilitation	15% <u>coinsurance</u> *	50% <u>coinsurance</u> *	Limited to 36 visits per calendar year.
	Habilitation services	15% <u>coinsurance</u> *	50% <u>coinsurance</u> *	Habilitation visits will count towards the rehabilitation limits.
	Skilled nursing care	15% <u>coinsurance</u> *	50% <u>coinsurance</u> *	Precertification required.**
	Durable medical equipment	15% <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.
	Hospice services	15% <u>coinsurance</u> *	50% <u>coinsurance</u> *	None
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

* 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>If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.medimpact.com</p>	Generic drugs	15% <u>coinsurance</u> * to a maximum copay of \$25 and a minimum copay of \$5	15% <u>coinsurance</u> * to a maximum copay of \$50 and a minimum copay of \$10	<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	15% <u>coinsurance</u> * to a maximum copay of \$50 and a minimum copay of \$10	15% <u>coinsurance</u> * to a maximum copay of \$100 and a minimum copay of \$20	
	Non-preferred brand drugs	15% <u>coinsurance</u> * to a maximum copay of \$100 and a minimum copay of \$25	15% <u>coinsurance</u> * to a maximum copay of \$200 and a minimum copay of \$50	
	Specialty drugs **	15% <u>coinsurance</u> *	15% <u>coinsurance</u> *	
	<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 & 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; Department of Labor/Employee Benefits Security Administration, 1-866-444-EBSA (3272), 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 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.

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	\$1500
■ Specialist coinsurance	15%
■ Hospital (facility) coinsurance	15%
■ Other coinsurance	15%

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1500
Copayments	\$0
Coinsurance	\$1500
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3060

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$1500
■ Specialist coinsurance	15%
■ Hospital (facility) coinsurance	15%
■ Other coinsurance	15%

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	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1500
Copayments	\$0
Coinsurance	\$960
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$2520

Mia's Simple Fracture

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

■ The plan's overall deductible	\$1500
■ Specialist coinsurance	15%
■ Hospital (facility) coinsurance	15%
■ Other coinsurance	15%

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	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1500
Copayments	\$0
Coinsurance	\$60
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1560