



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, call 1-800-238-8379 or visit us at <http://www.arkansasbluecross.com/employers/benefitcertificates.aspx>. 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.arkansasbluecross.com/about/glossary.aspx or call 1-800-238-8379 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers \$1,500 individual / \$3,000 family ; for out-of-network providers \$4,500 individual / \$9,000 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. Preventive care and prescription drugs 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?	For in-network provider - \$3,500 individual / \$7,000 family. For out-of-network providers - \$9,000 individual/ \$18,000 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, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Out-of-network Deductibles, premiums, balance-billing charges, 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 https://secure.arkansasbluecross.com/providerdirectory/trueblueppo.aspx or call 1-800-238-8379 for a list of In-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 you choose 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
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a healthcare provider's office or clinic	Primary care visit to treat an injury or illness	\$30 <u>copay</u> /visit	40% <u>coinsurance</u>	---none---
	<u>Specialist</u> visit	\$50 <u>copay</u> /visit	40% <u>coinsurance</u>	---none---
	<u>Preventive care/screening/immunization</u>	No Charge	20% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	---none---
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Coverage requires prior authorization
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.arkansasbluecross.com .	Generic drugs	Retail \$10 <u>copay</u> /prescription Mail \$20 <u>copay</u> /prescription; <u>deductible</u> does not apply	Not Covered	Covers up to a 30-day supply (retail subscription)Mail order is covered
	Preferred brand drugs	Retail \$40 <u>copay</u> /prescription Mail \$80 <u>copay</u> /prescription; <u>deductible</u> does not apply	Not Covered	Covers up to a 30-day supply (retail subscription)Mail order is covered
	Non-preferred brand drugs	Retail \$60 <u>copay</u> /prescription Mail \$120 <u>copay</u> /prescription; <u>deductible</u> does not apply	Not Covered	Covers up to a 30-day supply (retail subscription)Mail order is covered
	<u>Specialty drugs</u>	Retail \$120 <u>copay</u> /prescription; <u>deductible</u> does not apply	Not Covered	Prior authorization, step therapy or quantity limitations may apply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	---none---
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	---none---
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	---none---
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	---none---
	<u>Urgent care</u>	\$50 <u>copay</u> /visit	40% <u>coinsurance</u>	---none---

*For more information about limitations and exceptions, see the **plan** or policy document at <http://www.arkansasbluecross.com/employers/benefitcertificates.aspx>.

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 have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Out-of-Network/out-of-state inpatient admissions require prior notification
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	---none---
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	---none---
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	---none---
If you are pregnant	Office visits	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Coverage for routine ultrasounds limited to 1; Maternity care may include tests and services described elsewhere in the SBC
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	---none---
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	---none---
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Coverage is limited to 40 visits/calendar year
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Outpatient services limited to 30 visits/person/calendar year
	<u>Habilitation services</u>	Not Covered	Not Covered	None
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 30 days/calendar year; Prior authorization required
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Does not contribute to out-of-pocket limit
	<u>Hospice services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Coverage requires prior authorization
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

*For more information about limitations and exceptions, see the **plan** or policy document at <http://www.arkansasbluecross.com/employers/benefitcertificates.aspx>.

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.)

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|--------------------|-------------------------|------------------------|
| • Acupuncture | • Habilitation services | • Routine foot care |
| • Cosmetic Surgery | • Hearing aids | • Weight loss programs |
| • Dental Care | • Long term care | |
| • Eye exam | • Private-duty nursing | |
| • Glasses | • Routine Eye Care | |

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

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|---------------------|--|--|
| • Bariatric Surgery | • Chiropractic care (Outpatient rehabilitation services limited to 30 visits/person/calendar year) | • Infertility treatment |
| | | • Non-emergency care when traveling outside of U.S. (Subject to discretion of the company) |

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: Arkansas Insurance Department at 1-800-852-5494, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or contact the plan at 1-800-238-8379. 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 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 the plan at 1-800-238-8379. 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. Additionally, a consumer assistance program can help you file your appeal. The contact information is:

Arkansas Insurance Department
1 Commerce Way, Suite 102, Little Rock, AR 72202
Telephone 1-800-852-5494, Email address: insurance.consumers@arkansas.gov

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 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 1-844-662-2276.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-662-2276.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-844-662-2276.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-844-662-2276.

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	\$1,500
■ Specialist copayment	\$50
■ Hospital (facility) coinsurance	20%
■ Other <u>coinsurance</u>	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	\$12,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$100
Coinsurance	\$1,900
<i>What isn't covered</i>	
Limits or exclusions	\$70
The total Peg would pay is	\$3,570

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 copayment	\$50
■ Hospital (facility) coinsurance	20%
■ Other <u>coinsurance</u>	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	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$1,300
Coinsurance	\$20
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$2,880

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

■ The plan's overall deductible	\$1,500
■ Specialist copayment	\$50
■ Hospital (facility) coinsurance	20%
■ Other <u>coinsurance</u>	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	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,400
Copayments	\$100
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,500

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