




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 <https://www.arkansasbluecross.com/sbc-glossary> or call 1-800-800-4298 to request a copy.

| Important Questions | Answers | Why This Matters: |
|--|--|---|
| What is the overall deductible? | For <u>network provider</u> \$4,050 individual / \$8,100 family; for <u>out-of-network provider</u> \$6,100 individual / \$12,200 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 deductible? | 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 https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other deductibles for specific services? | No. | You don't have to meet <u>deductibles</u> for specific services. |
| What is the out-of-pocket limit for this plan? | For <u>network provider</u> - \$6,925 Individual / \$13,850 family. For <u>out-of-network provider</u> - \$10,300 individual/ \$20,600 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 out-of-pocket limit? | <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 network provider? | Yes. See https://secure.arkansasbluecross.com/providerdirectory/trueblueppo.aspx or call 1-800-800-4298 for a list of <u>network providers</u> . | 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 charge</u> 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 referral to see a specialist? | No. | You can see the <u>specialist</u> you choose without a <u>referral</u> . |

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 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 healthcare provider's office or clinic | Primary care visit to treat an injury or illness | \$35 <u>copay</u> /visit; 3 visits free before <u>copay</u> ; <u>deductible</u> does not apply | 50% <u>coinsurance</u> | <u>Coinsurance</u> applies after <u>deductible</u> |
| | <u>Specialist</u> visit | \$90 <u>copay</u> /visit and 40% <u>coinsurance</u> for other outpatient services | 50% <u>coinsurance</u> | Consultation and evaluation only are paid at \$90 <u>copay</u> in-network. Services and procedures other than consult and eval are paid at 40% <u>coinsurance</u> in-network after deductible. |
| | <u>Preventive care/screening/immunization</u> | No Charge | Not Covered | You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for. |
| If you have a test | <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> |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://www.arkansasbluecross.com/metallic-formulary-2024 | Generic drugs | Retail \$25 <u>copay</u> /prescription Mail \$50 <u>copay</u> /prescription; <u>deductible</u> does not apply | Not Covered | Covers up to 30-day supply (retail prescriptions); 31-90 day supply (mail order prescription) |
| | Preferred brand drugs | Retail \$85 <u>copay</u> /prescription Mail \$170 <u>copay</u> /prescription; <u>deductible</u> does not apply | Not Covered | Covers up to 30-day supply (retail prescriptions); 31-90 day supply (mail order prescription) |
| | Non-preferred brand drugs | Retail \$1,600 <u>copay</u> /prescription Mail \$3,200 <u>copay</u> /prescription; <u>deductible</u> does not apply | Not Covered | Covers up to 30-day supply (retail prescriptions); 31-90 day supply (mail order prescription) |
| | <u>Specialty</u> drugs | \$5,000 <u>copay</u> /prescription; <u>deductible</u> does not apply | 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; |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 40% <u>coinsurance</u> | 50% <u>coinsurance</u> | <u>Coinsurance</u> applies after <u>deductible</u> |
| | Physician/surgeon fees | 40% <u>coinsurance</u> | 50% <u>coinsurance</u> | <u>Coinsurance</u> applies after <u>deductible</u> |

*For more information about limitations and exceptions, see the plan or policy document at <https://secure.arkansasbluecross.com/members/bcdlist.aspx>

| 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 immediate medical attention | Emergency room care | \$575 <u>copay</u> /visit | \$575 <u>copay</u> /visit | <u>Copay</u> applies after <u>deductible</u> |
| | Emergency medical transportation | 40% <u>coinsurance</u> | 40% <u>coinsurance</u> | <u>Coinsurance</u> applies after <u>deductible</u> |
| | Urgent care | \$90 <u>copay</u> /visit; <u>deductible</u> does not apply | 50% <u>coinsurance</u> | <u>Coinsurance</u> applies after <u>deductible</u> |
| If you have a hospital stay | Facility fee (e.g., hospital room) | \$575 <u>copay</u> /day | 50% <u>coinsurance</u> | <u>Copay</u> and <u>coinsurance</u> apply after <u>deductible</u> |
| | Physician/surgeon fees | 40% <u>coinsurance</u> | 50% <u>coinsurance</u> | <u>Coinsurance</u> applies after <u>deductible</u> |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$35 <u>copay</u> /visit and 40% <u>coinsurance</u> for other outpatient services | 50% <u>coinsurance</u> | Consultation and evaluation only are paid at \$35 <u>copay</u> in-network with 3 visits free before <u>copay</u> ; Other services and procedures are paid at 40% <u>coinsurance</u> in-network after <u>deductible</u> |
| | Inpatient services | \$575 <u>copay</u> /day | 50% <u>coinsurance</u> | <u>Copay</u> and <u>coinsurance</u> apply after <u>deductible</u> |
| 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 <u>out-of-network</u> newborn services is limited to \$2,000 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 |
|---|---|---|---|--|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you need help recovering or have other special health needs | <u>Home health care</u> | 40% <u>coinsurance</u> | 50% <u>coinsurance</u> | Coverage is limited to 50 visits/person/calendar year; <u>Coinsurance</u> applies after <u>deductible</u> |
| | <u>Rehabilitation services</u> | \$35 <u>copay</u> /visit and 40% <u>coinsurance</u> for other outpatient services | Not Covered | Outpatient services limited to 30 visits/person/calendar year and paid at \$35 <u>copay</u> with 3 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> |
| | <u>Habilitation services</u> | \$35 <u>copay</u> /visit and 40% <u>coinsurance</u> for other outpatient services | 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 \$35 <u>copay</u> with 3 visits free before <u>copay</u> in-network |
| | <u>Skilled nursing care</u> | \$575 <u>copay</u> /day | 50% <u>coinsurance</u> | Limited to 60 days/person/calendar year; <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> | <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; <u>Coinsurance</u> applies after <u>deductible</u> |
| | If your child needs dental or eye care | Children's eye exam | No Charge | Not Covered |
| 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)
- Hearing aids (\$1,400/ear/person)
- Infertility treatment
- Routine eye care (Adult) (1 visit/person every 2 years)
- Routine foot care is covered for podiatric conditions.

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 <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 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
1 Commerce Way, Suite 102, Little Rock, Arkansas 72202
Telephone 1-800-852-5494, Email address: insurance.consumers@arkansas.gov

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Not Applicable.

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): Dineke'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-844-662-2276.

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 <u>plan's</u> overall <u>deductible</u> | \$4,050 |
| ■ <u>Specialist copayment</u> | \$90 |
| ■ <u>Hospital (facility) copayment</u> | \$575 |
| ■ <u>Other coinsurance</u> | 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*)

| | |
|---------------------------|-----------------|
| Total Example Cost | \$12,800 |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$4,100 |
| <u>Copayments</u> | \$0 |
| <u>Coinsurance</u> | \$3,400 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$40 |
| The total Peg would pay is | \$7,540 |

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

| | |
|---|---------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$4,050 |
| ■ <u>Specialist copayment</u> | \$90 |
| ■ <u>Hospital (facility) copayment</u> | \$575 |
| ■ <u>Other coinsurance</u> | 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*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$7,400 |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i> | |
|---------------------------|----------------|
| <u>Deductibles</u> | \$4,100 |
| <u>Copayments</u> | \$500 |
| <u>Coinsurance</u> | \$900 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| Total Example Cost | \$5,560 |

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

| | |
|---|---------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$4,050 |
| ■ <u>Specialist copayment</u> | \$90 |
| ■ <u>Hospital (facility) copayment</u> | \$575 |
| ■ <u>Other coinsurance</u> | 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*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$1,900 |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i> | |
|---------------------------|----------------|
| <u>Deductibles</u> | \$1,900 |
| <u>Copayments</u> | \$0 |
| <u>Coinsurance</u> | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| Total Example Cost | \$1,900 |