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 www.arkansasbluecross.com/employers/administrative/benefit-certificates. 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.arkansasbluecross.com/sbc-glossary 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 $4,000 individual / $8,000 family ; for out-of-network providers $8,000 individual / $16,000 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 is 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 - $4,000 individual / $8,000 family. For out-of-network providers - $16,000 individual/ $32,000 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?	Out-of-network Deductible,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/truebluepo.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	0% coinsurance	20% coinsurance	---none---
	Specialist visit	0% coinsurance	20% coinsurance	---none---
	Preventive care/screening/ immunization	No Charge	No Charge	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)	0% coinsurance	20% coinsurance	---none---
	Imaging (CT/PET scans, MRIs)	0% coinsurance	20% coinsurance	---none---
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.arkansasbluecross.com/members/pharmacy-resources.	Generic drugs	Retail 0% coinsurance	Not Covered	After deductible covers up to a 30-day supply (retail subscription); Mail order is covered
	Preferred brand drugs	Retail 0% coinsurance	Not Covered	After deductible covers up to a 30-day supply (retail subscription); Mail order is covered
	Non-preferred brand drugs	Retail 0% coinsurance	Not Covered	After deductible covers up to a 30-day supply (retail subscription); Mail order is covered
	Specialty drugs	Retail 0% coinsurance	Not Covered	Prior authorization, step therapy or quantity limitations may apply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	20% coinsurance	---none---
	Physician/surgeon fees	0% coinsurance	20% coinsurance	---none---
If you need immediate medical attention	Emergency room care	0% coinsurance	0% coinsurance	---none---
	Emergency medical transportation	0% coinsurance	0% coinsurance	---none---
	Urgent care	0% coinsurance	20% coinsurance	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	20% coinsurance	---none---
	Physician/surgeon fees	0% coinsurance	20% coinsurance	---none---

*For more information about limitations and exceptions, see the **plan** or policy document at www.arkansasbluecross.com/employers/administrative/benefit-certificates.

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	Outpatient services	0% coinsurance	20% coinsurance	---none---
	Inpatient services	0% coinsurance	20% coinsurance	---none---
If you are pregnant	Office visits	0% coinsurance	20% coinsurance	Coverage for routine ultrasounds limited to 1; Maternity care may include tests and services described elsewhere in the SBC
	Childbirth/delivery professional services	0% coinsurance	20% coinsurance	---none---
	Childbirth/delivery facility services	0% coinsurance	20% coinsurance	---none---
If you need help recovering or have other special health needs	Home health care	0% coinsurance	20% coinsurance	Coverage is limited to 40 visits/calendar year
	Rehabilitation services	0% coinsurance	20% coinsurance	Outpatient services limited to 30 visits/ person/calendar year
	Habilitation services	Not Covered	Not Covered	None
	Skilled nursing care	0% coinsurance	20% coinsurance	Limited to 30 days/calendar year
	Durable medical equipment	0% coinsurance	20% coinsurance	---none---
	Hospice services	0% coinsurance	20% coinsurance	---none---
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

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
- Eye exam
- Glasses
- Habilitation services
- Hearing aids
- Long term care
- Private-duty nursing
- Routine Eye Care
- 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
- 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, kwiijigo 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	$4,000
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$4,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$4,070**

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

The plan's overall deductible	$4,000
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,960**

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

The plan's overall deductible	$4,000
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

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