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, 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. Emergency room facility services, and In-Network: Standard Preventive care, urgent care, diabetic retinopathy screening, and routine vision screening 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	Office visit: $25 copay Other office services: 20% coinsurance	40% coinsurance	————none————
	Specialist visit	20% coinsurance	40% coinsurance	————none————
	Preventive care/screening/ immunization	No charge	Not covered	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. 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. 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————

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.blueadvantagearkansas.com.	Generic drugs (Tier 1)	$10 copay	Not covered	Listed copays apply to a 34-day supply. Up to a 100-day supply may be purchased from a mail order pharmacy for the equivalent of two copay amounts.
	Preferred brand drugs (Tier 2)	$60 copay	Not covered	
	Non-preferred brand drugs (Tier 3)	$80 copay	Not covered	
	Specialty drugs	Hepatitis C drugs: 50% coinsurance All other drugs: 20% coinsurance up to $500.	Not covered	Specialty Drugs. Coverage of Specialty Drugs is limited to a 30-day supply per fill. Specialty Drugs must be purchased through the CVS Specialty Pharmacy. 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	$250 copay + 20% coinsurance	$250 copay + 20% coinsurance	Copay is waived if admitted to the hospital for an inpatient stay.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Ground transport limited to $1,000/trip. Air transport limited to $5,000/trip and one trip per plan year.

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)	
	Urgent care	Emergency and non-emergent services PCP/Specialist visit: $25 copay Other office services: 20% coinsurance	Emergency services PCP/Specialist visit: $25 copay Other office services: 20% coinsurance Non-emergency 40% coinsurance	——none——
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 copay per inpatient day, up to $500 per admission + 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	$100 copay per inpatient day, up to $500 per admission + 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.
If you are pregnant	Office visits	Office visit: $25 copay Other office services: 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. Dependent daughter is not covered under the plan; however any In-Network 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	$100 copay per inpatient day, up to $500 per admission + 20% coinsurance	40% coinsurance	

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 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	Not covered	Not covered	Habilitation services are not covered.
	Skilled nursing care	20% coinsurance	40% coinsurance	Skilled nursing care is limited to
	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 exams: No charge Medical eye exam for illness or injury: 20% coinsurance	Routine eye exams over the age of six No charge after deductible Medical eye exam for illness or injury 20% 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. 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.

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 • Dependent daughter maternity care	• Glasses • Habilitation services • Hearing aids • Infertility treatment	• Long-term care • Non-emergency care when traveling outside the U.S. • 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	• Routine eye care	• Private-duty nursing (when rendered as part of a pre-approved home health treatment plan.)

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.*

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) copay** **$100 + 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	$300
Coinsurance	$2,100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,460**

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	$1,300
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,820**

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) copay** **$250 + 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	$250
Coinsurance	$110
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,360**

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