




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, 1-800-370-5853 or visit [www.blueadvantagearkansas.com](http://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 1-800-370-5853 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	<a href="#">In-Network providers</a> \$1,000 individual / \$2,000 family <a href="#">Out-of-network providers</a> \$2,000 individual / \$4,000 family	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. Telehealth services by MDLIVE and the following <a href="#">In-Network providers</a> : physician office services, <a href="#">preventive care</a> , chiropractic care, allergy and physician visit /office services and pharmacy charges are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No.	You don't have to meet <a href="#">deductibles</a> or specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	<b>Medical benefits:</b> <a href="#">In-Network providers</a> \$3,000 individual / \$6,000 family <a href="#">Out-of-network providers</a> \$6,000 individual / \$12,000 family <b>Pharmacy benefits:</b> \$2,000 individual / \$4,000 family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, precertification penalties, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .

Important Questions	Answers	Why This Matters:
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.blueadvantagearkansas.com">www.blueadvantagearkansas.com</a> or call 1-800-370-5853 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see a <a href="#">specialist</a> without a <a href="#">referral</a> .

 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 <a href="#">provider's office</a> or <a href="#">clinic</a>	Primary care visit to treat an injury or illness	\$35 <a href="#">copay</a> ; <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a>	You will pay 20% <a href="#">coinsurance</a> for additional <a href="#">In-Network</a> services in a PCP's office such as lab, x-ray, injections and surgery; <a href="#">deductible</a> does not apply.
	<a href="#">Specialist</a> visit	\$50 <a href="#">copay</a> ; <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a>	You will pay 20% <a href="#">coinsurance</a> for additional <a href="#">In-Network</a> services in a Specialist's office such as lab, x-ray, injections and surgery; <a href="#">deductible</a> does not apply. Coverage includes telehealth services by MDLIVE, subject to a \$30 <a href="#">copay</a> .
	<a href="#">Preventive care/screening/immunization</a>	No charge	Not covered	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply	————— <a href="#">none</a> —————
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Prior approval is required.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.blueadvantagearkansas.com](http://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)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.medimpact.com">www.medimpact.com</a> .	Generic drugs	\$12 <a href="#">copay</a> /prescription	Not covered	One <a href="#">copay</a> is applied to a 30-day supply of drugs. A 90-day supply may be obtained from a mail order pharmacy or a retail pharmacy for the equivalent of three <a href="#">copays</a> .
	Preferred brand drugs	\$50 <a href="#">copay</a> /prescription	Not covered	
	Non-preferred brand drugs	\$80 <a href="#">copay</a> /prescription	Not covered	
	<a href="#">Specialty drugs</a>	\$100 <a href="#">copay</a> /prescription	Not covered	Specialty drugs are limited to a 30-day supply per fill and must be purchased from a specialty pharmacy.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	—————none—————
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	—————none—————
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$200 <a href="#">copay</a> 20% <a href="#">coinsurance</a>	\$200 <a href="#">copay</a> 20% <a href="#">coinsurance</a>	The <a href="#">copay</a> is waived in patient is admitted for an inpatient stay.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Ground and water transport is limited to \$2,000 per trip. Air transport is limited to \$10,000 per trip.
	<a href="#">Urgent care</a>	Medical emergency and non-emergency: \$35 <a href="#">copay</a> ; <a href="#">deductible</a> does not apply	Medical emergency: \$35 <a href="#">copay</a> ; <a href="#">deductible</a> does not apply.  Non-emergency: 20% <a href="#">coinsurance</a>	—————none—————
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Precertification is required for inpatient admissions.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	—————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)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visit: \$35 <a href="#">copay</a> ; <a href="#">deductible</a> does not apply Outpatient: 20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	————— <a href="#">none</a> —————
	Inpatient services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Precertification is required for inpatient admissions.
If you are pregnant	Office visits	No charge	40% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	40% <a href="#">coinsurance</a>	————— <a href="#">none</a> —————
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	————— <a href="#">none</a> —————
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	————— <a href="#">none</a> —————
	<a href="#">Rehabilitation services</a>	\$35 <a href="#">copay</a> ; <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a>	Speech therapy is limited to 20 visits per calendar year. <a href="#">In-Network</a> Chiropractic care: 50% <a href="#">coinsurance</a> and is not subject to <a href="#">deductible</a> ; limited to 20 visits/year. <a href="#">Out-of-Network</a> Chiropractic care is not covered.
	<a href="#">Habilitation services</a>	\$35 <a href="#">copay</a> ; <a href="#">deductible</a> does not apply	40% <a href="#">coinsurance</a>	Speech therapy is limited to 20 visits per calendar year.
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Precertification is required for inpatient admissions. Coverage limited to 60 days per confinement.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	————— <a href="#">none</a> —————
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Prior approval is required.

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.blueadvantagearkansas.com](http://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)	
If your child needs dental or eye care	Children's eye exam	<i>Illness or Injury:</i> 20% <a href="#">coinsurance</a>  <i>Routine eye exam:</i> No charge, limited to children under age six.	<i>Illness or Injury:</i> 40% <a href="#">coinsurance</a>  <i>Routine eye exam:</i> Not covered	Additional services may be available under a separate vision benefit <a href="#">plan</a> .
	Children's glasses	Not covered	Not covered	No coverage for glasses under the Medical Benefit <a href="#">Plan</a> . Additional services may be available under a separate vision benefit <a href="#">plan</a> .
	Children's dental check-up	Not covered	Not covered	No coverage for dental check-ups under Medical Benefit <a href="#">Plan</a> . No coverage for dental check-ups under Medical Benefit <a href="#">Plan</a> . Additional services may be available under a separate dental benefit <a href="#">plan</a> .

**Excluded Services & Other Covered Services:**

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)			
<ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Dental care</li> <li>• Hearing aids</li> </ul>	<ul style="list-style-type: none"> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Routine eye care</li> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul>	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>• Acupuncture (in lieu of anesthesia)</li> <li>• Bariatric surgery (limited to one weight loss and one reversal surgery per lifetime. Prior approval required.)</li> </ul>	<ul style="list-style-type: none"> <li>• Chiropractic care</li> <li>• Infertility treatment (Prior approval required.)</li> </ul>	<ul style="list-style-type: none"> <li>• Private-duty nursing</li> </ul>

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.blueadvantagearkansas.com](http://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](http://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](http://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: Arkansas State University, 501 Woodlane Drive Suite 600, Little Rock, Arkansas, 72201 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://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 1-800-370-5853.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-370-5853.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-370-5853.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-370-5853.

*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](#) \$1,000
- [Specialist](#) \$50 + 20% [coinsurance](#)
- 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$1,000
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$2,000
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,060</b>

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$1,000
- [Specialist](#) \$50 + 20% [coinsurance](#)
- 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$1,000
<a href="#">Copayments</a>	\$500
<a href="#">Coinsurance</a>	\$600
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,120</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$1,100
- [Specialist](#) \$50 + 20% [coinsurance](#)
- Hospital (facility) [coinsurance](#) \$200 + 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$1,000
<a href="#">Copayments</a>	\$400
<a href="#">Coinsurance</a>	\$300
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,700</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.