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, 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 at https://www.healthcare.gov/sbc-glossary or call 1-800-370-5852 or to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network providers $1,000 individual / $ 2,000 family Out-of-network providers $1,000 individual / $2,000 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?	Yes. The following in-network services: preventive care office/telehealth, prescription drugs received from the pharmacy, and urgent care are covered before you meet your deductible.	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 providers $5,000 individual / $10,000 family Out-of-network providers $8,000 individual / $16,000 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, prior approval 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.blueadvantagearkansas.com or call 1-800-370-5852 or 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 a 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	$30 copay/per visit; ; deductible does not apply.	40% coinsurance	In-network telehealth services are no charge. Telehealth services received from an authorized telehealth vendor are also available at no charge.
	Specialist visit	$50 copay/per visit; deductible does not apply	40% coinsurance	
	Preventive care/screening/ immunization	No charge	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. The 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)	$30 copay/per office visit; deductible does not apply	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.express-scripts.com.	Generic drugs	$10 copay/prescription (retail 30-days) $20 copay/prescription (retail and home delivery 90-days) Deductible does not apply.	Not covered	Coverage is limited up to a 90-day supply (retain and home delivery); up to a 30-day supply (retail and home deliver) for specialty drugs. Certain limitations may apply, including for example: prior authorization, step therapy, quantity limits. No cost share for generics only available on the preventive therapy drug list.
	Preferred brand drugs	$40 copay/prescription (retail 30-days) $80 copay/prescription (retail and home delivery 90-days) Deductible does not apply	Not covered	
	Non-preferred brand drugs	$60 copay/prescription (retail 30-days) $120 copay/prescription (retail and home delivery 90-days) Deductible does not apply.	Not covered	
	Specialty drugs	As listed above.	Not covered	
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——————
If you need immediate medical attention	Emergency room care	20% coinsurance:	20% coinsurance:	——————none——————
	Emergency medical transportation	20% coinsurance	20% coinsurance	——————none——————
	Urgent care	Medical Emergency: $50 copay/per visit; deductible does not apply. Non-Medical Emergency: $50 copay/per visit; deductible does not apply:	Medical Emergency: $50 copay/per visit; deductible does not apply. Non-Medical Emergency: 20% 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 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 provider inpatient admissions. Failure to obtain prior approval will result in a $750 reduction in benefits.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	——————none——————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office services: $30 copay/per visit; deductible does not apply Outpatient services: 20% coinsurance	40% coinsurance	In-network telehealth services are no charge. Telehealth services received from an authorized telehealth vendor is also available at no charge.
	Inpatient services	20% coinsurance	40% coinsurance	The covered person is responsible for obtaining prior approval for all out-of-network provider inpatient admissions. Failure to obtain prior approval will result in a $750 reduction in benefits.
If you are pregnant	Office visits	$30 copay/per visit; deductible does not apply	40% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Routine obstetrical ultrasound is limited to one per pregnancy.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	——————none——————
	Childbirth/delivery facility 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 you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Home health care is limited to 40 visits per calendar year.
	Rehabilitation services	Office and outpatient services: $30 copay/per visit; deductible does not apply. Inpatient services: 20% coinsurance	40% coinsurance	Cardiac rehabilitation is limited to 36 outpatient/office visits per calendar year. Chiropractic services, pulmonary and cognitive therapies have a combined limit of 30 outpatient/office visits per calendar year. Physical and occupational therapies have a combined limit of 30 outpatient/office visits per calendar year. Speech therapy is limited to 25 outpatient/office visits per calendar year. Pulmonary and cognitive therapies have a combined limit of 30 outpatient/office visits per calendar year.
	Habilitation services	Office and outpatient services: $30 copay/per visit; deductible does not apply. Inpatient services: 20% coinsurance	40% coinsurance	Physical and occupational habilitative therapies have a combined limit of 30 outpatient/office visits per calendar year. Speech therapy is limited to 25 outpatient/office visits per calendar year.
	Skilled nursing care	20% coinsurance	40% coinsurance	Skilled nursing care is limited to 60 days per calendar year. The covered person is responsible for obtaining prior approval for all out-of-network provider inpatient admissions. Failure to obtain prior approval will result in a $750 reduction in benefits.
	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	Preventive care: No charge Medical Illness or Injury: See above	40% coinsurance	Children's preventive care 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	No coverage for dental check-ups under 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
- Dental care
- Infertility treatment
- Long-term 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 (morbid obesity services are limited to $15,000 per lifetime)
- Chiropractic care (calendar year limits apply)
- Cosmetic surgery (limited to reconstructive surgery)
- Habilitation services (calendar year limits apply)
- Hearing aids (limited to $1,400 per ear every three years)
- Non-emergency care when traveling outside the U.S. (limited services are available when considered medically necessary, a medical emergency or an injury)
- Private-duty nursing (limited to when services are billed through a home health agency)
- Routine eye care (limited to children under the age of six)
- Routine foot care (limited to metabolic, peripheral neuropathies, or peripheral vascular disease)

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 on how 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: BlueAdvantage Administrators of Arkansas P.O. Box 1460, Little Rock, AR 72203 or by telephone at 1-800-370-5852 or 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.

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	**$1,000**
Specialist copay	**$50**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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	$0
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,060**

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

The plan's overall deductible	**$1,000**
Specialist copay	**$50**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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	$800
Copayments	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,420**

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

The plan's overall deductible	**$1,000**
Specialist copay	**$50**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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	$400
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,600**

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