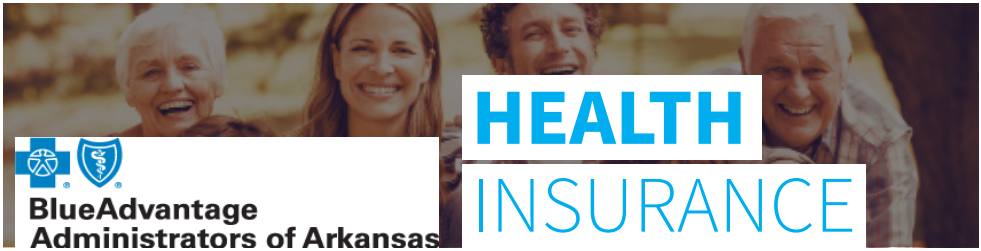

HEALTH INSURANCE

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]	[redacted]	$1,000
Per Family Unit	[redacted]	[redacted]	$2,000
Coinsurance	[redacted]	[redacted]	20%
OUT-OF-POCKET CALENDAR YEAR MAXIMUM			
Per Covered Person	[redacted]	[redacted]	$4,500
Per Family Unit	[redacted]	[redacted]	$9,000

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	[redacted]		20% after deductible
Outpatient Surgery/ Ambulatory Surgical Center			20% after deductible
Emergency Room Services			$100 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	[redacted]		20% after deductible
PHYSICIAN SERVICES			
Inpatient visits	[redacted]		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
Routine Vision Exam (limit 1 every 24 months)			No Cost to You
MATERNITY SERVICES			
Physician Services Initial Office Visit	[redacted]		$20 Copayment
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
Durable Medical Equipment			20% after Deductible
MENTAL DISORDERS / SUBSTANCE ABUSE			
Inpatient Hospital Services	[redacted]		20% after deductible
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			$45 Copayment
Tier 3 - Nonpreferred			$60 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			$90 Copayment
Tier 3 - Nonpreferred			$120 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.