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

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$500/person and $1,500/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, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes, preventive care, benefits subject to a co-pay, and prescription drug expenses.	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?	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 deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	$3,000/person, $6,000/two-member and $9,000/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, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	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 out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.blueshieldca.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	$30/visit. Deductible does not apply.	Not covered	None
	Specialist visit	$30/visit. Deductible does not apply.	Not covered	None
	Chiropractic visit	$10/visit. Deductible does not apply.	$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	20% coinsurance*	Not covered	None
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	Not covered	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.
	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.
If you have a test	Diagnostic test (x-ray, blood work)	No charge. Deductible does not apply.	Not covered	None
	Imaging (CT/PET scans, MRIs)	$100/visit. Deductible does not apply.	Not covered	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge. Deductible does not apply.	Not covered	None
	Physician/surgeon fees	20% coinsurance*	Not covered	None
If you need immediate medical attention	Emergency room care	20% coinsurance after $150/visit. Deductible does not apply.	Paid as in-network	Copay waived of admitted. Out-of-network non-emergent use is not covered.
	Emergency medical transportation	$100/trip. Deductible does not apply.	Paid as in-network	None
	Urgent care	$60/visit. Deductible does	Not covered	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)	
		not apply.		
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance*	Not covered	Precertification required.**
	Physician/surgeon fees	20% coinsurance*	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30/visit. Deductible does not apply.	Not covered	None
	Inpatient services	20% coinsurance*	Not covered	Precertification required.**
If you are pregnant	Office visits	$30/visit. Deductible does not apply.	Not covered	Cost-sharing does not apply for in-network routine prenatal services that are considered preventive care.
	Childbirth/delivery professional services	No charge. Deductible does not apply.	Not covered	None
	Childbirth/delivery facility services	20% coinsurance*	Not covered	None
If you need help recovering or have other special health needs	Home health care	$30/visit. Deductible does not apply.	Not covered	Limited to 100 visits/year.
	Rehabilitation services	$30/visit. Deductible does not apply.	Not covered	Includes physical, speech, occupational, cardiac & pulmonary therapies.
	Habilitation services	$30/visit. Deductible does not apply.	Not covered	Limited to the treatment of autism and developmental delays.
	Skilled nursing care	Days 1-10: No charge; Days 11-100: $25/day. Deductible does not apply.	Not covered	Precertification required.** Limited to 100 days/year.
	Durable medical equipment	No charge. Deductible does not apply.	Not covered	None
	Hospice services	20% coinsurance*	Not covered	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)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.empirxhealth.com	Individual deductible	$100		
	Individual out-of-pocket limit	$2,000		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.
	Family out-of-pocket limit	$4,000		
	Generic drugs	$20/prescription. Deductible does not apply.	$40/prescription. Deductible does not apply.	Certain medications considered preventive care 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	$30/prescription*	$60/prescription*	
	Non-preferred brand drugs	$50/prescription*	$100/prescription*	
	Specialty drugs	20% coinsurance*, 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; 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: HealthNow Administrative Services, 1-877-356-0666, www.myhnas.com; Department of Labor/Employee Benefits Security Administration, 1-866-444-EBSA (3272), 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, kwiijigo 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	$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)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$20
Coinsurance	$1590
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2160**

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	$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)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1130
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1150**

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

The plan's overall deductible	$500
Specialist 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)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$410
Coinsurance	$160
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$570**

The plan would be responsible for the other costs of these EXAMPLE covered services.