

**CITY OF TULARE
Pre-65 Retiree Rates for 2021**

Rates for Calendar Year	Option 1/\$1000 deductible	Option 2/\$500 deductible	Option 3/\$0 deductible	Option 4/\$3000 deductible	Option 5/EPO \$0 deductible
Pre-65 Retirees (including medical, dental and vision)					
Retiree Only	\$1,161.06	\$1,267.50	\$1,323.85	\$854.22	\$1,425.27
Retiree Only Coverage Cost (Monthly)					
Retiree + 1	\$2,319.54	\$2,532.44	\$2,645.16	\$1,705.88	\$3,133.36
Retiree + 1 Coverage Cost (Monthly)					
Family Coverage Cost (Retiree + 1 or more dependents)					
Family Coverage Cost (Monthly)	\$3,249.02	\$3,547.09	\$3,704.87	\$2,389.89	\$4,417.70

**CITY OF TULARE
Post-65 Retiree Rates for 2021**

Rates for Calendar Year	Hartford
Post-65 Retirees (including medical, dental and vision)	
Retiree Only	
Retiree Only Coverage Cost (Monthly)	\$584.93

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
Plan Option 1: City of Tulare

Coverage Period: 01/01/2021 – 12/31/2021
Coverage for: Pre-65 Retirees | Plan Type: PPO



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 1-877-356-0666. 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 or call 1-877-356-0666 to request a copy.

Important Questions	Answers	Why This Matters:
<p>What is the overall deductible?</p>	<p>For in-network providers \$1,000/person and \$2,000/family. For out-of-network providers \$3,000/person and \$9,000/family.</p>	<p>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.</p>
<p>Are there services covered before you meet your deductible?</p>	<p>Yes, preventive care expenses.</p>	<p>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/.</p>
<p>Are there other deductibles for specific services?</p>	<p>No.</p>	<p>You don't have to meet deductibles for specific services.</p>
<p>What is the out-of-pocket limit for this plan?</p>	<p>For in-network providers \$3,000/person and \$6,000/family. For out-of-network providers \$4,500/person and \$13,500/family.</p>	<p>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.</p>
<p>What is not included in the out-of-pocket limit?</p>	<p>Deductible, copayments, premiums, balance-billed charges, penalties, and health care this plan doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p>
<p>Will you pay less if you use a network provider?</p>	<p>Yes. See www.blueshieldca.com/NetworkPPO or call 1-800-810-2583 for a list of network providers.</p>	<p>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.</p>
<p>Do you need a referral to see a specialist?</p>	<p>No.</p>	<p>You can see the specialist you choose without a referral.</p>



All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$15/visit. <u>Deductible</u> does not apply.	40% <u>coinsurance</u> *	None
	Specialist visit	\$15/visit. <u>Deductible</u> does not apply.	40% <u>coinsurance</u> *	None
	Telemedicine -- through Plan vendor	\$5 copay. <u>Deductible</u> 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.
If you have a test	Chiropractic visit	10% <u>coinsurance</u> * after \$15/visit	Not covered	Limited to 20 visits/year.
	Preventive care/screening/immunization	No charge. <u>Deductible</u> does not apply.	40% <u>coinsurance</u> *	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.
	Diagnostic test (x-ray, blood work)	10% <u>coinsurance</u> *	40% <u>coinsurance</u> *	None
If you have outpatient surgery	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u> *	40% <u>coinsurance</u> *	Recertification required on select procedures. **
	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u> *	40% <u>coinsurance</u> *	None
	Physician/surgeon fees	10% <u>coinsurance</u> *	40% <u>coinsurance</u> *	Recertification required on select procedures. **
If you need immediate medical attention	Emergency room care -- emergent use	10% <u>coinsurance</u> after \$75/visit. <u>Deductible</u> does not apply.	10% <u>coinsurance</u> after \$75/visit. <u>Deductible</u> does not apply.	Copay waived if admitted.
	Emergency room care -- non-emergent use	40% <u>coinsurance</u> *	40% <u>coinsurance</u> *	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
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u> *	10% <u>coinsurance</u> *	None
	<u>Urgent care</u>	\$15/visit. <u>Deductible</u> does not apply.	40% <u>coinsurance</u> *	None
	Facility fee (e.g., hospital room)	10% <u>coinsurance</u> * after \$100/admit	40% <u>coinsurance</u> *	Precertification required.**
If you have a hospital stay	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> *	Certain behavioral health services are not covered.
	Inpatient services	10% <u>coinsurance</u> * after \$100/admit	40% <u>coinsurance</u> *	Precertification required.** Certain behavioral health services are not covered.
	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 preventive care.
If you are pregnant	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
	<u>Home health care</u>	10% <u>coinsurance</u> *	40% <u>coinsurance</u> *	Precertification required for out-of-network services.** Limited to 100 visits/year.
If you need help recovering or have other special health needs	Rehabilitation services - physical, speech, occupational, and other rehabilitative therapies	10% <u>coinsurance</u> *	40% <u>coinsurance</u> *	Precertification required for speech therapy.** Limited to an aggregated 60 visits/year.
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	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.
	Durable medical equipment	10% <u>coinsurance</u> *	40% <u>coinsurance</u> *	Precertification required on select items.**
	Hospice services	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

For more information about limitations and exceptions, see the plan or policy document at www.myhnas.com.

* 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 (34 day supply)	Mail Order Pharmacy (90 day supply)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.enveloperx.com	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. 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".
	Family maximum out-of-pocket amount		\$4,000	
	Generic drugs	\$15/prescription	\$30/prescription	
	Preferred brand drugs	\$25/prescription	\$50/prescription	
	Non-preferred brand drugs	\$40/prescription	\$80/prescription	

For more information about limitations and exceptions, see the plan or policy document at www.myhnas.com.

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.)

- | | | |
|---|---|--|
| <ul style="list-style-type: none">• Acupuncture• Cosmetic surgery• Dental care (adult)• Hearing aids | <ul style="list-style-type: none">• Infertility treatment• Long-term care• Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none">• Private duty nursing• Routine eye care (adult)• Routine foot care• Weight loss programs |
|---|---|--|

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

- | | |
|---|---|
| <ul style="list-style-type: none">• Bariatric surgery | <ul style="list-style-type: none">• 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; Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: HealthNow Administrative Services, 1-877-356-0666, 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 niinyo 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): Dinekehgo shika at'ohwol ninisingo, kwijijigo holne' 1-877-356-0666.

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

For more information about limitations and exceptions, see the plan or policy document at www.myhnas.com.

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 \$1000
- Specialist 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)

Total Example Cost \$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,000
Copayments	\$110
Coinsurance	\$1,000
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,170

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

- The plan's overall deductible \$1000
- Specialist 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)

Total Example Cost \$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$120
Copayments	\$820
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$960

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

- The plan's overall deductible \$1000
- Specialist 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)

Total Example Cost \$2,800

In this example, Mia would pay:

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

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



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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 1-877-356-0666. 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 or call 1-877-356-0666 to request a copy.

Important Questions	Answers	Why This Matters:
<p>What is the overall <u>deductible</u>?</p>	<p>For in-network providers \$500/person and \$1,000/family. For out-of-network providers \$1,500/person and \$4,500/family.</p>	<p>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 <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u>.</p>
<p>Are there services covered before you meet your <u>deductible</u>?</p>	<p>Yes, preventive care expenses.</p>	<p>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/.</p>
<p>Are there other <u>deductibles</u> for specific services?</p>	<p>No.</p>	<p>You don't have to meet <u>deductibles</u> for specific services.</p>
<p>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</p>	<p>For in-network providers \$3,000/person and \$6,000/family. For out-of-network providers \$4,500/person and \$13,500/family.</p>	<p>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.</p>
<p>What is not included in the <u>out-of-pocket limit</u>?</p>	<p>Deductible, copayments, premiums, balance-billed charges, penalties, and health care this plan doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.</p>
<p>Will you pay less if you use a <u>network provider</u>?</p>	<p>Yes. See www.blueshieldca.com/NetworkPPO or call 1-800-810-2583 for a list of <u>network providers</u>.</p>	<p>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 provider for the difference between the provider's charge and what 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.</p>
<p>Do you need a referral to see a <u>specialist</u>?</p>	<p>No.</p>	<p>You can see the <u>specialist</u> you choose without a <u>referral</u>.</p>

 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)	
	Primary care visit to treat an injury or illness	\$15/visit. <u>Deductible</u> does not apply.	40% <u>coinsurance</u> *	None
	Specialist visit	\$15/visit. <u>Deductible</u> does not apply.	40% <u>coinsurance</u> *	None
If you visit a health care provider's office or clinic	Telemedicine – through Plan vendor	\$5 copay. <u>Deductible</u> 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% <u>coinsurance</u> * after \$15/visit	Not covered	Limited to 20 visits/year.
	Preventive care/screening/immunization	No charge. <u>Deductible</u> does not apply.	40% <u>coinsurance</u> *	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 <u>plan</u> will pay for.
	Diagnostic test (X-ray, blood work)	10% <u>coinsurance</u> *	40% <u>coinsurance</u> *	None
If you have a test	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u> *	40% <u>coinsurance</u> *	Precertification required on select procedures. **
	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u> *	40% <u>coinsurance</u> *	None
If you have outpatient surgery	Physician/surgeon fees	10% <u>coinsurance</u> *	40% <u>coinsurance</u> *	Precertification required on select procedures. **
	Emergency room care – emergent use	10% <u>coinsurance</u> after \$75/visit. <u>Deductible</u> does not apply.	10% <u>coinsurance</u> after \$75/visit. <u>Deductible</u> does not apply.	Copay waived if admitted.
If you need immediate medical attention	Emergency room care – non-emergent use	40% <u>coinsurance</u> *	40% <u>coinsurance</u> *	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
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u> *	10% <u>coinsurance</u> *	None
	<u>Urgent care</u>	\$15/visit. <u>Deductible</u> does not apply.	40% <u>coinsurance</u> *	None
	Facility fee (e.g., hospital room)	10% <u>coinsurance</u> * after \$100/admit	40% <u>coinsurance</u> *	Precertification required. **
If you have a hospital stay	Physician/surgeon fees	10% <u>coinsurance</u> *	40% <u>coinsurance</u> *	None
	Outpatient services	\$15/visit. <u>Deductible</u> does not apply.	40% <u>coinsurance</u> *	Certain behavioral health services are not covered.
If you need mental health, behavioral health, or substance abuse services	Inpatient services	10% <u>coinsurance</u> * after \$100/admit	40% <u>coinsurance</u> *	Precertification required. ** Certain behavioral health services are not covered.
	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 preventive care.
	Childbirth/delivery professional services	10% <u>coinsurance</u> *	40% <u>coinsurance</u> *	None
If you are pregnant	Childbirth/delivery facility services	10% <u>coinsurance</u> * after \$100/admit	40% <u>coinsurance</u> *	None
	Home health care	10% <u>coinsurance</u> *	40% <u>coinsurance</u> *	Precertification required for out-of-network services. ** Limited to 100 visits/year.
If you need help recovering or have other special health needs	<u>Rehabilitation services</u> - physical, speech, occupational, and other rehabilitative therapies	10% <u>coinsurance</u> *	40% <u>coinsurance</u> *	Precertification required for speech therapy. ** Limited to an aggregated 60 visits/year.
	<u>Habilitation services</u>	Not covered	Not covered	None
	<u>Skilled nursing care</u>	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.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u> *	40% <u>coinsurance</u> *	Precertification required on select items. **
	<u>Hospice services</u>	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

For more information about limitations and exceptions, see the plan or policy document at www.myhnas.com.

- * 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 (34 day supply)	Mail Order Pharmacy (90 day supply)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.envalverx.com	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. 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".
	Family maximum out-of-pocket amount		\$4,000	
	Generic drugs	\$10/prescription	\$20/prescription	
	Preferred brand drugs	\$25/prescription	\$50/prescription	
	Non-preferred brand drugs	\$40/prescription	\$80/prescription	

For more information about limitations and exceptions, see the plan or policy document at www.myhnas.com.

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.)

- | | | |
|---|---|--|
| <ul style="list-style-type: none">• Acupuncture• Cosmetic surgery• Dental care (adult)• Hearing aids | <ul style="list-style-type: none">• Infertility treatment• Long-term care• Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none">• Private duty nursing• Routine eye care (adult)• Routine foot care• Weight loss programs |
|---|---|--|

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

- | | |
|---|---|
| <ul style="list-style-type: none">• Bariatric surgery | <ul style="list-style-type: none">• 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; Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, www.ccio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: HealthNow Administrative Services, 1-877-356-0666, 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): Dinekehgo shika atohwol 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 plan's overall deductible **\$500**
- Specialist 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*)

Total Example Cost **\$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$500
Copayments	\$110
Coinsurance	\$1050
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,720

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

- The plan's overall deductible **\$500**
- Specialist 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*)

Total Example Cost **\$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$120
Copayments	\$660
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$800

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

- The plan's overall deductible **\$500**
- Specialist 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*)

Total Example Cost **\$2,800**


In this example, Mia would pay:

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

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

 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 1-877-356-0666. 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 or call 1-877-356-0666 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers \$0/person and \$0/family. For out-of-network providers \$200/person and \$600/family.	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 expenses.	This plan covers some items and services even if you haven't met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For in-network providers \$3,000/person and \$6,000/family. For out-of-network providers \$4,500/person and \$13,500/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?	Deductible, 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 out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.blueshieldca.com/NetworkPPO 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
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Primary care visit to treat an injury or illness	\$15/visit	30% <u>coinsurance</u> *	None
	Specialist visit	\$15/visit	30% <u>coinsurance</u> *	None
If you visit a health care provider's office or clinic	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.
If you have a test	<u>Preventive care/screening/immunization</u>	No charge	30% <u>coinsurance</u> *	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
	<u>Diagnostic test</u> (x-ray, blood work)	15% <u>coinsurance</u>	30% <u>coinsurance</u> *	None
If you have a test	Imaging (CT/PET scans, MRIs)	15% <u>coinsurance</u>	30% <u>coinsurance</u> *	Pre-certification required on select procedures. **
	Facility fee (e.g., ambulatory surgery center)	15% <u>coinsurance</u>	30% <u>coinsurance</u> *	None
If you have outpatient surgery	Physician/surgeon fees	15% <u>coinsurance</u>	30% <u>coinsurance</u> *	Pre-certification required on select procedures. **
	Emergency room care – emergent use	15% <u>coinsurance</u> after \$75/visit	15% <u>coinsurance</u> after \$75/visit	Copay waived if admitted.
If you need immediate medical attention	Emergency room care – non-emergent use	30% <u>coinsurance</u>	30% <u>coinsurance</u> *	None
	Emergency medical transportation	15% <u>coinsurance</u>	15% <u>coinsurance</u>	None
	Urgent care	\$15/visit	30% <u>coinsurance</u> *	None
If you have a hospital	Facility fee (e.g., hospital room)	15% <u>coinsurance</u> after	30% <u>coinsurance</u> *	Pre-certification required. **

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
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
stay	Physician/surgeon fees	\$100/admit		None
	Outpatient services	15% <u>coinsurance</u>	30% <u>coinsurance</u> *	None
If you need mental health, behavioral health, or substance abuse services	Inpatient services	\$15/visit	30% <u>coinsurance</u> *	Certain behavioral health services are not covered.
	Office visits	15% <u>coinsurance</u> after \$100/admit	30% <u>coinsurance</u> *	Pre-certification required. ** Certain behavioral health services are not covered.
	Office visits	No charge	30% <u>coinsurance</u> *	Cost-sharing does not apply for in-network routine prenatal services that are considered preventive care.
If you are pregnant	Childbirth/delivery professional services		30% <u>coinsurance</u> *	None
	Childbirth/delivery facility services	15% <u>coinsurance</u> after \$100/admit	30% <u>coinsurance</u> *	None
	Home health care	15% <u>coinsurance</u>	30% <u>coinsurance</u> *	Pre-certification required for out-of-network services. ** Limited to 100 visits/year.
If you need help recovering or have other special health needs	Rehabilitation services - physical, speech, occupational, and other rehabilitative therapies	15% <u>coinsurance</u>	30% <u>coinsurance</u> *	Pre-certification required for speech therapy. ** Limited to an aggregated 60 visits/year.
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	15% <u>coinsurance</u>	30% <u>coinsurance</u> *	Pre-certification required. ** Limited to 100 consecutive days/year in-network; 60 consecutive days/year out-of-network.
	Durable medical equipment	15% <u>coinsurance</u>	30% <u>coinsurance</u> *	Pre-certification required on select items. **
	Hospice services	15% <u>coinsurance</u>	30% <u>coinsurance</u> *	Pre-certification 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.

** Pre-certification is required before certain medical services. Emergency admissions must be certified within 48 hours following the admission. To pre-certify services, call the phone number indicated on your ID card. **Failure to pre-certify out-of-network services will result in a 50% penalty.**

For more information about limitations and exceptions, see the plan or policy document at www.mynhas.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Retail Pharmacy (34 day supply)	Mail Order Pharmacy (90 day supply)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.envolvrx.com	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. 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".
	Family maximum out-of-pocket amount		\$4,000	
	Generic drugs	\$10/prescription	\$20/prescription	
	Preferred brand drugs	\$15/prescription	\$30/prescription	
	Non-preferred brand drugs	\$30/prescription	\$60/prescription	

For more information about limitations and exceptions, see the plan or policy document at www.myhnas.com.

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.)

- | | | |
|---|---|--|
| <ul style="list-style-type: none">• Acupuncture• Cosmetic surgery• Dental care (adult)• Hearing aids | <ul style="list-style-type: none">• Infertility treatment• Long-term care• Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none">• Private duty nursing• Routine eye care (adult)• Routine foot care• Weight loss programs |
|---|---|--|

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

- | | |
|---|---|
| <ul style="list-style-type: none">• Bariatric surgery | <ul style="list-style-type: none">• Chiropractic care |
|---|---|

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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

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:

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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): Dinekenho 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.* _____

For more information about limitations and exceptions, see the plan or policy document at www.myhnas.com.

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 **\$0**
- Specialist 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*)

Total Example Cost **\$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$110
Coinsurance	\$1650
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,820

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

- The plan's overall deductible **\$0**
- Specialist 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*)

Total Example Cost **\$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$660
Coinsurance	\$20
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$700

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

- The plan's overall deductible **\$0**
- Specialist 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*)

Total Example Cost **\$2,800**

In this example, Mia would pay:

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

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

 **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 1-877-356-0666. 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 or call 1-877-356-0666 to request a copy.**

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	For in-network providers \$3,000/person and \$6,000/family. For out-of-network providers \$5,950/person and \$11,900/family.	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 <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> . This plan 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 plan covers certain <u>preventive services</u> without cost-sharing and before you meet your deductible. See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there services covered before you meet your <u>deductible</u> ?	Yes, preventive care expenses.	You don't have to meet <u>deductibles</u> for specific services.
Are there other <u>deductibles</u> for specific services?	No.	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 plan, 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 the <u>out-of-pocket limit</u> for this plan?	For in-network providers \$5,950/person and \$11,900/family. For out-of-network providers \$5,950/person and \$11,900/family.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
What is not included in the <u>out-of-pocket limit</u> ?	Copayments, premiums, balance-billed charges, penalties, and health care this plan doesn't cover.	This plan uses a <u>provider network</u> . 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 <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.
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.blueshieldca.com/NetworkPPO or call 1-800-810-2583 for a list of <u>network providers</u> .	You can see the <u>specialist</u> you choose without a <u>referral</u> .
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	

 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)	
	Primary care visit to treat an injury or illness	15% <u>coinsurance</u> *	30% <u>coinsurance</u> *	None
	Specialist visit	15% <u>coinsurance</u> *	30% <u>coinsurance</u> *	None
If you visit a health care provider's office or clinic	Telemedicine – through Plan vendor	\$5 copay. <u>Deductible</u> 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	15% <u>coinsurance</u> *	Not covered	Limited to 20 visits/year.
If you have a test	Preventive care/screening/immunization	No charge. <u>Deductible</u> does not apply.	30% <u>coinsurance</u> *	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.
	Diagnostic test (x-ray, blood work)	15% <u>coinsurance</u> *	30% <u>coinsurance</u> *	None
If you have outpatient surgery	Imaging (CT/PET scans, MRIs)	15% <u>coinsurance</u> *	30% <u>coinsurance</u> *	Precertification required on select procedures. **
	Facility fee (e.g., ambulatory surgery center)	15% <u>coinsurance</u> *	30% <u>coinsurance</u> *	None
If you need immediate medical attention	Physician/surgeon fees	15% <u>coinsurance</u> *	30% <u>coinsurance</u> *	Precertification required on select procedures. **
	Emergency room care – emergent use	15% <u>coinsurance</u> *	15% <u>coinsurance</u> *	None
	Emergency room care – non-emergent use	30% <u>coinsurance</u> *	30% <u>coinsurance</u> *	None
	Emergency medical transportation	15% <u>coinsurance</u> *	15% <u>coinsurance</u> *	None
If you have a hospital	Urgent care	15% <u>coinsurance</u> *	30% <u>coinsurance</u> *	None
	Facility fee (e.g., hospital room)	15% <u>coinsurance</u> *	30% <u>coinsurance</u> *	Precertification required. **

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
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Physician/surgeon fees	15% <u>coinsurance</u> *	30% <u>coinsurance</u> *	None
	Outpatient services	15% <u>coinsurance</u> *	30% <u>coinsurance</u> *	Certain behavioral health services are not covered.
	Inpatient services	15% <u>coinsurance</u> *	30% <u>coinsurance</u> *	Pre-certification required. ** Certain behavioral health services are not covered.
If you are pregnant	Office visits	15% <u>coinsurance</u> *	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> *	30% <u>coinsurance</u> *	None
If you need help recovering or have other special health needs	<u>Home health care</u>	15% <u>coinsurance</u> *	30% <u>coinsurance</u> *	Pre-certification required for out-of-network services. ** Limited to 100 visits/year.
	<u>Rehabilitation services</u> - physical, speech, occupational, and other rehabilitative therapies	15% <u>coinsurance</u> *	30% <u>coinsurance</u> *	Pre-certification required for speech therapy. ** Limited to an aggregated 60 visits/year.
	<u>Habilitation services</u>	Not covered	Not covered	None
	<u>Skilled nursing care</u>	15% <u>coinsurance</u> *	30% <u>coinsurance</u> *	Pre-certification required. ** Limited to 100 consecutive days/year in-network; 60 consecutive days/year out-of-network.
	<u>Durable medical equipment</u>	15% <u>coinsurance</u> *	30% <u>coinsurance</u> *	Pre-certification required on select items. ** Pre-certification required for inpatient care. ** Limited to 180 days/lifetime.
If your child needs dental or eye care	<u>Hospice services</u>	15% <u>coinsurance</u> *	30% <u>coinsurance</u> *	
	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.

** Pre-certification is required before certain medical services. Emergency admissions must be certified within 48 hours following the admission. To pre-certify services, call the phone number indicated on your ID card. **Failure to pre-certify out-of-network services will result in a 50% penalty.**

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
		Retail Pharmacy (34 day supply)	Mail Order Pharmacy (90 day supply)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.envolverx.com	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. 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".
	Family maximum out-of-pocket amount		\$4,000	
	Generic drugs	15% <u>coinsurance</u> *	15% <u>coinsurance</u> *	
	Preferred brand drugs	15% <u>coinsurance</u> *	15% <u>coinsurance</u> *	
	Non-preferred brand drugs	15% <u>coinsurance</u> *	15% <u>coinsurance</u> *	
	*Deductible applies			

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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.)

- | | | |
|---|---|--|
| <ul style="list-style-type: none">• Acupuncture• Cosmetic surgery• Dental care (adult)• Hearing aids | <ul style="list-style-type: none">• Infertility treatment• Long-term care• Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none">• Private duty nursing• Routine eye care (adult)• Routine foot care• Weight loss programs |
|---|---|--|

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

- | | |
|---|---|
| <ul style="list-style-type: none">• Bariatric surgery | <ul style="list-style-type: none">• 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; Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, www.cchio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: HealthNow Administrative Services, 1-877-356-0666, 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.

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

For more information about limitations and exceptions, see the plan or policy document at www.myhnas.com.

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 **\$3000**
- Specialist coinsurance **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)

Total Example Cost \$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$3,000
Copayments	\$0
Coinsurance	\$1,210
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$4,270

Managing Joe's type 2 Diabetes

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

- The plan's overall deductible **\$3000**
- Specialist coinsurance **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)

Total Example Cost \$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$3,000
Copayments	\$0
Coinsurance	\$360
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$3,380

Mia's Simple Fracture

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

- The plan's overall deductible **\$3000**
- Specialist coinsurance **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)

Total Example Cost \$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$2,800
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
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.



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 1-877-356-0666. 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 or call 1-877-356-0666 to request a copy.

Important Questions	Answers	Why This Matters:
<p>What is the overall <u>deductible</u>?</p>	<p>For all <u>providers</u> \$0/person and \$0/family.</p>	<p>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 <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u>.</p>
<p>Are there services covered before you meet your <u>deductible</u>?</p>	<p>Yes, preventive care expenses.</p>	<p>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/.</p>
<p>Are there other <u>deductibles</u> for specific services?</p>	<p>No.</p>	<p>You don't have to meet <u>deductibles</u> for specific services.</p>
<p>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</p>	<p>For all <u>providers</u> \$3,000/person and \$6,000/family.</p>	<p>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.</p>
<p>What is not included in the <u>out-of-pocket limit</u>?</p>	<p>Prescription drug copayments, premiums, balance-billed charges, penalties, and health care this plan doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.</p>
<p>Will you pay less if you use a <u>network provider</u>?</p>	<p>Yes. See www.blueshieldca.com/NetworkPPO or call 1-800-810-2583 for a list of <u>network providers</u>.</p>	<p>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 provider for the difference between the provider's charge and what 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.</p>
<p>Do you need a <u>referral</u> to see a <u>specialist</u>?</p>	<p>No.</p>	<p>You can see the <u>specialist</u> you choose without a <u>referral</u>.</p>

 All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$15/visit	Not covered	None
	Specialist 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.
If you have a test	Chiropractic visit	15% <u>coinsurance</u> after \$15/visit	Not covered	Limited to 20 visits/year. 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 <u>plan</u> will pay for.
	Preventive care/screening/immunization	No charge	Not covered	
	Diagnostic test (x-ray, blood work)	15% <u>coinsurance</u>	Not covered	None
If you have outpatient surgery	Imaging (CT/PET scans, MRIs)	15% <u>coinsurance</u>	Not covered	Pre-certification required on select procedures. **
	Facility fee (e.g., ambulatory surgery center)	15% <u>coinsurance</u>	Not covered	None
	Physician/surgeon fees	15% <u>coinsurance</u>	Not covered	Pre-certification required on select procedures. **
If you need immediate medical attention	Emergency room care – emergent use	15% <u>coinsurance</u> after \$75/visit	Paid as in-network	Copay waived if admitted.
	Emergency room care – non-emergent use	30% <u>coinsurance</u>	Paid as in-network	None
	Emergency medical transportation	15% <u>coinsurance</u>	Paid as in-network	None
	Urgent care	\$15/visit	30% <u>coinsurance</u>	None

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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, or substance abuse services	Outpatient services	\$15/visit	Not covered	Certain behavioral health services are not covered.
	Inpatient services	15% <u>coinsurance</u> after \$100/admit	Not covered	Precertification required.** Certain behavioral health services are not covered.
	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
If you are pregnant	Childbirth/delivery facility services	15% <u>coinsurance</u> after \$100/admit	Not covered	None
	Home health care	15% <u>coinsurance</u>	Not covered	Limited to 100 visits/year.
If you need help recovering or have other special health needs	<u>Rehabilitation services</u> - 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.
	<u>Habilitation services</u>	Not covered	Not covered	None
	<u>Skilled nursing care</u>	15% <u>coinsurance</u>	Not covered	Precertification required.** Limited to 100 consecutive days/year in-network.
	<u>Durable medical equipment</u>	15% <u>coinsurance</u>	Not covered	Precertification required on select items.**
	<u>Hospice services</u>	15% <u>coinsurance</u>	Not covered	Precertification required for inpatient care.** Limited to 180 days/lifetime.
	<u>Children's eye exam</u>	Not covered	Not covered	None
If your child needs dental or eye care	<u>Children's glasses</u>	Not covered	Not covered	None
	<u>Children's dental check-up</u>	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 (34 day supply)	Mail Order Pharmacy (90 day supply)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.envolverx.com	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. Certain medications considered preventive care under ACA are payable at no cost-share to the member. 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".
	Family maximum out-of-pocket amount		\$4,000	
	Generic drugs	\$10/prescription	\$20/prescription	
	Preferred brand drugs	\$15/prescription	\$30/prescription	
	Non-preferred brand drugs	\$30/prescription	\$60/prescription	

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- | | | |
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- | | |
|---|---|
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Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$0
- Specialist 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 (anesthesis)

Total Example Cost \$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$110
Coinsurance	\$1,650
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,820

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

- The plan's overall deductible \$0
- Specialist 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)

Total Example Cost \$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$660
Coinsurance	\$20
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$700

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

- The plan's overall deductible \$0
- Specialist 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)

Total Example Cost \$2,800

In this example, Mia would pay:

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

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