

 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> ?	\$0	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
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> ?	\$1,500/person, \$3,000/two-member and \$4,500/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)	
<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	\$15/visit	Not covered	None
	<a href="#">Specialist</a> visit	\$15/visit	Not covered	None
	Chiropractic visit	\$10/visit	\$10/visit. For emergency care only.	Limited to 30 visits per benefit year. Purchase of chiropractic appliances limited to \$50 per benefit year.
	Acupuncture visit	\$15/visit	Not covered	None
	<a href="#">Preventive care/screening/immunization</a>	No charge	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.
	Telemedicine – through plan vendor	\$15/visit.	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.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	\$100/test	Not covered	None
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$250/procedure	Not covered	None
	Physician/surgeon fees	No charge	Not covered	None
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$100/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>	\$15/visit. <a href="#">Deductible</a> does not apply.	Not covered	None
<b>If you have a hospital</b>	Facility fee (e.g., hospital room)	\$250/admit	Not covered	Precertification required.**

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>stay</b>	Physician/surgeon fees	No charge	Not covered	None
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$15/visit	Not covered	None
	Inpatient services	\$250/admit	Not covered	Precertification required.**
<b>If you are pregnant</b>	Office visits	\$15/visit	Not covered	Cost-sharing does not apply for in-network routine prenatal services that are considered <u>preventive care</u> .
	Childbirth/delivery professional services	No charge	Not covered	None
	Childbirth/delivery facility services	\$250/admit	Not covered	None
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	\$15/visit	Not covered	Limited to 100 visits/year.
	<a href="#">Rehabilitation services</a>	\$15/visit	Not covered	Includes physical, speech, occupational, cardiac & pulmonary therapies.
	<a href="#">Habilitation services</a>	\$15/visit	Not covered	Limited to the treatment of autism and developmental delays.
	<a href="#">Skilled nursing care</a>	Days 1-10: No charge; Days 11-100: \$25/day.	Not covered	Precertification required.** Limited to 100 days/year.
	<a href="#">Durable medical equipment</a>	No charge	Not covered	None
	<a href="#">Hospice services</a> – inpatient	\$250/admit	Not covered	None
	<a href="#">Hospice services</a> – outpatient	No charge	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

\*\* 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)	
<p><b>If you need drugs to treat your illness or condition</b></p> <p>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></p>	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	\$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.
	Preferred brand drugs	\$20/prescription*	\$40/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	\$35/prescription*	\$70/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](#).)

- 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](#) \$0
- [Specialist](#) copayment \$15
- Hospital (facility) copayment \$250
- Other coinsurance 0%

**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	\$0
Copayments	\$260
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$320</b>

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist](#) copayment \$15
- Hospital (facility) copayment \$250
- Other coinsurance 0%

**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	\$0
Copayments	\$660
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$680</b>

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist](#) copayment \$15
- Hospital (facility) copayment \$250
- Other coinsurance 0%

**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	\$0
Copayments	\$280
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$280</b>