This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **https://secure.arkansasbluecross.com/members/bcdlist.aspx** or by calling **1-800-800-4298**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network $6,200 person / $12,400 family. Out-of-network $12,400 person / $24,800 family.	You must pay all the costs up to the **deductible** amount before this health insurance plan begins to pay for covered services you use. Check your policy to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. In-network - $7,150 person / $14,300 family. For out-of-network - $14,300 person / $25,000 family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Out-of-network coinsurance, premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of In-network providers, see www.arkbluecross.com or call 1-800-800-4298.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-800-800-4298 or visit us at www.arkbluecross.com.
If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.arkansasbluecross.com/about/glossary.aspx or call 1-800-800-4298 to request a copy.

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OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146
11/17/2016

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions*
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 copay/visit	50% coinsurance	---none---
	Specialist visit	40% coinsurance	50% coinsurance	Services and procedures other than consultation and evaluation are paid at 40% coinsurance in-network
	Other practitioner office visit	$35 copay/visit	50% coinsurance	Coverage for chiropractic care subject to 30 visit Rehabilitation limit.
	Preventive care/screening/immunization	$0 copay/visit	Not Covered	---none---
If you have a test	Diagnostic test (x-ray, blood work)	40% coinsurance	50% coinsurance	---none---
	Imaging (CT/PET scans, MRIs)	40% coinsurance	50% coinsurance	Coverage requires prior authorization.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.arkansasbluecross.com/pd_list/exchange/metallicdruglist.aspx?yr=2017	Generic drugs	Retail $25 copay Mail order $25 copay	Not Covered	Covers up to a month's supply (retail prescriptions). Not subject to deductible.
	Preferred brand drugs	Retail 40% coinsurance Mail order 40% coinsurance	Not Covered	Covers up to a month's supply (retail prescriptions)
	Non-preferred brand drugs	Retail 40% coinsurance Mail order 40% coinsurance	Not Covered	Covers up to a month's supply (retail prescriptions)
	Specialty drugs	50% coinsurance	Not Covered	Prior authorization, step therapy, or quantity limitations may apply. Non-preferred specialty drugs are paid at a higher coinsurance in-network.

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Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions*
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% coinsurance	50% coinsurance	---none---
	Physician/surgeon fees	40% coinsurance	50% coinsurance	---none---
If you need immediate medical attention	Emergency room services	40% coinsurance	40% coinsurance	---none---
	Emergency medical transportation	40% coinsurance	40% coinsurance	Coverage is limited to $1000/trip (ground or water) and $5000/trip (air)
	Urgent care	$70 copay	50% coinsurance	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copay/day and 0% coinsurance	50% coinsurance	Copay applies before deductible with 0% coins after deductible in-network
	Physician/surgeon fee	40% coinsurance	50% coinsurance	---none---
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$35 copay/office visit and 40% coinsurance	50% coinsurance	Consultation and evaluation only are paid at $35 copay in-network; Other services and procedures are paid at 40% coinsurance in-network
	Mental/Behavioral health inpatient services	$250 copay/day and 0% coinsurance	50% coinsurance	Copay applies before deductible with 0% coins after deductible in-network
	Substance use disorder outpatient services	$35 copay/office visit and 40% coinsurance	50% coinsurance	Consultation and evaluation only are paid at $35 copay in-network; Other services and procedures are paid at 40% coinsurance in-network
	Substance use disorder inpatient services	$250 copay/day and 0% coinsurance	50% coinsurance	Copay applies before deductible with 0% coins after deductible in-network
If you are pregnant	Prenatal and postnatal care	40% coinsurance	50% coinsurance	Coverage for routine ultrasounds is limited to 1.
	Delivery and all inpatient services	40% coinsurance	50% coinsurance	Coverage for Out of Network newborn services is limited to $2000 per person for all services first 90 days after birth

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions*
If you need help recovering or have other special health needs	Home health care	40% coinsurance	50% coinsurance	Coverage is limited to 50 visits per person per calendar year.
	Rehabilitation services	$35 copay/office visit and 40% coinsurance	Not Covered	Coverage for outpatient services is limited to 30 visits per person per calendar year and paid at $35 copay in-network; Coverage for inpatient services is limited to 60 days per person per calendar year and paid at 40% coinsurance in-network
	Habilitation services	$35 copay/office visit and 40% coinsurance	Not Covered	Coverage for developmental services is limited to 180 units per person per calendar year and paid at 40% coinsurance in-network; Coverage for outpatient services is limited to 30 visits per person per calendar year and paid at $35 copay in-network
	Skilled nursing care	$250 copay/day and 0% coinsurance	50% coinsurance	Coverage is limited to 60 days per person per calendar year. Coverage requires prior authorization. Copay applies before deductible with 0% coins after deductible in-network
	Durable medical equipment	40% coinsurance	50% coinsurance	Coverage requires prior authorization for costs which exceed $5,000.
	Hospice service	40% coinsurance	50% coinsurance	Must be certified by a physician as having a life expectancy of six months or less
If your child needs dental or eye care	Eye exam	0% coinsurance	Not Covered	Coverage is limited to 1 exam per child per calendar year.
	Glasses	40% coinsurance	50% coinsurance	Coverage is limited to 1 pair of glasses with lenses or contacts per child per calendar year.
	Dental check-up	Not Covered	Not Covered	

*For any health intervention, there are six general coverage criteria that must be met in order for that intervention to qualify for coverage under your plan; 1) the primary coverage criteria (medical necessity requirement) must be met; 2) the health intervention must conform to specific limitations stated in your plan; 3) the health intervention must not be specifically excluded under the terms of your plan; 4) at the time of the intervention, you must meet the plan's eligibility standards; 5) you must comply with the plan's provider network and cost sharing arrangements; and 6) you must follow the plan's procedures for filing claims.

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Abortions, except where a pregnancy is the result of rape or incest, or for a pregnancy which, as certified by a physician, places the woman in danger of death unless an abortion is performed.
- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care
- Long term care
- Non-Emergency Care when traveling outside of U.S. (Subject to discretion of the company)
- Private-duty nursing
- Routine foot care is covered for prevention of complications associated with diabetes
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Hearing aids
- Infertility treatment
- Routine Eye Care

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

• You commit fraud

• The insurer stops offering services in the State

• You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-800-800-4298. You may also contact your state insurance department at 1-800-852-5494.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the plan at 1-800-800-4298. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Arkansas Insurance Department at 1-800-852-5494.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-800-4298.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $1,070
- **Patient pays** $6,470

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$6,200
Copays	$30
Coinsurance	$200
Limits or exclusions	$40
Total	$6,470

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $2,200
- **Patient pays** $3,200

Sample care costs:

Prescriptions	$2,900
Medical Equipment & Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1,600
Copays	$800
Coinsurance	$700
Limits or exclusions	$100
Total	$3,200

Questions and answers about Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different, based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✔ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box for each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✔ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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NON-DISCRIMINATION AND LANGUAGE ASSISTANCE NOTICE

NOTICE: Our Company complies with applicable federal and state civil rights laws and does not discriminate, exclude, or treat people differently on the basis of race, color, national origin, age, disability, or sex.

We provide free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, written information in various formats (large print, audio, accessible electronic formats, other formats), and language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. **If you need these services, contact our Civil Rights Coordinator.**

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator
601 Gaines Street, Little Rock, AR 72201
Phone: 1-844-662-2276; TDD: 1-844-662-2275

You can file a grievance in person, by mail, or by email. If you need help filing a grievance our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201
Phone: 1-800-368-1019; TDD: 1-800-537-7697

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: Language assistance services, free of charge, are available to you. Call 1-844-662-2276.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-662-2276.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-844-662-2276.

Questions: Call 1-800-800-4298 or visit us at www.arkbluecross.com.
If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.arkansasbluecross.com/about/glossary.aspx or call 1-800-800-4298 to request a copy.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-662-2276

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-662-2276 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-844-662-2276.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-844-662-2276.

ملاحظة: إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية مجانا. دعوة 1-844-662-2276 العدد.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-844-662-2276.

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-844-662-2276.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-844-662-2276.

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-844-662-2276.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-844-662-2276.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-844-662-2276 まで、お電話にてご連絡ください。

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-844-662-2276.

ملاحظة: إذا كنت تتحدث باللغة الفارسية، والخدمات اللغوية المقدمة مجانا بالنسبة لك. يرجى الاتصال 1-844-662-2276.

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નઃશુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-844-662-2276.

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-844-662-2276 पर कॉल करें।

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-844-662-2276.

انتباہ: آپ اردو بولتے ہیں تو، زبان کی مدد کی خدمات بلا معاوضہ دستیاب ہیں. کال کریں 1-844-662-2276

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ສຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-844-662-2276.

LALE: Ñe kwōj kōnono Kajin Ṃajōḷ, kwomaroñ bōk jerbal in jipañ ilo kajin ṇe aṃ ejjeḷọk wōṇāān. Kaalọk 1-844-662-2276

Notice 1557

Questions: Call 1-800-800-4298 or visit us at www.arkbluecross.com.
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