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 1-877-629-1500. 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 1-877-629-1500 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in- and out-of-network providers combined $250/person and $750/family. Deductible is waived at Enloe.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes, preventive care, benefits subject to a co-pay, prescription drug expenses and hospice.	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?	Medical: For Tier I & Tier II[1] providers combined $2,500/person and $7,500/family. For Tier III providers No limit.[2] Rx: $2,000/person and $4,000/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. [1]Tier II services will only accumulate to the out-of-pocket limit when services are authorized and cannot be performed at Enloe or are for an emergency. [2]Tier III services will only accumulate to the Tier I/Tier II out-of-pocket limit when services are authorized and cannot be performed at a Tier I or Tier II facility or are for an emergency.
What is not included in the out-of-pocket limit?	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 1-800-541-6652 for a list of network providers in CA; or 1-800-810-2583 outside of CA.	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). You pay the least if you use a provider in Enloe. You pay more if you use a provider in the Blue Shield 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?	A referral authorization is needed for Tier II and Tier III services.	A referral authorization will be needed prior to receiving any services at a non-Enloe facility. Please call the number as indicated on your identification card. **If authorization is not obtained, benefits will be denied.**

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier I - Enloe (You will pay the least)	Tier II - Blue Shield PPO Network Provider	Tier III - Non-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25/visit. Deductible does not apply.	$25/visit. Deductible does not apply.	20% coinsurance*	None
	Specialist visit	$25/visit. Deductible does not apply.	$25/visit. Deductible does not apply.	20% coinsurance*	None
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	No charge. Deductible does not apply.	20% coinsurance*	Includes preventive services as mandated by ACA. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. Some preventive care is not available at Enloe.
	Telemedicine – through Teladoc	Not a hospital level service	$10/visit. Deductible 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.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier I - Enloe (You will pay the least)	Tier II - Blue Shield PPO Network Provider	Tier III - Non-Network Provider (You will pay the most)	
If you have a test	Outpatient Diagnostic test (x-ray, blood work)	No charge. Deductible does not apply.	Not covered	Not covered	Outpatient services are not covered outside of Enloe unless Enloe does not provide the service. Lab/cultures taken at Enloe may be sent to a non-Enloe lab for processing. If this occurs, you may call the plan administrator to have those expenses paid at the Enloe benefit level.
	Outpatient Imaging (CT/PET scans, MRIs)	No charge. Deductible does not apply.	Not covered	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance. Deductible does not apply.	Not covered	Not covered	Coverage is only available outside of Enloe in the event of an emergency or for services that are not provided at Enloe.
	Physician/ surgeon fees	20% coinsurance*	20% coinsurance*	20% coinsurance*	None
	All other outpatient services & supplies	10% coinsurance. Deductible does not apply.	Not covered	Not covered	Coverage is only available outside of Enloe in the event of an emergency or for services that are not provided at Enloe.
If you need immediate medical attention	Emergency room care - Emergency	$75/visit. Deductible does not apply.	$75/visit. Deductible does not apply.	$75/visit. Deductible does not apply.	Co-pay waived if admitted. The Tier III co-pay will accumulate to the Tier I/ Tier II out-of-pocket limit.
	Emergency room care – Non-emergency	$75/visit. Deductible does not apply.	40% coinsurance*	40% coinsurance*	None
	Emergency room care – Physician services	20% coinsurance*	20% coinsurance*	20% coinsurance*	None
	Emergency medical transportation	10% coinsurance. Deductible does not apply.	20% coinsurance*	20% coinsurance*	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier I - Enloe (You will pay the least)	Tier II - Blue Shield PPO Network Provider	Tier III - Non-Network Provider (You will pay the most)	
	Urgent care – Office Visit	$25/visit. Deductible does not apply.	$25/visit. Deductible does not apply. (Only if outside Chico)	$25/visit. (Only if outside Chico)	None
	Urgent care – Diagnostic Services	No charge. Deductible does not apply.	20% coinsurance. Deductible does not apply.	20% coinsurance*	Lab & radiology services obtained at a non-Enloe facility will only be covered if services are urgent in nature.
	Urgent care – Other Services	10% coinsurance. Deductible does not apply.	20% coinsurance. Deductible does not apply.	20% coinsurance*	Physician charges for reading x-rays at an urgent care center are covered at 20% coinsurance.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance. Deductible does not apply.	Not covered	Not covered	Precertification required.** Coverage is only available outside of Enloe in the event of an emergency or for services that are not provided at Enloe.
	Physician/ surgeon fees	20% coinsurance*	20% coinsurance*	20% coinsurance*	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier I - Enloe (You will pay the least)	Tier II - Blue Shield PPO Network Provider	Tier III - Non-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services – Office Visit	Not a hospital level service	$25/visit. Deductible does not apply.	20% coinsurance*	None
	Outpatient services – All other services including partial hospitalization	10% coinsurance. Deductible does not apply.	20% coinsurance	20% coinsurance	
	Inpatient services – Mental Health	10% coinsurance. Deductible does not apply.	20% coinsurance	20% coinsurance	Precertification required.** Certain behavioral health services are not covered. Coverage is only available outside of Enloe in the event of an emergency or for services that are not provided at Enloe. Substance Use Disorders treatment is not available at Enloe.
	Inpatient services – Substance Use Disorders	Not a hospital level service	20% coinsurance	20% coinsurance	
If you are pregnant	Office visits	Not a hospital level service	$25/visit. Deductible does not apply.	20% coinsurance*	Cost-sharing does not apply for in-network routine prenatal services that are considered preventive care. Depending on the type of services, coinsurance may apply. Maternity care may include tests & services described elsewhere in the SBC (i.e. ultrasound). For inpatient care, coverage is only available outside of Enloe in the event of an emergency or for services that are not provided at Enloe.
	Childbirth/delivery physician/midwife services	20% coinsurance*	20% coinsurance*	20% coinsurance*	
	Childbirth/delivery facility services	10% coinsurance. Deductible does not apply.	Not covered	Not covered	
If you need help recovering or have other special health needs	Home health care	10% coinsurance. Deductible does not apply.	Not covered	Not covered	Precertification required.** Limited to 100 visits/year.
	Rehabilitation services	10% coinsurance. Deductible does not apply.	Not covered	Not covered	Includes physical, speech, occupational, and other rehabilitative therapies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier I - Enloe (You will pay the least)	Tier II - Blue Shield PPO Network Provider	Tier III - Non-Network Provider (You will pay the most)	
	Habilitation services	Not covered	Not covered	Not covered	None
	Skilled nursing care	Not a hospital level service	20% coinsurance*	20% coinsurance*	Precertification required.**
	Durable medical equipment	10% coinsurance. Deductible does not apply.	Not covered	Not covered	None
	Hospice services - Inpatient	10% coinsurance. Deductible does not apply.	Not covered	Not covered	Precertification required.**
	Hospice services - Outpatient	10% coinsurance. Deductible does not apply.	Not covered	Not covered	None
If your child needs dental or eye care	Children's eye exam	Not a hospital level service	No charge. Deductible does not apply.	20% coinsurance*	Eye refraction is not covered (preventive exam only).
	Children's glasses	Not covered	Not covered	Not covered	Refer to VSP.
	Children's dental check-up	Not covered	Not covered	Not covered	Refer to Delta Dental.

* 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 will result in a $500 penalty.**

Please note: A referral authorization will be needed prior to receiving any services at a non-Enloe facility. Please call the number as indicated on your identification card. **If authorization is not obtained, benefits will be denied.**

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Enloe Retail Pharmacy (30-90 day supply)	MedImpact Retail Pharmacy (30 day supply)	MedImpact Mail Order Pharmacy (Up to 90-day supply)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.medimpact.com	Individual Out-Of-Pocket Limit	$2,000			Includes prescription drug co-pays. The out-of-pocket limit is the most you could pay during a benefit year for your share of the cost of covered expenses. When an individual or family reaches the annual limit, the Plan pays 100% of additional covered expenses for the rest of the benefit year. Balance-billed charges and penalties do not apply to the out-of-pocket amount.
	Family Out-Of-Pocket Limit	$4,000			
	Generic drugs	$10/prescription per 30-day supply. Deductible does not apply.	$15/prescription. Deductible does not apply.	Not covered	Certain medications considered preventive care under ACA are payable at no cost-share to the member. MedImpact pharmacies are covered only when Enloe pharmacies are closed or for urgent non-maintenance fills.
	Preferred brand drugs	$25/prescription per 30-day supply. Deductible does not apply.	$25/prescription. Deductible does not apply.	Not covered	
	Non-preferred brand drugs	Not covered, unless pre-authorized. The formulary co-pay applies if approved.	Not covered, unless pre-authorized. The formulary co-pay applies if approved.	Not covered	
	Specialty drugs	Not covered	Not covered	Not covered	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Chiropractic are
- Cosmetic surgery
- Dental care (adult)
- Habilitation services
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye care (adult)
- Routine eye refractions (children)
- 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.)

- Bariatric surgery, limited to morbid obesity
- Hearing aids

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, 1-877-629-1500, www.myhnas.com; Department of Labor/Employee Benefits Security Administration, 1-866-444-EBSA (3272), www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: HealthNow Administrative Services, 1-877-629-1500, www.myhnas.com; Department of Labor/Employee Benefits Security Administration, 1-866-444-EBSA (3272), www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes
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 1-877-629-1500.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-629-1500.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-877-629-1500.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-629-1500.

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	$250
Specialist copayment	$25
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	$250
Copayments	$10
Coinsurance	$1320
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1640**

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

The plan's overall deductible	$250
Specialist copayment	$25
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	$0
Copayments	$760
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$780**

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

The plan's overall deductible	$250
Specialist copayment	$25
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	$0
Copayments	$130
Coinsurance	$130
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$260**

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