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 1-855-323-1124. 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 or call 1-855-323-1124 to request a copy or it can be accessed at www.dol.gov/ebsa/healthreform.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For Tier 2 in-network & Tier 3 out-of-network providers combined $300/person and $600/family. Applies to inpatient, outpatient & ambulatory surgery only.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes, preventive care, benefits subject to a copay, prescription drug expenses and any expenses not noted above.	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 Tier 2 in-network providers, 50 copayments per person and $1,550/person and $3,100/family. For prescription drug $5,300/person and $10,600/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?	Tier 3 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 out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. In CA: See www.blueshieldca.com/networkTandemPPO or call 1-800-810-2583 for a list of network providers. Outside of CA: See www.blueshieldca.com or call 1-800-810-2583 for a list of network providers.	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
		Tier 2 In-Network Provider (You will pay the least)	Tier 3 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	$25/visit. Deductible does not apply.	50% coinsurance. Deductible 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.
	Specialist visit	$25/visit. Deductible does not apply.	50% coinsurance. Deductible does not apply.	Only 1 copayment will be applied per visit.
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	50% coinsurance. Deductible does not apply.	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) Facility & Professional	$25/visit. Deductible does not apply.	50% coinsurance. Deductible 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. No cost share for radiology services rendered at Tier 1 providers Cal Imaging or RadNet.
	Imaging (CT/PET scans, MRIs) Facility & Professional	$25/visit. Deductible does not apply.	50% coinsurance. Deductible 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.** No cost share or precertification requirements for services rendered at Tier 1 providers Cal Imaging or RadNet.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge*	50% coinsurance*	Precertification required.**

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Tier 2 In-Network Provider (You will pay the least)	Tier 3 Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	No charge*	50% coinsurance*	Surgery in a participating provider office is covered under the office visit copayment. Precertification required.**
If you need immediate medical attention	Emergency room care	$200/visit. Deductible does not apply.	$200/visit. Deductible does not apply.	None
	Emergency medical transportation	20% coinsurance. Deductible does not apply.	Paid as in-network	None
	Urgent care	$40/visit. Deductible does not apply.	50% coinsurance. Deductible does not apply.	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge*	50% coinsurance*	Precertification required.**
	Physician/surgeon fees	No charge*	50% coinsurance*	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25/visit. Deductible does not apply.	50% coinsurance. Deductible does not apply.	Precertification required.** Managed by Halcyon: 1-888-425-4800.
	Inpatient services	No charge*	50% coinsurance*	
If you are pregnant	Office visits	$25/visit. Deductible does not apply.	50% coinsurance. Deductible does not apply.	Cost-sharing does not apply for in-network routine prenatal services that are considered preventive care.
	Childbirth/delivery professional services	No charge*	50% coinsurance*	None
	Childbirth/delivery facility services	No charge*	50% coinsurance*	None
If you need help recovering or have other special health needs	Home health care	No charge. Deductible does not apply.	50% coinsurance. Deductible does not apply.	Limited to 60 visits per year – must be within 7 days of a hospital confinement. Precertification required.**
	Rehabilitation services	$25/visit. Deductible does not apply.	50% coinsurance. Deductible does not apply.	Includes physical, speech, occupational, and other rehabilitative therapies. PT/OT/ST is managed by Physmetrics: 1-877-519-8839.
	Habilitation services	20% coinsurance. Deductible does not apply.	50% coinsurance. Deductible does not apply.	Precertification required for skilled nursing facility confinement.**

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Tier 2 In-Network Provider (You will pay the least)	Tier 3 Out-of-Network Provider (You will pay the most)	
	Skilled nursing care	20% coinsurance. Deductible does not apply.	50% coinsurance. Deductible does not apply.	Precertification required.**
	Durable medical equipment	No charge. Deductible does not apply.	50% coinsurance. Deductible does not apply.	Precertification required.**
	Hospice services	No charge. Deductible does not apply.	No charge. Deductible does not apply.	Case management must be involved. Precertification required.**
If your child needs dental or eye care	Children's eye exam	No charge. Deductible does not apply.	50% coinsurance. Deductible 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)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com	Generic drugs	$9/prescription. Deductible does not apply.	$18/prescription. Deductible does not apply.	Certain medications considered preventive care under ACA are payable at no cost-share to the member. All refills for maintenance drugs after two fills at a retail pharmacy are required to be filled through the mail order pharmacy. Prescription drugs obtained from a non-participating provider are not covered.
	Preferred brand drugs	$30/prescription. Deductible does not apply.	$60/prescription. Deductible does not apply.	
	Non-preferred brand drugs	$40/prescription. Deductible does not apply.	$80/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.)

- 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; Department of Labor/Employee Benefits Security Administration, 1-866-444-EBSA (3272), www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

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

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$300
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$370**

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)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$770
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$790**

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)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$330
Coinsurance	$190
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$520**

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