

 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 <u>deductible</u> ?	For \$4,000 - individual - in-network <u>providers</u> / <u>out-of-network providers</u> ; for \$8,000 - family - in-network <u>providers</u> / <u>out-of-network providers</u> .	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 <u>deductible</u> ?	Yes. <u>Preventive care</u> and <u>prescription drugs</u> are covered before you meet your <u>deductible</u> .	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 <u>deductibles</u> for specific services?	No.	You don't have to meet deductibles for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	For in-network <u>provider</u> - \$7,500 individual / \$15,000 family. For <u>out-of-network providers</u> - \$18,000 individual/ \$36,000 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 <u>out-of-pocket limit</u> ?	Out-of-network <u>Deductibles</u> , <u>premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> 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 <u>network provider</u> ?	Yes. See https://secure.arkansasbluecross.com/providerdirectory/trueblueppo.aspx or call 1-800-238-8379 for a list of In-network <u>providers</u> .	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 <u>referral</u> to see a <u>specialist</u> ?	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	\$50 <u>copay</u> /visit	50% <u>coinsurance</u>	---none---
	<u>Specialist</u> visit	30% <u>coinsurance</u>	50% <u>coinsurance</u>	---none---
	<u>Preventive care/screening/immunization</u>	No Charge	30% <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)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	---none---
	Imaging (CT/PET scans, MRIs)	30% <u>coinsurance</u>	50% <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 \$20 <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 \$50 <u>copay</u> /prescription Mail \$50 <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 \$70 <u>copay</u> /prescription Mail \$70 <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 \$250 <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)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	---none---
	Physician/surgeon fees	30% <u>coinsurance</u>	50% <u>coinsurance</u>	---none---
If you need immediate medical attention	<u>Emergency room care</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	---none---
	<u>Emergency medical transportation</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	Coverage is limited to \$1,000/trip (ground or water) and \$5,000/trip (air)
	<u>Urgent care</u>	30% <u>coinsurance</u>	50% <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)	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Out-of-Network/out-of-state inpatient admissions require prior notification
	Physician/surgeon fees	30% <u>coinsurance</u>	50% <u>coinsurance</u>	---none---
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	---none---
	Inpatient services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	---none---
If you are pregnant	Office visits	30% <u>coinsurance</u>	50% <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	30% <u>coinsurance</u>	50% <u>coinsurance</u>	---none---
	Childbirth/delivery facility services	30% <u>coinsurance</u>	50% <u>coinsurance</u>	---none---
If you need help recovering or have other special health needs	<u>Home health care</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Coverage is limited to 40 visits/calendar year
	<u>Rehabilitation services</u>	30% <u>coinsurance</u>	50% <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>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 30 days/calendar year; Prior authorization required
	<u>Durable medical equipment</u>	30% <u>coinsurance</u>	50% <u>coinsurance</u>	Does not contribute to out-of-pocket limit
	<u>Hospice services</u>	30% <u>coinsurance</u>	50% <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.)

- | | | |
|--------------------|-------------------------|------------------------|
| • 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, Consumer Services Division
1200 West Third Street, Little Rock, Arkansas 72201
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.

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	30%
■ Hospital (facility) coinsurance	30%
■ Other <u>coinsurance</u>	30%

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	\$4,000
Copayments	\$100
Coinsurance	\$2,500
<i>What isn't covered</i>	
Limits or exclusions	\$70
The total Peg would pay is	\$6,670

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	30%
■ Hospital (facility) coinsurance	30%
■ Other <u>coinsurance</u>	30%

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	\$1,600
Copayments	\$1,700
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$3,360

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

■ The plan's overall deductible	\$4,000
■ Specialist coinsurance	30%
■ Hospital (facility) coinsurance	30%
■ Other <u>coinsurance</u>	30%

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

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

NON-DISCRIMINATION AND LANGUAGE ASSISTANCE NOTICE

NOTICE: Our Company complies with applicable federal and state civil rights laws and does not discriminate, exclude, or treat people differently on the basis of race, color, national origin, age, disability, or sex.

We provide free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, written information in various formats (large print, audio, accessible electronic formats, other formats), and language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. **If you need these services, contact our Civil Rights Coordinator.**

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator

601 Gaines Street, Little Rock, AR 72201
Phone: 1-844-662-2276; TDD: 1-844-662-2275

You can file a grievance in person, by mail, or by email. If you need help filing a grievance our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201
Phone: 1-800-368-1019; TDD: 1-800-537-7697

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

ATTENTION: Language assistance services, free of charge, are available to you. Call 1-844-662-2276.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-662-2276.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-844-662-2276。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-662-2276

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-662-2276 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-844-662-2276.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-844-662-2276.

ملاحظة: إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية مجاناً. دعوة 1-844-662-2276 العدد.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-844-662-2276.

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-844-662-2276.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-844-662-2276.

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-844-662-2276.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-844-662-2276.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-844-662-2276 まで、お電話にてご連絡ください。

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-844-662-2276.

ملاحظة: إذا كنت تتحدث باللغة الفارسية، والخدمات اللغوية المقدمة مجاناً بالنسبة لك. يرجى الاتصال 1-844-662-2276

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિઃશુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-844-662-2276.

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-844-662-2276 पर कॉल करें।

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-844-662-2276.

انتباه: آپ اردو بولتے ہیں تو، زبان کی مدد کی خدمات بلا معاوضہ دستیاب مفت ہیں۔ کال کریں 1-844-662-2276

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ສົ່ຄ່າ, ແມ່ນມີອ້າງໃຫ້ທ່ານ. ໂທ 1-844-662-2276.

LALE: Ñe kwōj kōnono Kajin Mājōl, kwomaroñ bōk jermal in jipañ ilo kajin ñe aṃ ejjelok wōñāān. Kaalok 1-844-662-2276