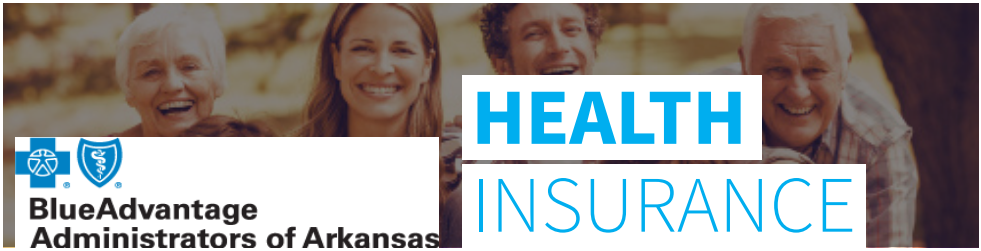

HEALTH INSURANCE

BlueAdvantage Administrators of Arkansas

Ozarka College offers a choice of three medical plans designed to help you and your family maintain good health and offer protection from the financial burden of a serious illness or injury. You can select from the following medical plans:

HEALTH BENEFITS	Base Plan	Core Plan	Enhanced Plan
CALENDAR YEAR DEDUCTIBLE			
Per Covered Person	[redacted]	$2,000	[redacted]
Per Family Unit		$4,000	
Coinsurance		20%	
OUT-OF-POCKET CALENDAR YEAR MAXIMUM			
Per Covered Person	[redacted]	$6,000	[redacted]
Per Family Unit		$12,000	

The following charges apply towards the maximum out-of-pocket. Once this amount is reached, the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise:

- Deductible(s)
- Coinsurance
- Medical and Pharmacy Copayments

- For both In-Network and Out-of-Network Benefits, some services may require pre-authorization by BlueAdvantage. For details and to access the most current listing of services requiring pre-authorization, visit www.blueadvantagearkansas.com
- All benefit payments are subject to the Maximum Allowable Charge. Use of an Out-of-Network provider may result in you being balanced billed and having higher out-of-pocket costs. Amounts in excess of the Maximum Allowable Charge do not count toward Deductible or Coinsurance limits.
- Calendar Year maximums are combined between In-Network and Out-of-Network. If, for example, "30 Visits per Calendar Year" are listed under both In-Network and Out-of-Network Providers, you are only allowed a combined maximum of 30 visits.

Preventive services are always 100% covered *in-network*. You can look up eligbile services and immunizations by clicking below.

https://www.blueadvantagearkansas.com/members/health-and-wellness/preventive-health-information

HEALTH BENEFITS	Base Plan	Core Plan	Enhanced Plan
IN-NETWORK SERVICES			
Inpatient Services		20% after deductible	
Outpatient Surgery/ Ambulatory Surgical Center		20% after deductible	
Emergency Room Services		$200 Copayment + 20% after deductible	
Urgent Care Services		$50 Copayment	
Ambulance Service Per Trip Maximum: $5,000 for Ground Ambulance and $10,000 for Air Ambulance		20%; deductible waived	
Skilled Nursing/ Rehabilitation Facility 60 days Calendar Year Maximum		20% after deductible	
PHYSICIAN SERVICES			
Inpatient visits		20% after deductible	
Primary Care Physician Office Visits (PCP) Evaluation & Management		$20 Copayment	
Specialists Office Visits (SCP) Evaluation & Management		$50 Copayment	
Routine Procedures such as Routine X-rays & Labs in a physician's office		0% after Copayment	
Complex Procedures such as Minor Surgeries and Specialized Lab performed in a physician's office		20% after Copayment	
Advanced Diagnostic services, such as advanced imaging (CT, MRI, PET, MRA), Nuclear Medicine, Pharmaceutical Products, Scopic Procedures; Therapeutic Treatments and Genetic Testing. As well as, advanced surgical services performed in a physician's office.		20% after Deductible	

HEALTH BENEFITS	Base Plan	Core Plan	Enhanced Plan
PREVENTIVE CARE SERVICES			
Preventive health benefits are intended for the early detection of diseases by screening for their presence in an individual who has neither symptoms nor find-ings suggestive of those diseases. Some tests are not covered as part of the preventive health screening benefit because they are not recommended by the United States Preventive Services Task Force (USPSTF) or approved medical polices. Those services that will be considered to be a preventive health service are subject to change at any time in order to align with and be consistent with the USPSTF guidelines and medical policies.			
Routine Well Baby & Audult Care & Immunizations	[redacted]	No Cost to You	[redacted]
Routine Vision Exam (limit 1 every 24 months)		No Cost to You	
MATERNITY SERVICES			
Physician Services Initial Office Visit	[redacted]	$20 Copayment	[redacted]
All other Services		20% after Deductible	
Facility Services		20% after deductible	
Home Health Care 100 days per Calendar Year Maximum		20% after Deductible	
Hospice Care 6 months per Calendar Year Maximum		20% after Deductible	
Therapy Services	Limited to 30 visits per Calendar Year for all therapies combined		
Occupational Therapy Physical Therapy Speech & Audiology Spinal Manipulation/ Chiropractic	[redacted]	$50 Copayment	[redacted]
Durable Medical Equipment		20% after Deductible	
MENTAL DISORDERS / SUBSTANCE ABUSE			
Inpatient Hospital Services	[redacted]	20% after deductible	[redacted]
Professional Services (Office/Outpatient Visits)		$20 Copayment	
Professional Services (Inpatient/Outpatient Facility)		20% after Deductible	

HEALTH BENEFITS	Base Plan	Core Plan	Enhanced Plan
Prosthetic and Orthotic Services and Devices		20% after Deductible	
Organ Transplants Lifetime maximum of 2 transplants		20% after deductible	
Temporomandibular Joint Disorders (TMJ)		20% after Deductible	
Hearing Aid Device Covered up to $1,400 per ear, once every 3 years	No Cost to You		
Hearing Exam Covered once every 3 years	No Cost to You		
INFERTILITY COVERAGE / BARIATRIC SERVICES			
Infertility Diagnostic Services Only		20% after Deductible	
Infertility Treatment	Not Covered		
Bariatric Services Lifetime Maximum of $10,000		20% after Deductible	
SUPPLEMENTAL ACCIDENT BENEFIT			
Payable at 100% for first $500 of covered charges. Injury/Accident Expense Benefits are paid at 100% for Covered Services incurred as a result of an injury. The Covered Services must be incurred within 60 days of the injury. Covered Services that exceed the Injury/Accident Maximum will be subject to deductible and coinsurance.			

PRESCRIPTION DRUG BENEFITS			
(30 DAY SUPPPLY RETAIL)	BASE PLAN	CORE PLAN	ENHANCED PLAN
Tier 1 - Generic		$5 Copayment	
Tier 2 - Preferred		$55 Copayment	
Tier 3 - Nonpreferred		$75 Copayment	
Specialty Generic		$200 Copayment	
Specialty Preferred		50% Coinsurance	
Specialty Nonpreferred		50% Coinsurance	

(90 DAY SUPPLY RETAIL OR MAIL ORDER)	BASE PLAN	CORE PLAN	ENHANCED PLAN
Tier 1 - Generic		$10 Copayment	
Tier 2 - Preferred		$110 Copayment	
Tier 3 - Nonpreferred		$150 Copayment	
Note: If your prescription drugs are dispensed at your physician's office/ facility, see your medical plan for your cost share.			

RATES WILL BE PROVIDED DURING THE ENROLLMENT PROCESS.