**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, 1-800-370-5792 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 1-800-370-5792 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | In-Network and Out-of-Network providers combined: $2,000 individual / $4,000 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, the overall family deductible must be met before the plan begins to pay. |
| **Are there services covered before you meet your deductible?** | Yes. In-Network: Standard Preventive care and routine eye exams 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 or specific services. |
| **What is the out-of-pocket limit for this plan?** | In-Network providers $7,000 individual / $14,000 family Out-of-network providers $7,000 individual / $14,000 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 1-800-370-5792 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 | 20% coinsurance | 40% coinsurance | ——————none—————— |
| | Specialist visit | 20% coinsurance | 40% coinsurance | ——————none—————— |
| | 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.<br><br>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.<br><br>Diabetic retinopathy limited to one exam per plan year; In-Network no charge, Out-of-Network no charge after deductible. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% coinsurance | 40% coinsurance | ——————none—————— |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 40% coinsurance | ——————none—————— |
| **If you need drugs to treat your illness or condition**<br>More information about **prescription drug coverage** is available at www.blueadvantagearkansas.com. | Generic drugs | 20% coinsurance | Not covered | Retail Pharmacy supply limit: 34-days<br>Mail Order Pharmacy supply limit: 100-days |
| | Preferred brand drugs | 20% coinsurance | Not covered | |
| | Non-preferred brand drugs | 20% coinsurance | Not covered | |

| 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) | |
| | Specialty drugs | Hepatitis C Drugs: 50% coinsurance<br><br>All other Drugs: 20% coinsurance | Not covered | Coverage of Specialty drugs is limited to a 30-day supply per fill. Specialty drugs must be purchased through CVS Specialty Pharmacy.<br><br>Some Specialty Medications may qualify for third party copayment assistance programs which could lower the out-of-pocket costs for those products. For any such Specialty Medication where third party copayment assistance is used, the covered person shall not receive credit toward their 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—————— |
| **If you need immediate medical attention** | Emergency room care | 20% coinsurance | 20% coinsurance | ——————none—————— |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | Coverage is limited to ground ambulance, $1,000/trip and air ambulance, $5,000/trip, not to exceed one trip per plan year. |
| | Urgent care | 20% coinsurance | 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 provider inpatient admissions. Failure to obtain prior approval will result in a $500 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 | Residential Treatment Facilities are limited to 30 days per plan year.<br><br>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 $500 reduction in benefits. |

| 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% coinsurance | 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). Coverage for routine obstetrical ultrasounds is limited to one ultrasound per pregnancy.<br><br>Dependent daughter is not covered under the plan; however any prenatal, post-natal or maternity care that is required as Standard Preventive care are covered under the plan. |
| | Childbirth/delivery professional services | 20% coinsurance | 40% coinsurance | |
| | Childbirth/delivery facility services | 20% coinsurance | 40% coinsurance | |
| **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 plan year. |
| | Rehabilitation services | 20% coinsurance | 40% coinsurance | Coverage for chiropractic services, speech, cardiac, occupational and physical therapies are limited to 45 combined visits per plan year. |
| | Habilitation services | No coverage | No coverage | Habilitation services are not covered |
| | Skilled nursing care | 20% coinsurance | 40% coinsurance | Skilled nursing care is limited to 30 days per plan year. |
| | Durable medical equipment | 20% coinsurance | 40% coinsurance | ——————none—————— |
| | Hospice services | 20% coinsurance | 40% coinsurance | ——————none—————— |
| **If your child needs dental or eye care** | Children's eye exam | Routine eye exam:<br>No charge<br><br>Medical eye exam for illness or injury:<br>20% coinsurance | Routine eye exam:<br>No charge after deductible<br><br>Medical eye exam for illness or injury:<br>40% coinsurance | Coverage for children age six and older is limited to one routine eye exam every 18 months. |
| | Children's glasses | Not covered | Not covered | No coverage for glasses under the Medical Benefit Plan. |
| | Children's dental check-up | Not covered | Not covered | No coverage for dental check-ups under Medical 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 | • Glasses | • Long-term Care |
| • Cosmetic surgery | • Habilitation services | • Private-duty nursing |
| • Dental care | • Hearing aids | • Routine foot care |
| • Dependent daughter maternity care | • Infertility treatment | • 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 | • Routine eye care | • Private-duty nursing (when rendered as part of a pre-approved home health treatment plan.) |
| • Chiropractic care | | |

**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: Pace Industries, 481 S. Shiloh Dr., Fayetteville, AR 72702, 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 1-800-370-5792.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-370-5792.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-370-5792.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-370-5792.

*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** | **$2,000** |
| **Specialist coinsurance** | **20%** |
| **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 | $2,000 |
| Copayments | $0 |
| Coinsurance | $2,100 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$4,160** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$2,000** |
| **Specialist coinsurance** | **20%** |
| **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 | $2,000 |
| Copayments | $0 |
| Coinsurance | $700 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$2,720** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$2,000** |
| **Specialist coinsurance** | **20%** |
| **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 | $2,000 |
| Copayments | $0 |
| Coinsurance | $200 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2,200** |

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