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 or call 1-800-800-4298 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network provider $4,000 individual / $8,000 family ; for out-of-network providers $8,000 individual / $16,000 family.	Generally, you must pay all of the costs from **providers** up to the **deductible** amount before this **plan** begins to pay. If you have other family members on the policy, the overall family **deductible** must be met before the **plan** begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care is covered before you meet your deductible.	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?	Yes. Prescription drugs -- $1,000/ individual or $2,000/family in-network. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific **deductible** amount before this **plan** begins to pay for these services.
What is the out-of-pocket limit for this plan?	For in-network provider - $7,350 individual / $14,700 family. For out-of-network providers - $14,700 individual/ $29,400 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**, the overall family **out-of-pocket limit** must be met.
What is not included in the out-of-pocket limit?	Out-of-network coinsurance ,premiums, balance-billing 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**.
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 In-network providers.	This **plan** uses a **provider network**. 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
		In-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	$40 copay/visit; 2 visits free before copay	50% coinsurance	Coinsurance applies after deductible
	Specialist visit	$75 copay/visit and 35% coinsurance for other outpatient services	50% coinsurance	Services and procedures other than consult and eval paid at 35% coinsurance in-network; Copay and coinsurance apply after deductible
	Preventive care/screening/ immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	35% coinsurance	50% coinsurance	Coinsurance applies after deductible
	Imaging (CT/PET scans, MRIs)	$250 copay/test	50% coinsurance	Copay and coinsurance applies after deductible; Coverage requires prior approval
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=2018.	Generic drugs	Retail $25 copay/prescription Mail $50 copay/prescription	Not Covered	Covers up to 30-day supply (retail prescriptions); 31-90 day supply (mail order prescription).
	Preferred brand drugs	Retail $75 copay/prescription Mail $150 copay/prescription	Not Covered	Covers up to 30-day supply (retail prescriptions); 31-90 day supply (mail order prescription); Coverage requires prior approval; Copay applies after deductible
	Non-preferred brand drugs	Retail $150 copay/ prescription Mail $300 copay/prescription	Not Covered	Covers up to 30-day supply (retail prescriptions); 31-90 day supply (mail order prescription); Coverage requires prior approval; Copay applies after deductible
	Specialty drugs	Retail $250 copay/ prescription Mail $500 copay/prescription	Not Covered	Prior authorization, step therapy or quantity limitations may apply; Non-preferred specialty drugs may apply at a higher copay in-network; Coverage requires prior approval; Copay applies after deductible
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	35% coinsurance	50% coinsurance	Coverage requires prior approval; Coinsurance applies after deductible
	Physician/surgeon fees	35% coinsurance	50% coinsurance	Coverage requires prior approval; Coinsurance applies after deductible

*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
		In-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	$500 copay/visit	$500 copay/visit	Copay applies after deductible
	Emergency medical transportation	35% coinsurance	35% coinsurance	Coverage limited to $1,000/trip for ground or water ambulance services and $5,000/trip for air ambulance services; Coinsurance applies after deductible
	Urgent care	$75 copay/visit	50% coinsurance	Copay and coinsurance applies after deductible
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay/day	50% coinsurance	Coverage requires prior approval; Copay and coinsurance applies after deductible
	Physician/surgeon fees	35% coinsurance	50% coinsurance	Coverage requires prior approval; Coinsurance applies after deductible
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$40 copay/visit and 35% coinsurance for other outpatient services	50% coinsurance	Consultation and evaluation only are paid at $40 copay in-network with 2 visits free before copay; Other services and procedures are paid at 35% coinsurance in-network after deductible; Coverage requires prior approval
	Inpatient services	$500 copay/day	50% coinsurance	Copay and coinsurance apply after deductible; Coverage requires prior approval
If you are pregnant	Office visits	35% coinsurance	50% coinsurance	Coverage for routine ultrasounds limited to 1; Cost sharing does not apply for preventive services. 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; Coverage requires prior notification; Coinsurance applies after deductible
	Childbirth/delivery professional services	35% coinsurance	50% coinsurance	Coverage requires prior notification; Coinsurance applies after deductible
	Childbirth/delivery facility services	35% coinsurance	50% coinsurance	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; Coinsurance applies after deductible

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 help recovering or have other special health needs	Home health care	35% coinsurance	50% coinsurance	Coverage is limited to 50 visits/person/calendar year; Coverage requires prior approval; Coinsurance applies after deductible
	Rehabilitation services	$40 copay/visit and 35% coinsurance	Not Covered	Outpatient services limited to 30 visits/person/calendar year and paid at $40 copay with 2 visits free before copay in-network; Inpatient services limited to 60 days/person/calendar year and paid at 35% coinsurance in-network after deductible; Coverage requires prior approval
	Habilitation services	$40 copay/visit and 35% coinsurance	Not Covered	Developmental services limited to 180 units/person/calendar year and paid at 35% coinsurance in-network after deductible; Outpatient services limited to 30 visits/person/calendar year and paid at $40 copay with 2 visits free before copay in-network; Coverage requires prior approval
	Skilled nursing care	$500 copay/day	50% coinsurance	Limited to 60 days/person/calendar year; Coverage requires prior approval; Copay and coinsurance apply after deductible
	Durable medical equipment	50% coinsurance	50% coinsurance	Prior approval is required for DME costs which exceeds $500; Coinsurance applies after deductible
	Hospice services	35% coinsurance	50% coinsurance	Hospice care must be certified by a physician as having a life expectancy of six months or less; Coverage requires prior approval; Coinsurance applies after deductible
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	Limited to one exam per child per calendar year
	Children's glasses	35% coinsurance	50% coinsurance	Limited to one pair of glasses with lenses or contacts per child per calendar year; Coinsurance applies after deductible
	Children's dental check-up	Not Covered	Not Covered	None

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

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
- Routine foot care is covered for prevention of complications associated with diabetes
- 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)

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** 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
1200 West Third Street, Little Rock, Arkansas 72201
Telephone 1-800-852-5494, Email address: 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, kwiijigo 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 plan's overall deductible	$5,000
Specialist copayment	$75
Hospital (facility) copayment	$500
Other coinsurance	35%

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:

Cost Sharing	
Deductibles	$4,000
Copayments	$90
Coinsurance	$3,000
What isn't covered	
Limits or exclusions	$90
The total Peg would pay is	**$7,180**

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

The plan's overall deductible	$5,000
Specialist copayment	$75
Hospital (facility) copayment	$500
Other coinsurance	35%

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:

Cost Sharing	
Deductibles	$2,300
Copayments	$1,900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$4,260**

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

The plan's overall deductible	$5,000
Specialist copayment	$75
Hospital (facility) copayment	$500
Other coinsurance	35%

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:

Cost Sharing	
Deductibles	$1,600
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,000**

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

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.

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