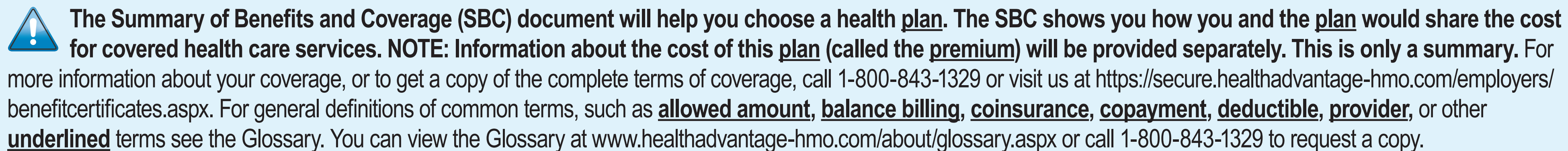
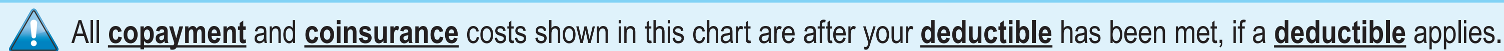


The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-843-1329 or visit us at https://secure.healthadvantage-hmo.com/employers/benefitcertificates.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.healthadvantage-hmo.com/about/glossary.aspx or call 1-800-843-1329 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers $1,500 individual / $3,000 family ; for out-of-network providers $4,500 individual / $9,000 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 **plan**, each family member must meet their own individual **deductible** until the total amount of **deductible** expenses paid by all family members meets the overall family **deductible**.
Are there services covered before you meet your deductible?	Yes. Preventive care and prescription drugs are 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?	For in-network provider - $3,000 individual / $6,000 family. For out-of-network providers - unlimited.	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**, they have to meet their own **out-of-pocket limits** until the overall family **out-of-pocket limit** has been met.
What is not included in the out-of-pocket limit?	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.healthadvantage-hmo.com/providerdirectory/default.aspx or call 1-800-843-1329 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	$35 copay/visit	40% coinsurance	---none---
	Specialist visit	$55 copay/visit and 20% coinsurance	40% coinsurance	Services and procedures other than consultation and evaluation are paid at 20% coinsurance in-network
	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)	Applicable copay and 20% coinsurance	40% coinsurance	---none---
	Imaging (CT/PET scans, MRIs)	Applicable copay and 20% coinsurance	40% coinsurance	Coverage requires prior authorization
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=2017.	Generic drugs	Retail $10 copay/ prescription; deductible does not apply	Not Covered	Covers up to a 30-day supply (retail subscription)
	Preferred brand drugs	Retail $40 copay/ prescription; deductible does not apply	Not Covered	Covers up to a 30-day supply (retail subscription)
	Non-preferred brand drugs	Retail $60 copay/ prescription; deductible does not apply	Not Covered	Covers up to a 30-day supply (retail subscription)
	Specialty drugs	Retail $60 copay/ prescription; deductible does not apply	Not Covered	Prior authorization, step therapy or quantity limitations may apply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 copay/visit and 20% coinsurance	40% coinsurance	---none---
	Physician/surgeon fees	$100 copay/visit and 20% coinsurance	40% coinsurance	---none---

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	$100 copay/visit and 20% coinsurance	$100 copay/visit and 20% coinsurance	---none---
	Emergency medical transportation	50% coinsurance	50% coinsurance	Coverage is limited to $1,000/trip (ground or water) and $5,000/trip (air)
	Urgent care	$55 copay/visit and 20% coinsurance	40% coinsurance	Services and procedure other than consultation and evaluation are paid at 20% coinsurance in-network
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 copay/admission and 20% coinsurance	40% coinsurance	Copay applies per admission and coinsurance applies after deductible and copayment in-network
	Physician/surgeon fees	20% coinsurance	40% coinsurance	---none---
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$35 copay/visit and 20% coinsurance	40% coinsurance	Services and procedures other than consultation and evaluation are paid at 20% coinsurance in-network
	Inpatient services	$200 copay/admission and 20% coinsurance	40% coinsurance	Copay applies per admission and coinsurance applies after deductible and copayment in-network
If you are pregnant	Office visits	1st office visit $55 specialist copay and 20% coinsurance	40% 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
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	---none---
	Childbirth/delivery facility services	$200 copay/admission and 20% coinsurance	40% coinsurance	Coverage for Out of Network newborn services is limited to $2000 per Member for all services first 90 days after birth; Copay applies per admission; Coinsurance applies after deductible and copayment in-network

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	20% coinsurance	40% coinsurance	Coverage is limited to 50 visits/contract year
	Rehabilitation services	$200 copay/admission and 20% coinsurance inpatient services; $35 copay/visit outpatient services	Not Covered	Copay applies per admission and coinsurance applies after deductible for inpatient services limited to 60 days/member/contract year in-network; Copay applies in-network for outpatient services (Physical/Occupational/Speech therapy) limited to 30 visits/member/contract year
	Habilitation services	$55 copay/visit and 20% coinsurance; $35 copay/visit outpatient services	Not Covered	Developmental services limited to 180 units/member/contract year and paid as $55 copay and 20% coinsurance in-network; Copay applies in-network for outpatient services (Physical/Occupational/Speech therapy) limited to 30 visits/member/contract year and $35 copay
	Skilled nursing care	$200 copay/admission and 20% coinsurance	40% coinsurance	Copay applies per admission; coinsurance applies after deductible and copayment. Limited to 60 days/contract year; Prior authorization required
	Durable medical equipment (DME)	50% copayment	50% coinsurance	Prior authorization is required for Durable medical equipment costs which exceeds $5,000
	Hospice services	20% coinsurance	Not Covered	Must be certified by a physician as having a life expectancy of six months or less; Prior authorization required
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	Limited to one exam per contract year
	Children's glasses	20% coinsurance	40% coinsurance	Limited to one pair of glasses with lenses or contacts per contract year
	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.)

- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care
- Infertility treatment
- Long term care
- Private-duty nursing
- Routine foot care
- 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/member/ contract year)
- Hearing aids ($1,400/ear/member)
- Non-Emergency Care when traveling outside of U.S. (Subject to discretion of the company)
- Routine Eye Care (Adult) (1 visit/member 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 the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov or contact the **plan** at 1-800-843-1329. 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 **plan** at 1-800-843-1329. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or **www.dol.gov/ebsa/healthreform**. 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** **$1,500**
- **Specialist copayment** **$55**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

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	$1,500
Copayments	$300
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$3,070**

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

- **The plan's overall deductible** **$1,500**
- **Specialist copayment** **$55**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

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	$1,400
Copayments	$1,600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$3,060**

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

- **The plan's overall deductible** **$1,500**
- **Specialist copayment** **$55**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

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	$1,500
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,600**

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 નિ:શુલ્ક 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 مفت ہیں. کال کریں 1-844-662-2276

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, 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