




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> \$0 individual / \$0 family; for <u>out-of-network provider</u> \$10,300 individual / \$20,600 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> - \$1,800 Individual / \$3,600 family. For <u>out-of-network provider</u> - \$13,700 individual/ \$27,400 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> .

SBC #: 35010 17-345-F SBC75293AR1200026-06-STD-25
 8/15/2023

 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	\$0 <u>copay</u> /visit; <u>deductible</u> does not apply	50% <u>coinsurance</u>	<u>Out-of-network coinsurance</u> will apply after <u>deductible</u> .
	<u>Specialist</u> visit	\$10 <u>copay</u> /visit and 25% <u>coinsurance</u> for other outpatient services; <u>deductible</u> does not apply	50% <u>coinsurance</u>	Consultation and evaluation only are paid at \$10 <u>copay</u> in-network. Services and procedures other than consult and eval are paid at 25% <u>coinsurance</u> in-network.
	<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)	25% <u>coinsurance</u> ; <u>deductible</u> does not apply	50% <u>coinsurance</u>	<u>Out-of-network coinsurance</u> will apply after <u>deductible</u> .
	Imaging (CT/PET scans, MRIs)	25% <u>coinsurance</u> ; <u>deductible</u> does not apply	50% <u>coinsurance</u>	<u>Out-of-network coinsurance</u> will apply 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 \$0 <u>copay</u> /prescription Mail \$0 <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 \$15 <u>copay</u> /prescription Mail \$30 <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 \$50 <u>copay</u> / prescription Mail \$100 <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 drugs</u>	Retail \$150 <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>copay</u> in- network; Coverage requires prior approval.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% <u>coinsurance</u> ; <u>deductible</u> does not apply	50% <u>coinsurance</u>	<u>Out-of-network coinsurance</u> will apply after <u>deductible</u> .
	Physician/surgeon fees	25% <u>coinsurance</u> ; <u>deductible</u> does not apply	50% <u>coinsurance</u>	<u>Out-of-network coinsurance</u> will apply 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	<u>Emergency room care</u>	25% <u>coinsurance</u> ; <u>deductible</u> does not apply	25% <u>coinsurance</u> ; <u>deductible</u> does not apply	In-Network <u>Coinsurance</u> only will apply for in-network and out-of-network services.
	<u>Emergency medical transportation</u>	25% <u>coinsurance</u> ; <u>deductible</u> does not apply	25% <u>coinsurance</u> ; <u>deductible</u> does not apply	In-Network <u>Coinsurance</u> only will apply for in-network and out-of-network services.
	<u>Urgent care</u>	\$5 <u>copay/visit</u> ; <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)	25% <u>coinsurance</u> ; <u>deductible</u> does not apply	50% <u>coinsurance</u>	<u>Out-of-network coinsurance</u> will apply after <u>deductible</u> .
	Physician/surgeon fees	25% <u>coinsurance</u> ; <u>deductible</u> does not apply	50% <u>coinsurance</u>	<u>Out-of-network coinsurance</u> will apply after <u>deductible</u> .
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$0 <u>copay/visit</u> and 25% <u>coinsurance</u> for other outpatient services	50% <u>coinsurance</u>	Consultation and evaluation only are paid at \$0 <u>copay</u> in-network; Other services and procedures are paid at 25% <u>coinsurance</u> in-network.
	Inpatient services	25% <u>coinsurance</u> ; <u>deductible</u> does not apply	50% <u>coinsurance</u>	<u>Out-of-network coinsurance</u> will apply after <u>deductible</u> .
If you are pregnant	Office visits	25% <u>coinsurance</u> ; <u>deductible</u> does not apply	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; <u>Out-of-network coinsurance</u> will apply after <u>deductible</u> .
	Childbirth/delivery professional services	25% <u>coinsurance</u> ; <u>deductible</u> does not apply	50% <u>coinsurance</u>	<u>Out-of-network coinsurance</u> will apply after <u>deductible</u> .
	Childbirth/delivery facility services	25% <u>coinsurance</u> ; <u>deductible</u> does not apply	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; <u>Out-of-network coinsurance</u> will apply 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>	25% <u>coinsurance</u> ; <u>deductible</u> does not apply	50% <u>coinsurance</u>	Coverage is limited to 50 visits/person/calendar year; <u>Out-of-network coinsurance</u> will apply after <u>deductible</u> .
	<u>Rehabilitation services</u>	\$0 <u>copay</u> /visit and 25% <u>coinsurance</u> for other outpatient services; <u>deductible</u> does not apply	Not Covered	Outpatient services limited to 30 visits/person/calendar year and paid at \$0 <u>copay</u> in-network; Inpatient services limited to 60 days/person/calendar year and paid at 25% <u>coinsurance</u> in-network.
	<u>Habilitation services</u>	\$0 <u>copay</u> /visit and 25% <u>coinsurance</u> for other outpatient services; <u>deductible</u> does not apply	Not Covered	Developmental services limited to 180 units/person/calendar year and paid at 25% <u>coinsurance</u> in-network; Outpatient services limited to 30 visits/person/calendar year and paid at \$0 <u>copay</u> in-network.
	<u>Skilled nursing care</u>	25% <u>coinsurance</u> ; <u>deductible</u> does not apply	50% <u>coinsurance</u>	Limited to 60 days/person/calendar year; <u>Out-of-network coinsurance</u> will apply after <u>deductible</u> .
	<u>Durable medical equipment</u>	25% <u>coinsurance</u> ; <u>deductible</u> does not apply	50% <u>coinsurance</u>	<u>Out-of-network coinsurance</u> will apply after <u>deductible</u> .
	<u>Hospice services</u>	25% <u>coinsurance</u> ; <u>deductible</u> does not apply	50% <u>coinsurance</u>	Hospice care must be certified by a physician as having a life expectancy of six months or less; <u>Out-of-network coinsurance</u> will apply after <u>deductible</u> .
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	25% <u>coinsurance</u> ; <u>deductible</u> does not apply	50% <u>coinsurance</u>	Limited to one pair of glasses with lenses or contacts per child per calendar year; <u>Out-of-network coinsurance</u> will apply 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): Dinek'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 **plan's** overall **deductible** **\$0**
- **Specialist copayment** **\$10**
- **Hospital (facility) coinsurance** **25%**
- **Other coinsurance** **25%**

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$3,200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$3,200

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

- The **plan's** overall **deductible** **\$0**
- **Specialist copayment** **\$10**
- **Hospital (facility) coinsurance** **25%**
- **Other coinsurance** **25%**

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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$500
<i>What isn't covered</i>	
Limits or exclusions	\$60
Total Example Cost	\$760

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

- The **plan's** overall **deductible** **\$0**
- **Specialist copayment** **\$10**
- **Hospital (facility) coinsurance** **25%**
- **Other coinsurance** **25%**

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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$50
<u>Coinsurance</u>	\$500
<i>What isn't covered</i>	
Limits or exclusions	\$0
Total Example Cost	\$550