
 The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately.** This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit [www.myhnas.com](http://www.myhnas.com) or call 1-855-581-1810. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at [www.myhnas.com](http://www.myhnas.com) or call 1-855-581-1810 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	For in-network <a href="#">providers</a> \$750/person and \$1,500/family.	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers. Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this plan begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes, preventive care, emergency room physician services, benefits subject to a co-pay, and prescription drug expenses.	This <a href="#">plan</a> covers some items and services even if you haven't met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For in-network <a href="#">providers</a> \$4,000/person and \$8,000/family.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Premiums, balance-billed charges, penalties, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.myhnas.com">www.myhnas.com</a> or call 1-855-581-1810 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware that your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$25/visit. <a href="#">Deductible</a> does not apply.	Not covered	None
	<a href="#">Specialist</a> visit	\$40/visit. <a href="#">Deductible</a> does not apply.	Not covered	Includes chiropractic care to a maximum 24 visits per year, and acupuncture to a maximum 12 visits per year.
	<a href="#">Preventive care/screening/immunization</a>	No charge. <a href="#">Deductible</a> does not apply.	Not covered	Includes preventive services as mandated by ACA. You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
	Telemedicine – through plan vendor	\$25/visit. <a href="#">Deductible</a> does not apply.	N/A	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. primary care visit) for the service.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	0% <a href="#">coinsurance</a>	Not covered	None
	Imaging (CT/PET scans, MRIs)	10% <a href="#">coinsurance</a>	Not covered	Precertification required.*
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	10% <a href="#">coinsurance</a>	Not covered	None
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	Not covered	None
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$200/visit. <a href="#">Deductible</a> does not apply.	In-network benefit applies	If admitted to the hospital, the hospital stay benefits will apply.
	<a href="#">Emergency medical transportation</a>	10% <a href="#">coinsurance</a>	In-network benefit applies	None
	<a href="#">Urgent care</a>	\$50/visit. <a href="#">Deductible</a> does not apply.	In-network benefit applies	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	10% <a href="#">coinsurance</a>	Not covered	Precertification required.*
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Office services	\$25/visit. <u>Deductible</u> does not apply.	Not covered	None
	Outpatient services	10% <u>coinsurance</u>	Not covered	Precertification required.*
	Inpatient services	10% <u>coinsurance</u>	Not covered	Precertification required.*
If you are pregnant	Office visits	\$0/visit. <u>Deductible</u> does not apply.	Not covered	The physician/ specialist office visit will apply to the first visit. Cost-sharing does not apply for in-network routine prenatal services that are considered <u>preventive care</u> . Depending on the type of service, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC.
	Childbirth/delivery professional services	10% <u>coinsurance</u>	Not covered	None
	Childbirth/delivery facility services	10% <u>coinsurance</u>	Not covered	None
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	10% <u>coinsurance</u>	Not covered	Limited to 120 visits/year (4 hours = 1 visit).
	<a href="#">Rehabilitation/ Habilitation services</a> - Office	\$40/visit. <u>Deductible</u> does not apply.	Not covered	Includes physical, speech, occupational, and other rehabilitative therapies.
	<a href="#">Rehabilitation/ Habilitation services</a> – Outpatient facility	10% <u>coinsurance</u>	Not covered	
	<a href="#">Skilled nursing care</a>	10% <u>coinsurance</u>	Not covered	Precertification required.* Limited to 120 days/year. Services provided as part of a hospice program are not subject to the maximum.
	<a href="#">Durable medical equipment</a>	10% <u>coinsurance</u>	Not covered	Precertification required* for DME over \$1,000. Limited to 1/ each type of DME (including repair and replacement) every 3 years.
	<a href="#">Hospice services</a>	10% <u>coinsurance</u>	Not covered	Precertification required.*

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	\$40/visit. <u>Deductible</u> does not apply.	Not covered	Limited to one exam every other calendar year.
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Retail Pharmacy (30 day supply)	Mail Order Pharmacy (90 day supply)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.southernscripts.net">www.southernscripts.net</a> .	Generic drugs	\$10/prescription. <u>Deductible</u> does not apply.	\$20/prescription. <u>Deductible</u> does not apply.	Certain medications considered <u>preventive care</u> under ACA are payable at no cost-share to the member.
	Preferred brand drugs	\$25/prescription. <u>Deductible</u> does not apply.	\$50/prescription. <u>Deductible</u> does not apply.	
	Non-preferred brand drugs	\$45/prescription. <u>Deductible</u> does not apply.	\$90/prescription. <u>Deductible</u> does not apply.	
	<a href="#">Specialty drugs</a>	\$45/prescription. <u>Deductible</u> does not apply.	\$45/prescription. <u>Deductible</u> does not apply. Limited to a 30 day supply.	

## 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](#).)

- Cosmetic surgery
- Dental care (adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Private duty nursing
- 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.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Non-emergency care when traveling outside the U.S
- Routine eye care (adult)

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: HealthNow Administrative Services, 1-855-581-1810, [www.myhnas.com](http://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](http://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](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: HealthNow Administrative Services, 1-855-581-1810, [www.myhnas.com](http://www.myhnas.com).

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

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

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

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

### Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-581-1810.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-581-1810.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-855-581-1810.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-581-1810.

—————*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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$750
■ <a href="#">Specialist</a> copayment	\$40
■ 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*)

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

<i>Cost Sharing</i>	
Deductibles	\$750
Copayments	\$10
Coinsurance	\$1030
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,850</b>

### Managing Joe's type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$750
■ <a href="#">Specialist</a> copayment	\$40
■ 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*)

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

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$790
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$810</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$750
■ <a href="#">Specialist</a> copayment	\$40
■ 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*)

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

<i>Cost Sharing</i>	
Deductibles	\$750
Copayments	\$410
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,260</b>