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, contact the claims administrator at 1-800-370-5852 or visit www.blueadvantagearkansas.com. 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 https://www.healthcare.gov/sbc-glossary or call 1-800-370-5852 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network Provider $1,500 individual/ $3,000 family Out-of-Network Provider $3,000 individual/ $6,000 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?	In-Network: Preventive care, & Pharmacy copays	This plan covers some items and services even if you haven't yet 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?	In-Network Provider $7,500 individual/ $15,000 family Out-of-Network Provider $15,000 individual/ $30,000 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.
What is not included in the out-of-pocket limit?	Premiums, balance billing charges, health care this plan doesn't cover, and cost containment penalties.	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.blueadvantagearkansas.com or call 1-800-370-5852 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, 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 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
		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	$20 copay/physician office visit charge	$50 copay/physician office visit charge	No charge for telehealth services received from an authorized telehealth vendor. An Out-of-Network office visit charge is reimbursed at 100%, up to $80 maximum per visit, after copay. Chiropractic services are limited to $1,000 per calendar year.
	Specialist visit	$20 copay/physician office visit charge	$50 copay/physician office visit charge	
	Preventive care/screening/ immunization	Zero cost share	40% coinsurance	At all times this Plan will comply with the Patient Protection and Affordable Care Act. The list of services included as Standard Preventive Care may change from time to time depending upon government guidelines. A current listing of required preventive care can be accessed at: www.HealthCare.gov/center/regulations/prevention.htmlThe Plan must provide coverage for the USPSTF published recommendations for the plan year that begins on or after the date that is one year after the date the recommendation is published. 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.
If you have a test	Diagnostic test (x-ray, blood work)	Office setting: No charge Other locations: 20% coinsurance	Office setting: No charge Other locations: 40% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	——————none——————

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition: More information about **prescription drug coverage** is available at www.blueadvantagearkansas.com.	Generic drugs	**Retail: Value Priced Generics:** $0 copay **Retail: All other Generic drugs:** $15 copay **Mail Order:** $30 copay	Not covered	**Retail:** 30-day supply of drugs is available for one copay. **Mail order:** 90-day supply. Coverage for erectile dysfunction drugs is limited to eight pills per 30-day supply with a $50 copay.
	Preferred brand drugs	**Retail:** $30 copay **Mail Order:** $60 copay	Not covered	
	Non-preferred brand drugs	**Retail:** $55 copay **Mail Order:** $110 copay	Not covered	
	Specialty drugs	**Retail:** $100 copay	Not covered	Coverage for specialty drugs is only applicable if the SHARx program fails to provide a solution. SHARx solutions come from a variety of sources, including manufacturer assistance programs, copay cards, grants, and mail order pharmacies. To obtain further information please contact SHARx customer service at 1-341-451-3555. Some specialty drugs may qualify for third party copayment assistance programs which could lower your out-of-pocket costs for those products. For any such specialty drugs where third party copayment assistance is used, credit shall not be received toward your out-of-pocket limit or deductible for any copayment amounts or coinsurance amounts that are applied from a manufacturer coupon or rebate.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	——————none——————
	Physician/surgeon fees	20% coinsurance	40% coinsurance	——————none——————

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	**Medical Emergency** 20% coinsurance **Non-Emergency:** $200 copay, then 20% coinsurance	**Medical Emergency** 20% coinsurance **Non-Emergency:** $200 copay, then 40% coinsurance	——————none——————
	Emergency medical transportation	20% coinsurance	20% coinsurance	——————none——————
	Urgent care	**Medical Emergency:** $50 copay/per physician visit charge **Non-Emergency:** $50copay/per physician visit charge	**Medical Emergency:** $50 copay/per physician visit charge **Non-Emergency:** 40% coinsurance	——————none——————
If you have a hospital stay:	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	The Covered Person is responsible for obtaining prior approval for all Out-of-Network inpatient admissions. Failure to obtain prior approval will result in a $300 reduction in benefits.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	——————none——————
If you need mental health, behavioral health, or substance abuse services:	Outpatient services	20% coinsurance	40% coinsurance	——————none——————
	Inpatient services	20% coinsurance	40% coinsurance	The Covered Person is responsible for obtaining prior approval for all Out-of-Network inpatient admissions. Failure to obtain prior approval will result in a $300 reduction in benefits. Residential Treatment Facility is limited to 60 days per calendar year.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant:	Office visits	$20 copay/per physician office visit charge	40% coinsurance	Routine obstetrical ultrasound limited to one per pregnancy copay.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	——————none——————
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	——————none——————
If you need help recovering or have other special health needs:	Home health care	20% coinsurance	40% coinsurance	Home health care is limited to 20 visits per calendar year.
	Rehabilitation services	20% coinsurance	40% coinsurance	Cardiac Rehabilitation limited to 36 visits per calendar year. Occupational and Physical Therapies have a combined 30 visit limit per calendar year. Speech therapy is limited to 25 visits per calendar year.
	Habilitation services	Not covered	Not covered	Habilitation services are not covered.
	Skilled nursing care	20% coinsurance	40% coinsurance	Skilled nursing care is limited to 60 days per calendar year.
	Durable medical equipment	20% coinsurance	40% coinsurance	——————none——————
	Hospice services	20% coinsurance	40% coinsurance	——————none——————

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care:	Children's eye exam	Medical eye exam following an eye injury or illness: $20 copay/per physician office visit charge. Routine eye exams for children under 6: No charge.	Medical eye exam following an eye injury or illness: $50 copay/per physician office visit charge. Routine eye exams for children under 6: 40% coinsurance	. Children's routine eye exams are limited under the age of six. Additional services may be available under a separate vision benefit plan.
	Children's glasses	Not covered	Not covered	No coverage for glasses under the Medical Benefit Plan. Additional services may be available under a separate vision benefit plan.
	Children's dental check-up	Not covered	Not covered	There is no coverage for dental check-ups under the medical benefit plan. Additional services may be available under a separate dental benefit plan.

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
- Cosmetic surgery
- Dental care
- Habilitation services
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care
- Routine foot care

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

- Chiropractic care
- Hearing aids (limited to $1,400 per ear, every three years.)
- Private-duty nursing (when combined with Home Health Services)
- Bariatric Surgery
- Weight loss program is limited to $200 per lifetime for the covered employee only.

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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: Bruce Oakley, Inc. P.O. Box 17880 North Little Rock, AR 72117 or by phone at 1-800-693-6107. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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

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

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

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

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-370-5852.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-370-5852.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-370-5852.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-370-5852.

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.blueadvantagearkansas.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** **$1,500**
- **Specialist** **$20 copay**
- **Hospital (facility)** **20% coinsurance**
- **Other** **20% coinsurance**

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	$1,500
Copayments	$10
Coinsurance	$2,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,770**

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

- **The plan's overall deductible** **$1,500**
- **Specialist** **$20 copay**
- **Hospital (facility)** **20% coinsurance**
- **Other** **20% coinsurance**

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	$900
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,620**

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

- **The plan's overall deductible** **$1,500**
- **Specialist** **$20 copay**
- **Hospital (facility)** **20% coinsurance**
- **Other** **20% coinsurance**

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	$1,500
Copayments	$70
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,770**

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