
 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 1-855-323-1124. 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 1-855-323-1124 to request a copy or it can be accessed at [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	For in-network & out-of-network <a href="#">providers</a> combined \$300/person and \$600/family. Applies to inpatient, outpatient & ambulatory surgery only.	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this plan begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes, preventive care, benefits subject to a copay, prescription drug expenses and any expenses not noted above.	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> , 50 copayments per person and \$1,550/person and \$3,100/family. For prescription drug \$5,300/person and \$10,600/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> ?	Out-of-network deductible amounts, 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. In CA: See <a href="http://www.blueshieldca.com/networkTandemPPO">www.blueshieldca.com/networkTandemPPO</a> or call 1-800-810-2583 for a list of network providers. Outside of CA: See <a href="http://www.blueshieldca.com">www.blueshieldca.com</a> or call 1-800-810-2583 for a list of network providers.	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 charge</a> 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> .
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 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	\$25/visit. <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a> . <a href="#">Deductible</a> does not apply.	Only 1 copayment will be applied per visit. Includes chiropractic care. Chiropractic care from a non-participating provider is not covered. Chiropractic care is managed by Physmetrics: 1-877-519-8839.
	<a href="#">Specialist</a> visit	\$25/visit. <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a> . <a href="#">Deductible</a> does not apply.	Only 1 copayment will be applied per visit.
	<a href="#">Preventive care/screening/immunization</a>	No charge. <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a> . <a href="#">Deductible</a> does not apply.	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) Facility & Professional	\$25/visit. <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a> . <a href="#">Deductible</a> does not apply.	Only 1 copayment will be applied when the patient is physically in the office or facility in which the procedure is performed.
	Imaging (CT/PET scans, MRIs) Facility & Professional	\$25/visit. <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a> . <a href="#">Deductible</a> does not apply.	Only 1 copayment will be applied when the patient is physically in the office or facility in which the procedure is performed. Precertification required for MRIs & CAT scans.**
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge*	50% <a href="#">coinsurance</a> *	Precertification required.**
	Physician/surgeon fees	No charge*	50% <a href="#">coinsurance</a> *	Surgery in a participating provider office is covered under the office visit copayment. Precertification required.**
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$200/visit. <a href="#">Deductible</a> does not apply.	\$200/visit. <a href="#">Deductible</a> does not apply.	None
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a> . <a href="#">Deductible</a> does not apply.	Paid as in-network	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)	
	<a href="#">Urgent care</a>	\$40/visit. <u>Deductible</u> does not apply.	50% <u>coinsurance</u> . <u>Deductible</u> does not apply.	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	No charge*	50% <u>coinsurance</u> *	Precertification required.**
	Physician/surgeon fees	No charge*	50% <u>coinsurance</u> *	None
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$25/visit. <u>Deductible</u> does not apply.	50% <u>coinsurance</u> . <u>Deductible</u> does not apply.	Precertification required.** Managed by Halcyon: 1-888-425-4800.
	Inpatient services	No charge*	50% <u>coinsurance</u> *	
<b>If you are pregnant</b>	Office visits	\$25/visit. <u>Deductible</u> does not apply.	50% <u>coinsurance</u> . <u>Deductible</u> does not apply.	Cost-sharing does not apply for in-network routine prenatal services that are considered <u>preventive care</u> .
	Childbirth/delivery professional services	No charge*	50% <u>coinsurance</u> *	None
	Childbirth/delivery facility services	No charge*	50% <u>coinsurance</u> *	None
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	No charge. <u>Deductible</u> does not apply.	50% <u>coinsurance</u> . <u>Deductible</u> does not apply.	Limited to 60 visits per year – must be within 7 days of a hospital confinement. Precertification required.**
	<a href="#">Rehabilitation services</a>	\$25/visit. <u>Deductible</u> does not apply.	50% <u>coinsurance</u> . <u>Deductible</u> does not apply.	Includes physical, speech, occupational, and other rehabilitative therapies. PT/OT/ST is managed by Physmetrics: 1-877-519-8839.
	<a href="#">Habilitation services</a>	20% coinsurance. <u>Deductible</u> does not apply.	50% <u>coinsurance</u> . <u>Deductible</u> does not apply.	Precertification required for skilled nursing facility confinement.**
	<a href="#">Skilled nursing care</a>	20% coinsurance. <u>Deductible</u> does not apply.	50% <u>coinsurance</u> . <u>Deductible</u> does not apply.	Precertification required.**
	<a href="#">Durable medical equipment</a>	No charge. <u>Deductible</u> does not apply.	50% <u>coinsurance</u> . <u>Deductible</u> does not apply.	Precertification required.**
	<a href="#">Hospice services</a>	No charge. <u>Deductible</u> does not apply.	No charge. <u>Deductible</u> does not apply.	Case management must be involved. Precertification required.**

<b>If your child needs dental or eye care</b>	Children's eye exam	No charge. <u>Deductible</u> does not apply.	50% <u>coinsurance</u> . <u>Deductible</u> does not apply.	Coverage as required by ACA under Preventive Care.
	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 may result in a denial of your claim.**

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="http://www.caremark.com">www.caremark.com</a>	Generic drugs	\$9/prescription. <u>Deductible</u> does not apply.	\$18/prescription. <u>Deductible</u> does not apply.	Certain medications considered preventive care under ACA are payable at no cost-share to the member.
	Preferred brand drugs	\$30/prescription. <u>Deductible</u> does not apply.	\$60/prescription. <u>Deductible</u> does not apply.	All refills for maintenance drugs after two fills at a retail pharmacy are required to be filled through the mail order pharmacy.
	Non-preferred brand drugs	\$40/prescription. <u>Deductible</u> does not apply.	\$80/prescription. <u>Deductible</u> does not apply.	Prescription drugs obtained from a non-participating provider are not covered.

## 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
- Cochlear implants
- Cosmetic surgery
- Dental care (adult)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Refractive eye surgery
- Routine eye care (adult)
- 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, limited to \$5,000 maximum benefit
- Chiropractic care
- Infertility treatment, limited to \$5,000 maximum benefit
- Medically necessary treatment of sleep disorders
- Treatment of TMJ
- Some routine foot 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, 1-855-323-1124, [www.myhnas.com](http://www.myhnas.com); Department of Labor/Employee Benefits Security Administration, 1-866-444-EBSA (3272), [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Department of Labor/Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

### Does this plan provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

### Does this plan meet the Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

### Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-323-1124.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-323-1124.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-855-323-1124.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-323-1124.

————— *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](#) \$300
- [Specialist](#) copayment \$25
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

**This EXAMPLE event includes services like:**  
Specialist office visits (*prenatal care*)  
Childbirth/Delivery Professional Services  
Childbirth/Delivery Facility Services  
Diagnostic tests (*ultrasounds and blood work*)  
Specialist visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$300
Copayments	\$10
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$370</b>

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

- The [plan's](#) overall [deductible](#) \$300
- [Specialist](#) copayment \$25
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

**This EXAMPLE event includes services like:**  
Primary care physician office visits (*including disease education*)  
Diagnostic tests (*blood work*)  
Prescription drugs  
Durable medical equipment (*glucose meter*)

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

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$770
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$790</b>

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

- The [plan's](#) overall [deductible](#) \$300
- [Specialist](#) copayment \$25
- Hospital (facility) coinsurance 0%
- Other coinsurance 0%

**This EXAMPLE event includes services like:**  
Emergency room care (*including medical supplies*)  
Diagnostic test (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

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

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$330
Coinsurance	\$190
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$520</b>