
 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> ?	For in- and out-of-network <a href="#">providers</a> combined \$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?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For in-network <a href="#">providers</a> \$2,000/person and \$6,000/family. For out-of-network <a href="#">providers</a> \$4,000/person and \$12,000/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, 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	\$15/visit. <a href="#">Deductible</a> does not apply.	30% <a href="#">coinsurance</a> *	None
	<a href="#">Specialist</a> visit	\$15/visit. <a href="#">Deductible</a> does not apply.	30% <a href="#">coinsurance</a> *	None
	Chiropractic visit	\$15/visit. <a href="#">Deductible</a> does not apply.	30% <a href="#">coinsurance</a> *; \$25 max payable per visit. For emergency care only.	Limited to 30 visits per benefit year. Purchase of chiropractic appliances limited to \$50 per benefit year.
	Acupuncture visit	10% <a href="#">coinsurance</a> *	30% <a href="#">coinsurance</a> *	None
	<a href="#">Preventive care/screening/immunization</a>	No charge. <a href="#">Deductible</a> does not apply.	30% <a href="#">coinsurance</a> *	Includes preventive services as mandated by ACA. You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
	Telemedicine – through plan vendor	\$15/visit. <a href="#">Deductible</a> does not apply.	N/A	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. primary care visit) for the service.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	10% <a href="#">coinsurance</a> *	30% <a href="#">coinsurance</a> *	None
	Imaging (CT/PET scans, MRIs)	10% <a href="#">coinsurance</a> *	30% <a href="#">coinsurance</a> *	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <a href="#">coinsurance</a> *	30% <a href="#">coinsurance</a> *	None
	Physician/surgeon fees	10% <a href="#">coinsurance</a> *	30% <a href="#">coinsurance</a> *	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	10% <a href="#">coinsurance</a> after \$100/visit. <a href="#">Deductible</a> does not apply.	Paid as in-network	Copay waived if admitted. Out-of-network non-emergent use is paid at 30% <a href="#">coinsurance</a> .*
	<a href="#">Emergency medical transportation</a>	10% <a href="#">coinsurance</a> after \$50/trip. <a href="#">Deductible</a> does not apply.	Paid as in-network	None
	<a href="#">Urgent care</a>	\$15/visit. <a href="#">Deductible</a>	30% <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)	
		does not apply.		
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u> *	30% <u>coinsurance</u> *	Precertification required.**
	Physician/surgeon fees	10% <u>coinsurance</u> *	30% <u>coinsurance</u> *	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$15/visit. <u>Deductible</u> does not apply.	30% <u>coinsurance</u> *	None
	Inpatient services	10% <u>coinsurance</u> *	30% <u>coinsurance</u> *	Precertification required.**
If you are pregnant	Office visits	10% <u>coinsurance</u> *	30% <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	10% <u>coinsurance</u> *	30% <u>coinsurance</u> *	None
	Childbirth/delivery facility services	10% <u>coinsurance</u> *	30% <u>coinsurance</u> *	None
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	10% <u>coinsurance</u> *	30% <u>coinsurance</u> *	Limited to 100 visits/year.
	<a href="#">Rehabilitation services</a>	10% <u>coinsurance</u> *	30% <u>coinsurance</u> *	Includes physical, speech, occupational, cardiac & pulmonary therapies.
	<a href="#">Habilitation services</a>	10% <u>coinsurance</u> *	30% <u>coinsurance</u> *	Limited to the treatment of autism and developmental delays.
	<a href="#">Skilled nursing care</a>	10% <u>coinsurance</u> *	30% <u>coinsurance</u> *	Precertification required.** Limited to 100 days/year.
	<a href="#">Durable medical equipment</a>	10% <u>coinsurance</u> *	30% <u>coinsurance</u> *	None
	<a href="#">Hospice services</a>	10% <u>coinsurance</u> *	30% <u>coinsurance</u> *	None
If your child needs dental or eye care	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="http://www.empirxhealth.com">prescription drug coverage</a> is available at <a href="http://www.empirxhealth.com">www.empirxhealth.com</a>	Generic drugs	\$10/prescription. <u>Deductible</u> does not apply.	\$20/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.  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. <u>Deductible</u> does not apply.	\$40/prescription. <u>Deductible</u> does not apply.	
	Non-preferred brand drugs	\$35/prescription. <u>Deductible</u> does not apply.	\$70/prescription. <u>Deductible</u> does not apply.	
	<a href="#">Specialty drugs</a>	20% <u>coinsurance</u> , up to \$100/prescription. <u>Deductible</u> does not apply.	N/A	

When filling prescriptions at non-participating pharmacies, you are required to pay the listed dollar copayment, plus 50% of the prescription drug's average wholesale price (AWP). You are also obliged to pay any amounts the pharmacy charges in excess of the AWP.

## 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
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- 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.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment

**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: 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).

### 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 [plan's](#) overall [deductible](#) \$500
- [Specialist](#) copayment \$15
- Hospital (facility) coinsurance 10%
- Other coinsurance 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>\$12,700</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$10
Coinsurance	\$1060
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1630</b>

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

- The [plan's](#) overall [deductible](#) \$500
- [Specialist](#) copayment \$15
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

**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>\$5,600</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$120
Copayments	\$660
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$800</b>

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

- The [plan's](#) overall [deductible](#) \$500
- [Specialist](#) copayment \$15
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

**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>\$2,800</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$400
Copayments	\$190
Coinsurance	\$170
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$760</b>