



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 1-855-550-3733. 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 1-855-550-3733 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	For in-network <u>providers</u> \$6,350/person and \$12,000/family. For out-of-network <u>providers</u> \$10,000/person and \$20,000/family.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this plan begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes, preventive care.	This <u>plan</u> covers some items and services even if you haven't met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	For in-network <u>providers</u> \$7,050/person and \$14,100/family. For out-of-network <u>providers</u> \$15,000/person and \$30,000/family.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	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 <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.myhnas.com or call 1-855-550-3733 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). your <u>plan</u> pays (<u>balance billing</u>). Be aware that your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0% coinsurance	20% coinsurance	None
	Specialist visit	0% coinsurance	20% coinsurance	None
	Preventive care/screening/immunization	No charge. Deductible does not apply.	20% coinsurance	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.
	Chiropractic Care	0% coinsurance	20% coinsurance	None
	Diagnostic test (x-ray, blood work)	0% coinsurance	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	0% coinsurance	20% coinsurance	Precertification required.*
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	20% coinsurance	Precertification required.*
	Physician/surgeon fees	0% coinsurance	20% coinsurance	None
If you need immediate medical attention	Emergency room care	0% coinsurance	Paid as in-network	None
	Emergency room care Non-Emergent	0% coinsurance	Paid as in-network	None
	Emergency medical transportation	0% coinsurance	Paid as in-network	None
	Urgent care	0% coinsurance	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	20% coinsurance	Precertification required.* OON limited to 90 days/ benefit year
	Physician/surgeon fees	0% coinsurance	20% coinsurance	None

** For more information about limitations and exceptions, see the [plan](#) or policy document at www.myhnas.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	Inpatient services	0% <u>coinsurance</u>	20% <u>coinsurance</u>	Precertification required.* OON limited to 90 days/ benefit year
If you are pregnant	Office visits	0% <u>coinsurance</u>	20% <u>coinsurance</u>	Cost-sharing does not apply for in-network routine prenatal services that are considered <u>preventive care</u> . Additional cost sharing may apply for services billed beyond office visit (i.e. ultrasound, etc.).
	Childbirth/delivery professional services	0% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	Childbirth/delivery facility services	0% <u>coinsurance</u>	20% <u>coinsurance</u>	Precertification is only required for stays exceeding the day limits outlined in the Newborns' and Mothers' Health Protection Act.
If you need help recovering or have other special health needs	Home health care	0% <u>coinsurance</u>	20% <u>coinsurance</u>	Precertification required.*
	Rehabilitation services	0% <u>coinsurance</u>	20% <u>coinsurance</u>	Includes physical, speech, occupational, and other rehabilitative therapies. Pulmonary rehab is limited to 24 visits/benefit year
	Cardiac Rehabilitation	0% <u>coinsurance</u>	20% <u>coinsurance</u>	Limited to 36 sessions/benefit year
	Habilitation services	0% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	Skilled nursing care	0% <u>coinsurance</u>	20% <u>coinsurance</u>	Limited to 60 days/period of confinement. Precertification required.*
	Durable medical equipment	0% <u>coinsurance</u>	20% <u>coinsurance</u>	Precertification may be required.*
	Hospice services	0% <u>coinsurance</u>	20% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	0% <u>coinsurance</u>	Not covered	Limited to 1 exam/benefit year per member
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

* Precertification is required before certain medical services. Emergency admissions must be certified within 48 hours following the admission. To precertify services, call the phone number indicated on your ID card. **Failure to precertify out-of-network services may result in a penalty.**

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Retail Pharmacy (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.primetherapeutics.com	Generic drugs	0% <u>coinsurance</u>	0% <u>coinsurance</u>	Certain medications considered <u>preventive care</u> under ACA are payable at no cost-share to the member. Non-participating pharmacies are not covered. Coinsurance applies after medical deductible. Participating Retail Pharmacy fills up to 90-days are covered at 0% <u>coinsurance</u> .
	Preferred brand drugs	0% <u>coinsurance</u>	0% <u>coinsurance</u>	
	Non-preferred brand drugs	0% <u>coinsurance</u>	0% <u>coinsurance</u>	
	<u>Specialty drugs</u> Only available as an up to 30-day supply.	Specialty follows the tier structure above.		

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](#).)

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

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

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|---|---------------------|----------------------------|
| • Bariatric surgery (subject to medical review) | • Chiropractic care | • Routine eye care (adult) |
|---|---------------------|----------------------------|

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, 1-855-550-3733, www.myhnas.com; Department of Labor/Employee Benefits Security Administration, 1-866-444-EBSA (3272), www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: HealthNow Administrative Services, 1-855-550-3733, www.myhnas.com; Department of Labor/Employee Benefits Security Administration, 1-866-444-EBSA (3272), www.dol.gov/ebsa/healthreform].

Does this plan provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the premium tax credit.

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 1-855-550-3733.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-550-3733.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-855-550-3733.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-550-3733..

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	\$6,350
■ Specialist coinsurance	0%
■ 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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$6,350
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$6,410

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$6,350
■ Specialist coinsurance	0%
■ 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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$5,420
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$5,440

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$6,350
■ Specialist coinsurance	0%
■ 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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$2800
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,800

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.