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 1-855-581-1811. 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 1-855-581-1811 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network and out-of-network providers $100/person and $300/family.	See the Common Medical Events chart below for your costs for services this plan covers. 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, 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For in-network and out-of-network providers $100/person and $400/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?	Prescription drug co-pays, 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. Call **800-541-6652** to locate a provider in CA, call **1-800-810-2583** to locate a provider outside of CA, or see **www.blueshieldca.com/networkPPO**.	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	No charge.	20% coinsurance	Includes chiropractic care and acupuncture.
	Specialist visit	No charge.	20% coinsurance	None
	Telemedicine – through plan vendor	No charge. Deductible 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.
	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.
If you have a test	Diagnostic test (x-ray, blood work)	No charge.	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge.	20% coinsurance	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	No charge	None
	Physician/surgeon fees	No charge	No charge	None
If you need immediate medical attention	Emergency room care	No charge.	No charge	Physician and facility benefits are limited to care within 72 hours of a medical emergency.
	Emergency medical transportation	10% coinsurance	10% coinsurance	None
	Urgent care	No charge	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge.	No charge	Precertification required.*
	Physician/surgeon fees	No charge	No charge	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	No charge	20% coinsurance	
	Inpatient services	No charge	20% coinsurance	Precertification required.*
If you are pregnant	Office visits	No charge	20% coinsurance	Cost-sharing does not apply for in-network routine prenatal services that are considered preventive care.
	Childbirth/delivery professional services	No charge	No charge	None
	Childbirth/delivery facility services	No charge	No charge	None
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	Limited to 1 visit/day/specialty.
	Rehabilitation services	No charge	20% coinsurance	Includes physical therapy.
	Rehabilitation services	20% coinsurance	20% coinsurance	Includes speech, occupational, and other rehabilitative therapies.
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	No charge	20% coinsurance	Precertification required.*
	Durable medical equipment	20% coinsurance	20% coinsurance	None
	Hospice services	20% coinsurance	20% coinsurance	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

* 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 penalty.**

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.express-scripts.com.	Individual Out-of-Pocket Limit	$200		Includes prescription drug co-pays. The out-of-pocket limit is the most you could pay during a *benefit year* for your share of the cost of covered prescription expenses. The out-of-pocket limit for this Plan is embedded. Once a member reaches their individual out-of-pocket maximum amount, the Plan will begin to pay at 100%. If you are enrolled in family coverage, the remainder of the family out-of-pocket limit amount can be satisfied by any one or more covered family members. However, no one family member can contribute more than their individual out-of-pocket amount toward the family out-of-pocket amount.
	Family Out-of-Pocket Limit	$400		
	Generic drugs	$2/prescription. Deductible does not apply.	$4/prescription. Deductible does not apply.	Certain medications considered preventive care under ACA are payable at no cost-share to the member.
	Preferred brand drugs	$10/prescription. Deductible does not apply.	$20/prescription. Deductible does not apply.	
	Non-preferred brand drugs	$10/prescription. Deductible does not apply.	$20/prescription. Deductible does not apply.	
	Specialty drugs	$10/prescription. Deductible does not apply.	$20/prescription. Deductible does not apply.	

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

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, 1-855-581-1811, www.myhnas.com; Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, www.cciio.cms.gov. 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, 1-855-581-1811, www.myhnas.com.

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 1-855-581-1811.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-581-1811.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-855-581-1811
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-581-1811.

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	$100
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
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	$100
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$160**

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

The plan's overall deductible	$100
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
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	$100
Copayments	$140
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$260**

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

The plan's overall deductible	$100
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
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	$100
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$100**

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