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?	$0	See the Common Medical Events chart below for your costs for services this **plan** covers.
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?	No.	You don't have to meet **deductibles** for specific services.
What is the out-of-pocket limit for this plan?	Not Applicable.	This plan does not have an **out-of-pocket limit** on your expenses.
What is not included in the out-of-pocket limit?	Not Applicable.	This plan does not have an **out-of-pocket limit** on your expenses.
Will you pay less if you use a network provider?	Yes. See https://www.arkansasbluecross.com/providerdirectory/trueblueppo 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	No Charge	No Charge	None
	Specialist visit	No Charge	No Charge	None
	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)	No Charge	No Charge	None
	Imaging (CT/PET scans, MRIs)	No Charge	No Charge	Coverage requires prior approval
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-2023.	Generic drugs	No Charge	Not Covered	Covers up to 30-day supply (retail prescriptions); 31-90 day supply (mail order prescription).
	Preferred brand drugs	No Charge	Not Covered	Covers up to a 30-day supply (retail prescriptions); 31-90 day supply (mail order prescription).
	Non-preferred brand drugs	No Charge	Not Covered	Covers up to a 30-day supply (retail prescriptions); 31-90 day supply (mail order prescription).
	Specialty drugs	No Charge	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.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	No Charge	Coverage requires prior approval
	Physician/surgeon fees	No Charge	No Charge	Coverage requires prior approval
If you need immediate medical attention	Emergency room care	No Charge	No Charge	None
	Emergency medical transportation	No Charge	No Charge	None
	Urgent care	No Charge	No Charge	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	No Charge	Coverage requires prior approval
	Physician/surgeon fees	No Charge	No Charge	Coverage requires prior approval

*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 mental health, behavioral health, or substance abuse services	Outpatient services	No Charge	No Charge	None
	Inpatient services	No Charge	No Charge	Coverage requires prior approval
If you are pregnant	Office visits	No Charge	No Charge	Coverage for routine ultrasounds limited to 1; Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC; Coverage requires prior notification
	Childbirth/delivery professional services	No Charge	No Charge	Coverage requires prior notification
	Childbirth/delivery facility services	No Charge	No Charge	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
If you need help recovering or have other special health needs	Home health care	No Charge	No Charge	Coverage is limited to 50 visits/person/calendar year; Coverage requires prior approval
	Rehabilitation services	No Charge	Not Covered	Outpatient services limited to 30 visits/person/ calendar year; Inpatient services limited to 60 days/person/calendar year
	Habilitation services	No Charge	Not Covered	Developmental services limited to 180 units/ person/ calendar year; Outpatient services limited to 30 visits/person/calendar year
	Skilled nursing care	No Charge	No Charge	Limited to 60 days/person/ calendar year; Coverage requires prior approval
	Durable medical equipment	No Charge	No Charge	Prior approval is required for DME costs which exceeds $500
	Hospice services	No Charge	No Charge	Hospice care must be certified by a physician as having a life expectancy of six months or less; Coverage requires prior approval

*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 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	No Charge	No Charge	Limited to one pair of glasses with lenses or contacts per child per calendar year
	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
- Adult Routine Eye Care
- 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 (Prior Approval Required)
- 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 **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.**
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, 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	$0
Specialist copayment	$0
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$0**

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	$0
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$60**

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

The plan's overall deductible	$0
Specialist copayment	$0
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$0**

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