
 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 1-877-356-0666. 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 1-877-356-0666 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$500/person and \$1,500/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> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes, preventive care, benefits subject to a co-pay, and prescription drug expenses.	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> .
Are there other <a href="#">deductibles</a> for specific services?	Yes. \$100 for prescription drugs. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$3,000/person, \$6,000/two-member and \$9,000/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.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Premiums, balance-billed charges, penalties, prescription drug charges 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> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.blueshieldca.com/networkPPO">www.blueshieldca.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</a> charge 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.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	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)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$30/visit. <a href="#">Deductible</a> does not apply.	Not covered	None
	<a href="#">Specialist</a> visit	\$30/visit. <a href="#">Deductible</a> does not apply.	Not covered	None
	Chiropractic visit	\$10/visit. <a href="#">Deductible</a> does not apply.	Not covered	Limited to 30 visits/year.
	<a href="#">Preventive care/screening/immunization</a>	No charge. <a href="#">Deductible</a> does not apply.	Not covered	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.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a> *	Not covered	None
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a> *	Not covered	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a> *	Not covered	None
	Physician/surgeon fees	20% <a href="#">coinsurance</a> *	Not covered	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	20% <a href="#">coinsurance</a> after \$150/visit. <a href="#">Deductible</a> does not apply.	Paid as in-network	Copay waived if admitted. Out-of-network non-emergent use is not covered.
	<a href="#">Emergency medical transportation</a>	\$100/trip. <a href="#">Deductible</a> does not apply.	Paid as in-network	None
	<a href="#">Urgent care</a>	\$60/visit. <a href="#">Deductible</a> does not apply.	Not covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a> *	Not covered	Precertification required.**
	Physician/surgeon fees	20% <a href="#">coinsurance</a> *	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30/visit. <a href="#">Deductible</a> does not apply.	Not covered	Certain behavioral health services are not covered.
	Inpatient services	20% <a href="#">coinsurance</a> *	Not covered	Precertification required.** Certain behavioral health services are not covered.

<b>If you are pregnant</b>	Office visits	\$30/visit. <u>Deductible</u> does not apply.	Not covered	Cost-sharing does not apply for in-network routine prenatal services that are considered <u>preventive care</u> .
	Childbirth/delivery professional services	20% <u>coinsurance</u> *	Not covered	None
	Childbirth/delivery facility services	20% <u>coinsurance</u> *	Not covered	None
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	\$30/visit. <u>Deductible</u> does not apply.	Not covered	Limited to 100 visits/year.
	<a href="#">Rehabilitation services</a>	\$30/visit. <u>Deductible</u> does not apply.	Not covered	Includes physical, speech, occupational, cardiac & pulmonary therapies.
	<a href="#">Habilitation services</a>	\$30/visit. <u>Deductible</u> does not apply.	Not covered	None
	<a href="#">Skilled nursing care</a>	Days 1-10: No charge; Days 11-100: \$25/day. <u>Deductible</u> does not apply.	Not covered	Precertification required.** Limited to 100 days/year.
	<a href="#">Durable medical equipment</a>	No charge. <u>Deductible</u> does not apply.	Not covered	None
	<a href="#">Hospice services</a>	20% <u>coinsurance</u> *	Not covered	None
<b>If your child needs dental or eye care</b>	Children's eye exam	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 will result in a 50% reduction in benefits. In addition, uncertified outpatient services will result in a \$100 deductible for each visit; uncertified inpatient services will result in a \$500 deductible per admission.**

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Retail Pharmacy (34 day supply)	Mail Order Pharmacy (90 day supply)	
<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.empirxhealth.com">www.empirxhealth.com</a>	Individual deductible	\$100		The out-of-pocket is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
	Individual out-of-pocket limit	\$2,000		
	Family out-of-pocket limit	\$4,000		
	Generic drugs	\$20/prescription. <u>Deductible</u> does not apply.	\$40/prescription. <u>Deductible</u> does not apply.	Certain medications considered <u>preventive care</u> under ACA are payable at no cost-share to the member.
	Preferred brand drugs	\$30/prescription*	\$60/prescription*	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".
	Non-preferred brand drugs	\$50/prescription*	\$100/prescription*	
	<a href="#">Specialty drugs</a>	20% <u>coinsurance</u> *, up to \$100/prescription.	N/A	
	*Deductible applies			

## 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
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- 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
- Infertility treatment
- Routine eye care

**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, 1-877-356-0666, [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 1-877-356-0666.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-356-0666.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-877-356-0666.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-877-356-0666.

————— *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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$500
■ <a href="#">Specialist</a> copayment	\$30
■ 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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#### In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$40
Coinsurance	\$2210
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2810</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>	\$500
■ <a href="#">Specialist</a> copayment	\$30
■ 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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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#### In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$230
Copayments	\$1670
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$1960</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>	\$500
■ <a href="#">Specialist</a> copayment	\$30
■ 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*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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#### In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$400
Coinsurance	\$120
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$520</b>