




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, contact the claims administrator at 1-800-370-5852 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 <https://www.healthcare.gov/sbc-glossary> or call 1-800-370-5852 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	In-Network: \$3,500 individual; \$7,000 family. Out-of-Network: \$7,000 individual; \$14,000 family.	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u>?	Yes. In-Network: standard preventive care, primary care physician and specialist office visits/ services, lab, x-ray, diagnostic testing, and In-network and Out-of-Network ambulance services and hearing aids/exam.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> 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 <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	In-Network: \$7,100 individual; \$14,200 family. Out-of-Network: unlimited individual; unlimited family.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>balance-billing</u> charges, manufacturing assistance programs for <u>prescription drugs</u> , penalties,, out-of-network charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. See www.blueadvantagearkansas.com or call 1-800-370-5852 for a list of <u>network providers</u> .	You will pay less if you use a <u>provider</u> in the <u>plan's</u> network. You will pay the most if you use an out-of-network <u>provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). "Be aware your network <u>provider</u> might use an out-of-network <u>provider</u> for some services (such as lab work). Check with your <u>provider</u> 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
		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	\$35 <u>copay</u> /visit	40% <u>coinsurance</u>	None.
	<u>Specialist</u> visit	Hearing exam: No charge All other specialist: \$70 <u>copay</u> /visit	Hearing exam: No charge All other specialist: 40% <u>coinsurance</u>	In-Network allergy testing and serums 20% <u>coinsurance</u> and allergy shot are no charge. Routine hearing exams are limited to one per member every three calendar years.
	<u>Preventive care/screening/immunization</u>	No charge	Not covered	At all times this <u>plan</u> will comply with the Patient Protection and Affordable Care Act. The list of services included as standard <u>preventive care</u> may change from time to time depending upon government guidelines. You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then determine what your <u>plan</u> will pay.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge	40% <u>coinsurance</u>	None.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.caremark.com	Generic drugs	Retail 30-day supply: \$15 <u>copay</u> Retail 90-day supply or Mail Order: \$30 <u>copay</u>	Retail 30-day supply \$15 <u>copay</u>	First prescription fill is limited to a 30-day supply. Certain medications may be required to be used before another medication is covered. Step therapy is the process of beginning drug therapy for a medical condition with the most cost-effective and safest drug therapy, and

* For more information about limitations and exceptions, see the plan or policy document at www.blueadvantagearkansas.com.

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)	
	Preferred brand drugs	Retail 30-day supply: \$55 <u>copay</u> Retail 90-day supply or Mail Order: \$110 <u>copay</u>	Retail 30-day supply \$55 <u>copay</u>	progressing to other and more costly therapy if the first line medication fails. Information about specific medications can be obtained by contacting customer service or visiting the website at www.ebrxnetwork.com .
	Non-preferred brand drugs	Retail 30-day supply: \$75 <u>copay</u> Retail 90-day supply or Mail Order: \$150 <u>copay</u>	Retail 30-day supply \$75 <u>copay</u>	
	<u>Specialty drugs</u>	Generic: \$200 <u>copay</u> Brand: 50% <u>coinsurance</u>	Generic: \$200 <u>copay</u> Brand: 50% <u>coinsurance</u>	None.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$100 <u>copay</u> plus 20% <u>coinsurance</u>	\$100 <u>copay</u> plus 40% <u>coinsurance</u>	Out-of-Network ambulatory services are limited to \$500.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None.
If you need immediate medical attention	<u>Emergency room care</u>	\$200 <u>copay</u> plus 20% <u>coinsurance</u>	\$200 <u>copay</u> plus 20% <u>coinsurance</u>	<u>Copay</u> is waived if admitted as inpatient.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Emergency medical transportation is limited to \$5,000 per trip for ground transportation and \$10,000 per trip for Air and Water ambulance.
	<u>Urgent care</u>	\$70 <u>copay</u> /visit, related services are no charge.	40% <u>coinsurance</u>	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$200 <u>copay</u> per admission plus 20% <u>coinsurance</u>	\$200 <u>copay</u> per admission plus 40% <u>coinsurance</u>	The covered person is responsible for obtaining precertification for an Out-of-Network inpatient admission. Failure to obtain precertification will result in a \$250 reduction in benefits.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$35 <u>copay</u> /office visit and 20% <u>coinsurance</u> for other outpatient services.	40% <u>coinsurance</u>	None.

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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)	
	Inpatient services	\$200 <u>copay</u> per admissions plus 20% <u>coinsurance</u>	\$200 <u>copay</u> per admission plus 40% <u>coinsurance</u>	The covered person is responsible for obtaining precertification for an Out-of-Network inpatient admission. Failure to obtain precertification will result in a \$250 reduction in benefits.
If you are pregnant	Office visits	\$35 <u>copay</u> /visit	40% <u>coinsurance</u>	Dependent daughter is not covered. However, any pre-natal, post-natal or maternity care that is required as Standard <u>Preventive Care</u> will be covered as shown under <u>Preventive Care Benefits</u> .
	Childbirth/delivery professional services	20% <u>coinsurance</u> .	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	\$200 <u>copay</u> per admission plus 20% <u>coinsurance</u>	\$200 <u>copay</u> per admission plus 40% <u>coinsurance</u>	Routine obstetrical ultrasounds are limited to one per pregnancy. Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Home health care is limited to 100 days per member per calendar year.
	<u>Rehabilitation services</u>	\$70 <u>copay</u> /per encounter	40% <u>coinsurance</u>	Chiropractic services, physical therapy, occupational therapy, and speech therapy are combined and have a 30 visit limit per member per calendar year.
	<u>Habilitation services</u>	Not covered	Not covered	Habilitation services are not covered.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Skilled nursing care is limited to 60 days per member per calendar year.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None.

* For more information about limitations and exceptions, see the plan or policy document at www.blueadvantagearkansas.com .

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)	
	<u>Hospice services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None.
If your child needs dental or eye care	Children's eye exam	Standard preventive eye exam under the age of six No charge Over the age of six: PCP:\$35 <u>copay</u> /office visit Specialist: \$70 <u>copay</u> /office visit 20% <u>coinsurance</u> for other outpatient services.	40% <u>coinsurance</u>	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
- Dental care
- Long-term 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 (\$10,000 surgical lifetime maximum per member, prior approval required.)
- Chiropractic care
- Cosmetic surgery (certain reconstructive surgeries are eligible)
- Hearing aids (limited to one hearing aid per 3 calendar years and further limited to \$1,400 per ear per member)
- Infertility treatment (limited to In-network diagnostic testing)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (when billed through a Home Health Agency)
- Routine eye care
- Routine foot care (when related to diabetes diagnosis)

* For more information about limitations and exceptions, see the plan or policy document at www.blueadvantagearkansas.com .

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 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: Arkansas Higher Education Consortium P.O. Box 10 Melbourne Arkansas, 72556 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

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 1-800-370-5852.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-370-5852.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-370-5852.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-370-5852.

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** \$3,500
- **Specialist** \$70 **copay**
- **Hospital (facility)** \$200 **copay** +
20% **coinsurance**
- **Other** 20% **coinsurance**

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	\$12,840
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$3,500
Copayments	\$330
Coinsurance	\$2,070
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$5,960

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The plan's overall **deductible** \$3,500
- **Specialist** \$70 **copay**
- **Hospital (facility)** 20% **coinsurance**
- **Other** 20% **coinsurance**

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	\$7,460
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$1,700
Copayments	\$1,600
Coinsurance	\$0
What isn't covered	
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** \$3,500
- **Specialist** \$70 **copay**
- **Hospital (facility)** \$200 **copay** +
20% **coinsurance**
- **Other** 20% **coinsurance**

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	\$2,010
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,110
Copayments	\$410
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,520