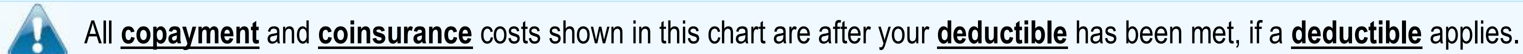
The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. 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 deductible?	In-Network: $1,500 individual; $3,000 family. Out-of-Network: $3,000 individual; $6,000 family.	See the Common Medical Events chart below for your costs for services this plan covers. 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. 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 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 for specific services.
What is the out-of-pocket limit for this plan?	In-Network: $5,500 individual; $11,000 family. Out-of-Network: unlimited individual; unlimited 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, manufacturing assistance programs for prescription drugs, penalties, out-of-network services, 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 1-800-370-5852 for a list of network providers.	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 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	$25 copay/visit	40% coinsurance	None.
	Specialist visit	Hearing exam: No charge All other specialist: $50 copay/visit	Hearing exam: No charge All other specialist: 40% coinsurance	In-Network allergy testing and serums 20% coinsurance and allergy shot are no charge. Routine hearing exams are limited to one per member every three calendar years.
	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 needed are preventive. Then determine what your plan will pay.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	40% coinsurance	None.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	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 copay Retail 90-day supply or Mail Order: $30 copay	Retail 30-day supply: $15 copay	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

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Preferred brand drugs	Retail 30-day supply: $45 copay Retail 90-day supply or Mail Order: $90 copay	Retail 30-day supply $45 copay	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: $60 copay Retail 90-day supply or Mail Order: $120 copay	Retail 30-day supply $60 copay	
	Specialty drugs	$200 copay	$200 copay	None.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 copay plus 20% coinsurance	$100 copay plus 40% coinsurance	Out-of-Network ambulatory services are limited to $500.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None.
If you need immediate medical attention	Emergency room care	$100 copay plus 20% coinsurance	$100 copay plus 20% coinsurance	Copay is waived if admitted as inpatient.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Emergency medical transportation is limited to $5,000 per trip for ground transportation and $10,000 per trip for Air and Water ambulance.
	Urgent care	$50 copay/visit, related services are no charge.	40% coinsurance	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 copay per admission plus 20% coinsurance	$200 copay per admission plus 40% coinsurance	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% coinsurance	40% coinsurance	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)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/office visit 20% coinsurance for other outpatient services	40% coinsurance	None.
	Inpatient services	$200 copay per admission plus 20% coinsurance	$200 copay per admission plus 40% coinsurance	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	$25 copay/visit	40% coinsurance	Dependent daughter is not covered. However, any pre-natal, post-natal or maternity care that is required as Standard Preventive Care will be covered as shown under Preventive Care Benefits. Routine obstetrical ultrasounds are limited to one per pregnancy. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	20% coinsurance.	40% coinsurance	None.
	Childbirth/delivery facility services	$200 copay per admission plus 20% coinsurance	$200 copay per admission plus 40% coinsurance	None.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Home health care is limited to 100 days per member per calendar year.
	Rehabilitation services	$50 copay/per encounter	40% coinsurance	Chiropractic services, physical therapy, occupational therapy, and speech therapy are combined and have a 30-visit limit per member per calendar 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)	
	Habilitation services	Not covered	Not covered	Habilitation services are not covered.
	Skilled nursing care	20% coinsurance	40% coinsurance	Skilled nursing care is limited to 60 days per member per calendar 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	Standard preventive eye exam under the age of six No charge Over the age of six: PCP: $25 copay/office visit Specialist: $50 copay/office visit 20% coinsurance for other outpatient services.	40% coinsurance	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)

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, kwiijigo 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** **$1,500**
- **Specialist** **$50 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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$310
Coinsurance	$2,010
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,880**

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

- **The plan's overall deductible** **$1,500**
- **Specialist** **$50 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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$1,480
Coinsurance	$40
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$3,080**

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

- **The plan's overall deductible** **$1,500**
- **Specialist** **$50 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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,110
Copayments	$350
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,460**

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