This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.hnas.com or by calling 1-844-836-6177.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network: $0; out-of-network: $500 person/$1,000 2-person; $1,500 family. Doesn't apply to emergency room visits, in-network physician & specialist office visits, breast pump, preventive care or prescription drugs.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. In-network: $2,000 person / $4,000 2-person / $6,000 family; out-of-network: $5,000 person / $10,000 2-person / $15,000 family.	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.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, some cost sharing and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.blueshieldca.com/networkPPO or call 1-800-541-6652 for a list of in-network providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from the plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 8. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **in-network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10/visit	30% coinsurance*	For other services rendered during an office visit, additional member cost-share may apply.
	Specialist visit	$10/visit	30% coinsurance*	
	Other practitioner office visit - Chiropractor	$25/visit	30% coinsurance*	Chiropractor is limited to 12 visits/year. Acupuncture is limited to 20 visits/year. Additional member cost-share applies for covered x-ray services received in conjunction with an office visit.
	Other practitioner office visit - Acupuncture	$25/visit	30% coinsurance*	
	Preventive care/screening/immunization	No charge	Not covered	Includes all mandated preventive care as required under PPACA.
If you have a test	Diagnostic test (x-ray, blood work) – free-standing location	$10/visit	30% coinsurance*	--none--
	Diagnostic test (x-ray, blood work) – outpatient hospital	$35/visit	30% coinsurance*	The maximum allowed amount for out-of-network providers is $350/day. Members are responsible for 30% of this $350/day, plus all charges in excess of $350.
	Imaging (CT/PET scans, MRIs) – free-standing location	10% coinsurance	30% coinsurance*	Precertification is required.**

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
	Imaging (CT/PET scans, MRIs) – outpatient hospital	10% coinsurance after $100/visit	30% coinsurance*	Precertification is required.** The maximum allowed amount for out-of-network providers is $350/day. Members are responsible for 30% of this $350/day, plus all charges in excess of $350.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance*	The maximum allowed amount for out-of-network providers is $350/day. Members are responsible for 30% of this $350/day, plus all charges in excess of $350.
	Physician/surgeon fees	10% coinsurance	30% coinsurance*	--none--
If you need immediate medical attention	Emergency room services - facility	$100/visit	$100/visit	Co-pay waived if admitted.
	Emergency room services – physician	10% coinsurance	10% coinsurance	--none--
	Emergency medical transportation	10% coinsurance	10% coinsurance	--none--
	Urgent care – free-standing center	$10/visit	30% coinsurance*	--none--
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance*	Precertification required.** The maximum allowed amount for out-of-network providers is $600/day. Members are responsible for 30% of this $600/day, plus all charges in excess of $600.
	Physician/surgeon fee	10% coinsurance	30% coinsurance*	--none--

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health routine outpatient services	$10/visit	30% coinsurance*	Services include office visits.
	Mental/Behavioral health non-routine outpatient services	No charge	30% coinsurance*	Precertification is required.** Services include behavioral health treatment, electroconvulsive therapy, intensive outpatient programs, partial hospitalization programs and transcranial magnetic stimulation. Higher copayment & facility charges per episode of care may apply for partial hospitalization.
	Mental/Behavioral health inpatient services - hospital services, residential services & physician services	10% coinsurance	30% coinsurance*	Precertification required.** The maximum allowed amount for out-of-network providers is $600/day. Members are responsible for 30% of this $600/day, plus all charges in excess of $600.
	Substance use disorder routine outpatient services	$10/visit	30% coinsurance*	Services include office visits.
	Substance use disorder non-routine outpatient services	No charge	30% coinsurance*	Precertification required.** Services include partial hospitalization, intensive outpatient programs & office-based opioid treatment. Higher copayment & facility charges per episode of care may apply for partial hospitalization.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
	Substance use disorder inpatient services – hospital services, residential services & physician services	10% coinsurance	30% coinsurance*	Precertification required.** The maximum allowed amount for out-of-network providers is $600/day. Members are responsible for 30% of this $600/day, plus all charges in excess of $600.
If you are pregnant	Prenatal care	No charge	30% coinsurance*	--none--
	Postnatal care	10% coinsurance	30% coinsurance*	--none--
	Delivery and all inpatient services	10% coinsurance	30% coinsurance*	The maximum allowed amount for out-of-network providers is $600/day. Members are responsible for 30% of this $600/day, plus all charges in excess of $600.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	10% coinsurance	Not covered	Precertification is required.** Limited to 100 visits/year. Out-of-network home health care & home infusion are not covered unless pre-authorized. When these services are pre-authorized, you pay the in-network coinsurance.
	Rehabilitation services – office visit & outpatient hospital	$10/visit	30% coinsurance*	Physical, occupational, speech & respiratory therapy services.
	Habilitation services – office visit & outpatient hospital	$10/visit	30% coinsurance*	--none--
	Skilled nursing care – free-standing facility	10% coinsurance	10% coinsurance*	Precertification required.** Limited to 100 days/year, combined with hospital-based skilled nursing care. The maximum allowed amount for out-of-network providers is $600/day. Members are responsible for 30% of this $600/day, plus all charges in excess of $600.
	Durable medical equipment	10% coinsurance	30% coinsurance*	Precertification is required.**
	Hospice service	No charge	Not covered	Precertification is required (except for pre-hospice consultation).** 10% coinsurance will apply to 24-hour continuous care & general inpatient hospice care services.

If your child needs dental or eye care	Eye exam	Not covered	Not covered	--none--
	Glasses	Not covered	Not covered	--none--
	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 may result in a denial of benefits.**

Common Medical Event	Services You May Need	Your Cost If You Use a Retail Pharmacy (34 day supply)	Your Cost If You Use a Mail Order Pharmacy (90 day supply)	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com.	Generic drugs	$10/prescription	$20/prescription	The Prescription Drug Plan will pay up to the generic price, less the generic co-payment, whenever a generic drug is dispensed. If a preferred or non-preferred 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 drug and the generic equivalent, plus the generic co-payment unless the physician specifies "Dispense as Written". Certain preventive care drugs are covered at a $0 co-pay.
	Preferred brand drugs	$20/prescription	$40/prescription	
	Non-preferred brand drugs	$35/prescription	$70/prescription	
	Specialty drugs	30% coinsurance, up to a maximum copay of $200	Not covered	
Out-of-network medication purchases at retail will require the applicable copayment plus 25% of the billed amount.				

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental care (adult/child)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing (except as provided under Home Health Care or Hospital)
- Routine eye care (adult/child)
- Routine foot care (unless for treatment of diabetes)
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture (limited to 20 visits/year)
- Bariatric surgery (precertification is required)
- Chiropractic care (limited to 12 visits/year)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending on your circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-844-836-6177. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact HNAS at 1-844-836-6177, or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-844-836-6177.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-836-6177.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-844-836-6177.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-836-6177.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,650
- **Patient pays** $830

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$20
Coinsurance	$660
Limits or exclusions	$150
Total	**$830**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,590
- **Patient pays** $900

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$820
Coinsurance	$0
Limits or exclusions	$80
Total	**$900**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.