



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, call 1-800-800-4298 or visit us at <https://secure.arkansasbluecross.com/members/bcdlist.aspx>. 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 [www.arkansasbluecross.com/about/glossary.aspx](http://www.arkansasbluecross.com/about/glossary.aspx) or call 1-800-800-4298 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	For in-network provider \$1,850 individual / \$3,700 family ; for <u>out-of-network providers</u> \$3,700 individual / \$7,400 family.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> is covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <u>deductibles</u> for specific services?	Yes. <u>Prescription drugs</u> -- \$600/individual or \$1,200/family in-network. There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	For in-network provider - \$7,900 individual / \$15,800 family. For <u>out-of-network providers</u> - \$15,800 individual/ \$31,600 family.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , the overall family <u>out-of-pocket limit</u> must be met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Out-of-network coinsurance</u> , <u>premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See <a href="https://secure.arkansasbluecross.com/providerdirectory/trueblueppo.aspx">https://secure.arkansasbluecross.com/providerdirectory/trueblueppo.aspx</a> or call 1-800-800-4298 for a list of In-network providers.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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
		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
<b>If you visit a healthcare provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$30 <u>copay</u> /visit; 2 visits free before <u>copay</u>	50% <u>coinsurance</u>	<u>Coinsurance</u> applies after <u>deductible</u>
	<u>Specialist</u> visit	\$75 <u>copay</u> /visit and 40% <u>coinsurance</u> for other outpatient services	50% <u>coinsurance</u>	Services and procedures other than consult and eval are paid at 40% <u>coinsurance</u> in-network; <u>Coinsurance</u> applies after <u>deductible</u>
	<u>Preventive care/screening/immunization</u>	No Charge	Not Covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	40% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Coinsurance</u> applies after <u>deductible</u>
	Imaging (CT/PET scans, MRIs)	40% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Coinsurance</u> applies after <u>deductible</u> ; Coverage requires prior approval
<b>If you need drugs to treat your illness or condition</b> More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://www.arkansasbluecross.com/pd_list/exchange/metallicdruglist.aspx?yr=2019">www.arkansasbluecross.com/pd_list/exchange/metallicdruglist.aspx?yr=2019</a> .	Generic drugs	Retail \$25 <u>copay</u> /prescription Mail \$50 <u>copay</u> /prescription	Not Covered	Covers up to 30-day supply (retail prescriptions); 31-90 day supply (mail order prescription).
	Preferred brand drugs	Retail \$75 <u>copay</u> /prescription Mail \$150 <u>copay</u> /prescription	Not Covered	Covers up to 30-day supply (retail prescriptions); 31-90 day supply (mail order prescription); Coverage requires prior approval; <u>Copay</u> applies after <u>deductible</u>
	Non-preferred brand drugs	Retail \$150 <u>copay</u> /prescription Mail \$300 <u>copay</u> /prescription	Not Covered	Covers up to 30-day supply (retail prescriptions); 31-90 day supply (mail order prescription); Coverage requires prior approval; <u>Copay</u> applies after <u>deductible</u>
	<u>Specialty drugs</u>	Retail 40% <u>coinsurance</u> /prescription	Not Covered	Prior authorization, step therapy or quantity limitations may apply; Non-preferred specialty drugs may apply a higher <u>coinsurance</u> in-network; Coverage requires prior approval; <u>Coinsurance</u> applies after <u>deductible</u>
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	40% <u>coinsurance</u>	50% <u>coinsurance</u>	Coverage requires prior approval; <u>Coinsurance</u> applies after <u>deductible</u>
	Physician/surgeon fees	40% <u>coinsurance</u>	50% <u>coinsurance</u>	Coverage requires prior approval; <u>Coinsurance</u> applies after <u>deductible</u>

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	\$500 <u>copay</u> /visit	\$500 <u>copay</u> /visit	<u>Copay</u> applies after <u>deductible</u>
	<u>Emergency medical transportation</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	Coverage limited to \$1,000/trip for ground or water ambulance services and \$5,000/trip for air ambulance services; <u>Coinsurance</u> applies after <u>deductible</u>
	<u>Urgent care</u>	\$100 <u>copay</u> /visit	50% <u>coinsurance</u>	<u>Coinsurance</u> applies after <u>deductible</u>
If you have a hospital stay	Facility fee (e.g., hospital room)	\$650 <u>copay</u> /day	50% <u>coinsurance</u>	Coverage requires prior approval; <u>Copay</u> and <u>coinsurance</u> applies after <u>deductible</u>
	Physician/surgeon fees	40% <u>coinsurance</u>	50% <u>coinsurance</u>	Coverage requires prior approval; <u>Coinsurance</u> applies after <u>deductible</u>
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 <u>copay</u> /visit and 40% <u>coinsurance</u> for other outpatient services	50% <u>coinsurance</u>	Consultation and evaluation only are paid at \$30 <u>copay</u> in-network with 2 visits free before <u>copay</u> ; Other services and procedures are paid at 40% <u>coinsurance</u> in-network after <u>deductible</u> ; Coverage requires prior approval
	Inpatient services	\$650 <u>copay</u> /day	50% <u>coinsurance</u>	<u>Copay</u> and <u>coinsurance</u> apply after <u>deductible</u> ; Coverage requires prior approval
If you are pregnant	Office visits	40% <u>coinsurance</u>	50% <u>coinsurance</u>	Coverage for routine ultrasounds limited to 1; <u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC; Coverage requires prior notification; <u>Coinsurance</u> applies after <u>deductible</u>
	Childbirth/delivery professional services	40% <u>coinsurance</u>	50% <u>coinsurance</u>	Coverage requires prior notification; <u>Coinsurance</u> applies after <u>deductible</u>
	Childbirth/delivery facility services	40% <u>coinsurance</u>	50% <u>coinsurance</u>	Coverage for Out of Network newborn services is limited to \$2000 per Covered Person for all services first 90 days after birth; Coverage requires prior notification; <u>Coinsurance</u> applies after <u>deductible</u>

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	Coverage is limited to 50 visits/person/calendar year; Coverage requires prior approval; <u>Coinsurance</u> applies after <u>deductible</u>
	<u>Rehabilitation services</u>	\$30 <u>copay</u> /visit and 40% <u>coinsurance</u>	Not Covered	Outpatient services limited to 30 visits/person/calendar year and paid at \$30 <u>copay</u> with 2 visits free before <u>copay</u> in-network; Inpatient services limited to 60 days/person/calendar year and paid at 40% <u>coinsurance</u> in-network after <u>deductible</u> ; Coverage requires prior approval
	<u>Habilitation services</u>	\$30 <u>copay</u> /visit and 40% <u>coinsurance</u>	Not Covered	Developmental services limited to 180 units/person/calendar year and paid at 40% <u>coinsurance</u> in-network after <u>deductible</u> ; Outpatient services limited to 30 visits/person/calendar year and paid at \$30 <u>copay</u> with 2 visits free before <u>copay</u> in-network; Coverage requires prior approval
	<u>Skilled nursing care</u>	\$650 <u>copay</u> /day	50% <u>coinsurance</u>	Limited to 60 days/person/calendar year; Coverage requires prior approval; <u>Copay</u> and <u>coinsurance</u> apply after <u>deductible</u>
	<u>Durable medical equipment</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	Prior approval is required for DME costs which exceeds \$500; <u>Coinsurance</u> applies after <u>deductible</u>
	<u>Hospice services</u>	40% <u>coinsurance</u>	50% <u>coinsurance</u>	Hospice care must be certified by a physician as having a life expectancy of six months or less; Coverage requires prior approval; <u>Coinsurance</u> applies after <u>deductible</u>
<b>If your child needs dental or eye care</b>	Children's eye exam	No Charge	Not Covered	Limited to one exam per child per calendar year
	Children's glasses	40% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to one pair of glasses with lenses or contacts per child per calendar year; <u>Coinsurance</u> applies after <u>deductible</u>
	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.)**

- Abortions are not covered. Pregnancy terminations under the direction of a physician are covered but only when performed in an in-network or outpatient hospital setting.
- 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
- Weight loss programs

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Chiropractic care (Limited to 30 visits/person/ calendar year). Requires prior approval
- Hearing aids (\$1,400/ear/person)
- Infertility treatment (Prior Approval Required)
- Routine eye care (Adult) (1 visit/person every 2 years)
- Routine foot care is covered for prevention of complications associated with diabetes

**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: Arkansas Insurance Department at 1-800-852-5494, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or contact the plan at 1-800-800-4298. 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 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 the Arkansas Insurance Department, Consumer Services Division. Additionally, a consumer assistance program can help you file your appeal. The contact information is:

Arkansas Insurance Department, Consumer Services Division  
1200 West Third Street, Little Rock, Arkansas 72201  
Telephone 1-800-852-5494, Email address: [insurance.consumers@arkansas.gov](mailto:insurance.consumers@arkansas.gov)

**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 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 1-844-662-2276.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-662-2276.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-844-662-2276.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-844-662-2276.

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 <b>plan's</b> overall <b>deductible</b>	\$2,450
■ <b>Specialist copayment</b>	\$75
■ <b>Hospital (facility) copayment</b>	\$650
■ Other <b>coinsurance</b>	40%

**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>\$12,800</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$1,900
Copayments	\$90
Coinsurance	\$4,300
<i>What isn't covered</i>	
Limits or exclusions	\$90
<b>The total Peg would pay is</b>	<b>\$6,380</b>

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

■ The <b>plan's</b> overall <b>deductible</b>	\$2,450
■ <b>Specialist copayment</b>	\$75
■ <b>Hospital (facility) copayment</b>	\$650
■ Other <b>coinsurance</b>	40%

**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>\$7,400</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$1,300
Copayments	\$3,200
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$4,560</b>

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

■ The <b>plan's</b> overall <b>deductible</b>	\$2,450
■ <b>Specialist copayment</b>	\$75
■ <b>Hospital (facility) copayment</b>	\$650
■ Other <b>coinsurance</b>	40%

**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>\$1,900</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$900
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,900</b>

## 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>.

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**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。

**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 مجاناً. 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 مجاناً بالنسبة لك. يرجى الاتصال 1-844-662-2276

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિઃશુલ્ક 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.

**انتباه:** آپ اردو بولتے ہیں تو، زبان کی مدد کی خدمات بلا معاوضہ دستیاب مفت ہیں۔ کال کریں 1-844-662-2276

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ສົ່ຄາ, ແມ່ນມີອ້ອມໃຫ້ທ່ານ. ໂທ 1-844-662-2276.

**LALE:** Ñe kwōj kōnono Kajin Majōl, kwomaroñ bōk jermal in jipañ ilo kajin ñe aṃ ejjelok wōṇāān. Kaalok 1-844-662-2276