




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-network <a href="#">providers</a> \$1,000/person and \$2,000/family. For out-of-network <a href="#">providers</a> \$3,000/person and \$9,000/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 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> \$4,000/person and \$8,000/family. For out-of-network <a href="#">providers</a> \$7,500/person and \$22,500/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> ?	Prescription drug copayments, 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 1-800-810-2583 for a list of <a href="#">network providers</a> .	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.	40% <a href="#">coinsurance</a> *	None
	<a href="#">Specialist</a> visit	\$15/visit. <a href="#">Deductible</a> does not apply.	40% <a href="#">coinsurance</a> *	None
	Telemedicine – through Plan vendor	\$5 copay. <a href="#">Deductible</a> does not apply.	Not covered	Applies to general physician and behavioral health 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. Physician Office Visit) for the service.
	Chiropractic visit	10% <a href="#">coinsurance</a> * after \$15/visit	Not covered	Limited to 20 visits/year.
	<a href="#">Preventive care/screening/immunization</a>	No charge. <a href="#">Deductible</a> does not apply.	40% <a href="#">coinsurance</a> *	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)	10% <a href="#">coinsurance</a> *	40% <a href="#">coinsurance</a> *	None
	Imaging (CT/PET scans, MRIs)	10% <a href="#">coinsurance</a> *	40% <a href="#">coinsurance</a> *	Precertification required on select procedures.**
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <a href="#">coinsurance</a> *	40% <a href="#">coinsurance</a> *	None
	Physician/surgeon fees	10% <a href="#">coinsurance</a> *	40% <a href="#">coinsurance</a> *	Precertification required on select procedures.**
If you need immediate medical attention	<a href="#">Emergency room care</a> – emergent use	10% <a href="#">coinsurance</a> after \$75/visit. <a href="#">Deductible</a> does not apply.	10% <a href="#">coinsurance</a> after \$75/visit. <a href="#">Deductible</a> does not apply.	Copay waived if admitted.
	<a href="#">Emergency room care</a> – non-emergent use	40% <a href="#">coinsurance</a> *	40% <a href="#">coinsurance</a> *	None
	<a href="#">Emergency medical transportation</a>	10% <a href="#">coinsurance</a> *	10% <a href="#">coinsurance</a> *	None
	<a href="#">Urgent care</a>	\$15/visit. <a href="#">Deductible</a> does not apply.	40% <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)	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u> * after \$100/admit	40% <u>coinsurance</u> *	Precertification required.**
	Physician/surgeon fees	10% <u>coinsurance</u> *	40% <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.	40% <u>coinsurance</u> *	None
	Inpatient services	10% <u>coinsurance</u> * after \$100/admit	40% <u>coinsurance</u> *	Precertification required.**
If you are pregnant	Office visits	No charge. <u>Deductible</u> does not apply.	40% <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> *	40% <u>coinsurance</u> *	None
	Childbirth/delivery facility services	10% <u>coinsurance</u> * after \$100/admit	40% <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> *	40% <u>coinsurance</u> *	Precertification required for out-of-network services.** Limited to 100 visits/year.
	<a href="#">Rehabilitation services</a> - physical, speech, occupational, and other rehabilitative therapies	10% <u>coinsurance</u> * after \$15/visit	40% <u>coinsurance</u> *	Precertification required for speech therapy.** Limited to an aggregated 60 in-network visits/year and 30 out-of-network visits/year.
	<a href="#">Habilitation services</a>	Not covered	Not covered	None
	<a href="#">Skilled nursing care</a>	10% <u>coinsurance</u> *	40% <u>coinsurance</u> *	Precertification required.** Limited to 100 consecutive days/year in-network; 60 consecutive days/year out-of-network.
	<a href="#">Durable medical equipment</a>	10% <u>coinsurance</u> *	40% <u>coinsurance</u> *	Precertification required on select items.**
	<a href="#">Hospice services</a>	10% <u>coinsurance</u> *	40% <u>coinsurance</u> *	Precertification required for inpatient care.** Limited to 180 days/lifetime.
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

\* 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% penalty.**

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Retail Pharmacy (30 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="#">www.magellanrx.com</a>	Individual maximum out-of-pocket amount	\$2,000		The out-of-pocket limit 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 maximum out-of-pocket amount	\$4,000		
	Generic drugs	\$15/prescription	\$30/prescription	Certain medications considered <u>preventive care</u> under ACA are payable at no cost-share to the member.
	Preferred brand drugs	\$25/prescription	\$50/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	\$40/prescription	\$80/prescription	



### 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         | • Infertility treatment                              | • Private duty nursing     |
| • Cosmetic surgery    | • Long-term care                                     | • Routine eye care (adult) |
| • Dental care (adult) | • Non-emergency care when traveling outside the U.S. | • Routine foot care        |
| • Hearing aids        |  | • 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 |
|---------------------|---------------------|

**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 Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, [www.cciio.cms.gov](http://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](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)

#### 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>	\$1000
■ <a href="#">Specialist</a> 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:

Cost Sharing	
Deductibles	\$1,000
Copayments	\$110
Coinsurance	\$1,000
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,170</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>	\$1000
■ <a href="#">Specialist</a> 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:

Cost Sharing	
Deductibles	\$120
Copayments	\$820
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$960</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>	\$1000
■ <a href="#">Specialist</a> 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:

Cost Sharing	
Deductibles	\$1,000
Copayments	\$160
Coinsurance	\$110
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,270</b>






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Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	For in-network <a href="#">providers</a> \$500/person and \$1,000/family. For out-of-network <a href="#">providers</a> \$1,500/person and \$4,500/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 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> \$3,500/person and \$7,000/family. For out-of-network <a href="#">providers</a> \$6,000/person and \$18,000 /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> ?	Prescription drug copayments, 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 1-800-810-2583 for a list of <a href="#">network providers</a> .	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.	40% <a href="#">coinsurance</a> *	None
	<a href="#">Specialist</a> visit	\$15/visit. <a href="#">Deductible</a> does not apply.	40% <a href="#">coinsurance</a> *	None
	Telemedicine – through Plan vendor	\$5 copay. <a href="#">Deductible</a> does not apply.	Not covered	Applies to general physician and behavioral health 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. Physician Office Visit) for the service.
	Chiropractic visit	10% <a href="#">coinsurance</a> * after \$15/visit	Not covered	Limited to 20 visits/year.
	<a href="#">Preventive care/screening/immunization</a>	No charge. <a href="#">Deductible</a> does not apply.	40% <a href="#">coinsurance</a> *	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)	10% <a href="#">coinsurance</a> *	40% <a href="#">coinsurance</a> *	None
	Imaging (CT/PET scans, MRIs)	10% <a href="#">coinsurance</a> *	40% <a href="#">coinsurance</a> *	Precertification required on select procedures.**
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <a href="#">coinsurance</a> *	40% <a href="#">coinsurance</a> *	None
	Physician/surgeon fees	10% <a href="#">coinsurance</a> *	40% <a href="#">coinsurance</a> *	Precertification required on select procedures.**
If you need immediate medical attention	<a href="#">Emergency room care</a> – emergent use	10% <a href="#">coinsurance</a> after \$75/visit. <a href="#">Deductible</a> does not apply.	10% <a href="#">coinsurance</a> after \$75/visit. <a href="#">Deductible</a> does not apply.	Copay waived if admitted.
	<a href="#">Emergency room care</a> – non-emergent use	40% <a href="#">coinsurance</a> *	40% <a href="#">coinsurance</a> *	None
	<a href="#">Emergency medical transportation</a>	10% <a href="#">coinsurance</a> *	10% <a href="#">coinsurance</a> *	None
	<a href="#">Urgent care</a>	\$15/visit. <a href="#">Deductible</a> does not apply.	40% <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)	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u> * after \$100/admit	40% <u>coinsurance</u> *	Precertification required.**
	Physician/surgeon fees	10% <u>coinsurance</u> *	40% <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.	40% <u>coinsurance</u> *	None
	Inpatient services	10% <u>coinsurance</u> * after \$100/admit	40% <u>coinsurance</u> *	Precertification required.**
If you are pregnant	Office visits	No charge. <u>Deductible</u> does not apply.	40% <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> *	40% <u>coinsurance</u> *	None
	Childbirth/delivery facility services	10% <u>coinsurance</u> * after \$100/admit	40% <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> *	40% <u>coinsurance</u> *	Precertification required for out-of-network services.** Limited to 100 visits/year.
	<a href="#">Rehabilitation services</a> - physical, speech, occupational, and other rehabilitative therapies	10% <u>coinsurance</u> * after \$15/visit	40% <u>coinsurance</u> *	Precertification required for speech therapy.** Limited to an aggregated 60 in-network visits/year and 30 out-of-network visits/year.
	<a href="#">Habilitation services</a>	Not covered	Not covered	None
	<a href="#">Skilled nursing care</a>	10% <u>coinsurance</u> *	40% <u>coinsurance</u> *	Precertification required.** Limited to 100 consecutive days/year in-network; 60 consecutive days/year out-of-network.
	<a href="#">Durable medical equipment</a>	10% <u>coinsurance</u> *	40% <u>coinsurance</u> *	Precertification required on select items.**
	<a href="#">Hospice services</a>	10% <u>coinsurance</u> *	40% <u>coinsurance</u> *	Precertification required for inpatient care.** Limited to 180 days/lifetime.
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

\* 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% penalty.**

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Retail Pharmacy (30 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="#">www.magellanrx.com</a>	Individual maximum out-of-pocket amount	\$2,000		The out-of-pocket limit 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 maximum out-of-pocket amount	\$4,000		
	Generic drugs	\$10/prescription	\$20/prescription	Certain medications considered <u>preventive care</u> under ACA are payable at no cost-share to the member.
	Preferred brand drugs	\$25/prescription	\$50/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	\$40/prescription	\$80/prescription	



### 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         | • Infertility treatment                              | • Private duty nursing     |
| • Cosmetic surgery    | • Long-term care                                     | • Routine eye care (adult) |
| • Dental care (adult) | • Non-emergency care when traveling outside the U.S. | • Routine foot care        |
| • Hearing aids        |  | • 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 |
|---------------------|---------------------|

**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 Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, [www.cciio.cms.gov](http://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](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)

#### 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	\$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>
---------------------------	-----------------

#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$500
Copayments	\$110
Coinsurance	\$1,050
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,720</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	\$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>
---------------------------	----------------

#### In this example, Joe would pay:

Cost Sharing	
Deductibles	\$120
Copayments	\$660
Coinsurance	\$0
What isn't covered	
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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$500
■ <a href="#">Specialist</a> 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>
---------------------------	----------------

#### In this example, Mia would pay:

Cost Sharing	
Deductibles	\$500
Copayments	\$160
Coinsurance	\$170
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$830</b>






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-network <a href="#">providers</a> \$0/person and \$0/family. For out-of-network <a href="#">providers</a> \$200/person and \$600/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 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> \$3,000/person and \$6,000/family. For out-of-network <a href="#">providers</a> \$4,700/person and \$14,100 /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> ?	Prescription drug copayments, 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 1-800-810-2583 for a list of <a href="#">network providers</a> .	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 <u>provider's</u> office or clinic</b>	Primary care visit to treat an injury or illness	\$15/visit	30% <u>coinsurance</u> *	None
	<u>Specialist</u> visit	\$15/visit	30% <u>coinsurance</u> *	None
	Telemedicine – through Plan vendor	\$5 copay	Not covered	Applies to general physician and behavioral health 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. Physician Office Visit) for the service.
	Chiropractic visit	15% <u>coinsurance</u> after \$15/visit	Not covered	Limited to 20 visits/year.
	<u>Preventive care/screening/immunization</u>	No charge	30% <u>coinsurance</u> *	Includes preventive services as mandated by ACA. You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	15% <u>coinsurance</u>	30% <u>coinsurance</u> *	None
	Imaging (CT/PET scans, MRIs)	15% <u>coinsurance</u>	30% <u>coinsurance</u> *	Precertification required on select procedures.**
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	15% <u>coinsurance</u>	30% <u>coinsurance</u> *	None
	Physician/surgeon fees	15% <u>coinsurance</u>	30% <u>coinsurance</u> *	Precertification required on select procedures.**
<b>If you need immediate medical attention</b>	<u>Emergency room care</u> – emergent use	15% <u>coinsurance</u> after \$75/visit	Paid as in-network	Copay waived if admitted.
	<u>Emergency room care</u> – non-emergent use	30% <u>coinsurance</u>	30% <u>coinsurance</u> *	None
	<u>Emergency medical transportation</u>	15% <u>coinsurance</u>	Paid as in-network	None
	<u>Urgent care</u>	\$15/visit	30% <u>coinsurance</u> *	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 have a hospital stay	Facility fee (e.g., hospital room)	15% <u>coinsurance</u> after \$100/admit	30% <u>coinsurance</u> *	Precertification required.**
	Physician/surgeon fees	15% <u>coinsurance</u>	30% <u>coinsurance</u> *	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$15/visit	30% <u>coinsurance</u> *	None
	Inpatient services	15% <u>coinsurance</u> after \$100/admit	30% <u>coinsurance</u> *	Precertification required.**
If you are pregnant	Office visits	No charge	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	15% <u>coinsurance</u>	30% <u>coinsurance</u> *	None
	Childbirth/delivery facility services	15% <u>coinsurance</u> after \$100/admit	30% <u>coinsurance</u> *	None
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	15% <u>coinsurance</u>	30% <u>coinsurance</u> *	Precertification required for out-of-network services.** Limited to 100 visits/year.
	<a href="#">Rehabilitation services</a> - physical, speech, occupational, and other rehabilitative therapies	15% <u>coinsurance</u> after \$15/visit	30% <u>coinsurance</u> *	Precertification required for speech therapy.** Limited to an aggregated 60 in-network visits/year and 30 out-of-network visits/year.
	<a href="#">Habilitation services</a>	Not covered	Not covered	None
	<a href="#">Skilled nursing care</a>	15% <u>coinsurance</u>	30% <u>coinsurance</u> *	Precertification required.** Limited to 100 consecutive days/year in-network; 60 consecutive days/year out-of-network.
	<a href="#">Durable medical equipment</a>	15% <u>coinsurance</u>	30% <u>coinsurance</u> *	Precertification required on select items.**
	<a href="#">Hospice services</a>	15% <u>coinsurance</u>	30% <u>coinsurance</u> *	Precertification required for inpatient care.** Limited to 180 days/lifetime.
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

\* 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% penalty.**

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Retail Pharmacy (30 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="#">www.magellanrx.com</a>	Individual maximum out-of-pocket amount	\$2,000		The out-of-pocket limit 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 maximum out-of-pocket amount	\$4,000		
	Generic drugs	\$10/prescription	\$20/prescription	Certain medications considered <u>preventive care</u> under ACA are payable at no cost-share to the member.
	Preferred brand drugs	\$15/prescription	\$30/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 <i>physician</i> specifies “Dispense as Written”.
	Non-preferred brand drugs	\$30/prescription	\$60/prescription	



### 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         | • Infertility treatment                              | • Private duty nursing     |
| • Cosmetic surgery    | • Long-term care                                     | • Routine eye care (adult) |
| • Dental care (adult) | • Non-emergency care when traveling outside the U.S. | • Routine foot care        |
| • Hearing aids        |  | • 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 |
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#### 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](#).

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—————To see examples of how this plan might cover costs for a sample medical situation, see the next section.—————

## About these Coverage Examples:



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### 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>	\$0
■ <a href="#">Specialist</a> copayment	\$15
■ Hospital (facility) coinsurance	15%
■ Other coinsurance	15%

#### 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>
---------------------------	-----------------

#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$110
Coinsurance	\$1,650
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,820</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>	\$0
■ <a href="#">Specialist</a> copayment	\$15
■ Hospital (facility) coinsurance	15%
■ Other coinsurance	15%

#### 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>
---------------------------	----------------

#### In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$660
Coinsurance	\$20
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$700</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>	\$0
■ <a href="#">Specialist</a> copayment	\$15
■ Hospital (facility) coinsurance	15%
■ Other coinsurance	15%

#### 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>
---------------------------	----------------

#### In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$160
Coinsurance	\$330
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$490</b>






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Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	For all <a href="#">providers</a> \$0/person and \$0/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 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 all <a href="#">providers</a> \$3,000/person and \$6,000/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> ?	Prescription drug copayments, 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 1-800-810-2583 for a list of <a href="#">network providers</a> .	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	Not covered	None
	<a href="#">Specialist</a> visit	\$15/visit	Not covered	None
	Telemedicine – through Plan vendor	\$5 copay	Not covered	Applies to general physician and behavioral health 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. Physician Office Visit) for the service.
	Chiropractic visit	15% <a href="#">coinsurance</a> after \$15/visit	Not covered	Limited to 20 visits/year.
	<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.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	15% <a href="#">coinsurance</a>	Not covered	None
	Imaging (CT/PET scans, MRIs)	15% <a href="#">coinsurance</a>	Not covered	Precertification required on select procedures.**
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% <a href="#">coinsurance</a>	Not covered	None
	Physician/surgeon fees	15% <a href="#">coinsurance</a>	Not covered	Precertification required on select procedures.**
If you need immediate medical attention	<a href="#">Emergency room care</a> – emergent use	15% <a href="#">coinsurance</a> after \$75/visit	Paid as in-network	Copay waived if admitted.
	<a href="#">Emergency room care</a> – non-emergent use	30% <a href="#">coinsurance</a>	Paid as in-network	None
	<a href="#">Emergency medical transportation</a>	15% <a href="#">coinsurance</a>	Paid as in-network	None
	<a href="#">Urgent care</a>	\$15/visit	30% coinsurance	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 have a hospital stay	Facility fee (e.g., hospital room)	15% <u>coinsurance</u> after \$100/admit	Not covered	Precertification required.**
	Physician/surgeon fees	15% <u>coinsurance</u>	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$15/visit	Not covered	None
	Inpatient services	15% <u>coinsurance</u> after \$100/admit	Not covered	Precertification required.**
If you are pregnant	Office visits	No charge	Not covered	Cost-sharing does not apply for in-network routine prenatal services that are considered <u>preventive care</u> .
	Childbirth/delivery professional services	15% <u>coinsurance</u>	Not covered	None
	Childbirth/delivery facility services	15% <u>coinsurance</u> after \$100/admit	Not covered	None
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	15% <u>coinsurance</u>	Not covered	Limited to 100 visits/year.
	<a href="#">Rehabilitation services</a> - physical, speech, occupational, and other rehabilitative therapies	15% <u>coinsurance</u> after \$15/visit	Not covered	Precertification required for speech therapy.** Limited to an aggregated 60 in-network visits/year.
	<a href="#">Habilitation services</a>	Not covered	Not covered	None
	<a href="#">Skilled nursing care</a>	15% <u>coinsurance</u>	Not covered	Precertification required.** Limited to 100 consecutive days/year in-network.
	<a href="#">Durable medical equipment</a>	15% <u>coinsurance</u>	Not covered	Precertification required on select items.**
	<a href="#">Hospice services</a>	15% <u>coinsurance</u>	Not covered	Precertification required for inpatient care.** Limited to 180 days/lifetime.
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 will result in a 50% penalty.**

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Retail Pharmacy (30 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="#">www.magellanrx.com</a>	Individual maximum out-of-pocket amount	\$2,000		The out-of-pocket limit 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 maximum out-of-pocket amount	\$4,000		
	Generic drugs	\$10/prescription	\$20/prescription	Certain medications considered <u>preventive care</u> under ACA are payable at no cost-share to the member.
	Preferred brand drugs	\$15/prescription	\$30/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 <i>physician</i> specifies “Dispense as Written”.
	Non-preferred brand drugs	\$30/prescription	\$60/prescription	



### 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         | • Infertility treatment                              | • Private duty nursing     |
| • Cosmetic surgery    | • Long-term care                                     | • Routine eye care (adult) |
| • Dental care (adult) | • Non-emergency care when traveling outside the U.S. | • Routine foot care        |
| • Hearing aids        |  | • 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 |
|---------------------|---------------------|

**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 Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, [www.cciio.cms.gov](http://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](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)

#### 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>	\$0
■ <a href="#">Specialist</a> copayment	\$15
■ Hospital (facility) coinsurance	15%
■ Other coinsurance	15%

#### 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>
---------------------------	-----------------

#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$110
Coinsurance	\$1,650
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,820</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>	\$0
■ <a href="#">Specialist</a> copayment	\$15
■ Hospital (facility) coinsurance	15%
■ Other coinsurance	15%

#### 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:

Cost Sharing	
Deductibles	\$0
Copayments	\$660
Coinsurance	\$20
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$700</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>	\$0
■ <a href="#">Specialist</a> copayment	\$15
■ Hospital (facility) coinsurance	15%
■ Other coinsurance	15%

#### 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:

Cost Sharing	
Deductibles	\$0
Copayments	\$160
Coinsurance	\$330
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$490</b>