



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, contact the claims administrator at 1-800-370-5792 or visit [www.blueadvantagearkansas.com](http://www.blueadvantagearkansas.com). 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 <https://www.healthcare.gov/sbc-glossary> or call 1-800-370-5792 to request a copy.

| Important Questions                                                                   | Answers                                                                                                                                                                                                                                                       | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|---------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>What is the overall <a href="#">deductible</a>?</b>                                | \$1,000 per person; \$2,750 per family.<br>In-Network and Out-of-Network combined.                                                                                                                                                                            | Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .                                                                                                                                                                                           |
| <b>Are there services covered before you meet your <a href="#">deductible</a>?</b>    | Yes. Supplemental Accident Expenses, In-Network primary care physician office setting, and In-Network <a href="#">preventive care</a> .                                                                                                                       | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                                      |
| <b>Are there other <a href="#">deductibles</a> for specific services?</b>             | Yes. Pharmacy Deductible \$100 person.                                                                                                                                                                                                                        | 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b> | In-Network: \$3,000 per person; \$8,750 per family. Out-of-Network: Unlimited.<br>Once the In-Network <a href="#">out-of-pocket limit</a> has been satisfied, In-Network covered charges are paid at 100% and Out-of-Network covered charges are paid at 60%. | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.                                                                                                                                                                                                                                                                                                                                            |
| <b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>               | Premiums, balance billing charges, health care this plan doesn't cover, Out-of-Network durable medical equipment.                                                                                                                                             | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| <b>Will you pay less if you use a <a href="#">network provider</a>?</b>               | Yes. See <a href="http://www.blueadvantagearkansas.com">www.blueadvantagearkansas.com</a> or call 1-800-370-5792 for a list of <a href="#">network providers</a> .                                                                                            | This plan uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an out-of-network <a href="#">provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| <b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>    | No.                                                                                                                                                                                                                                                           | You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |

 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<br>(You will pay the least)          | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| If you visit a health care <u>provider's</u> office or clinic                                                                                                                                                     | Primary care visit to treat an injury or illness | \$25 <u>copay</u> per visit, <u>deductible</u> waived | 40% <u>coinsurance</u>                             | —————none—————                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|                                                                                                                                                                                                                   | <u>Specialist</u> visit                          | 20% <u>coinsurance</u>                                | 40% <u>coinsurance</u>                             | Coverage includes telehealth services by MDLIVE, subject to \$10 <u>copay</u> per consultation.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|                                                                                                                                                                                                                   | <u>Preventive care/screening/immunization</u>    | No charge                                             | Not covered                                        | At all times this <u>plan</u> will comply with the Patient Protection and Affordable Care Act. The list of services included as Standard <u>Preventive Care</u> may change from time to time depending upon government guidelines. A current listing of required preventive care can be accessed at: <a href="http://www.HealthCare.gov/center/regulations/prevention.html">www.HealthCare.gov/center/regulations/prevention.html</a> .<br><br>You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then determine what your <u>plan</u> will pay. |
| If you have a test                                                                                                                                                                                                | <u>Diagnostic test</u> (x-ray, blood work)       | 20% <u>coinsurance</u>                                | 40% <u>coinsurance</u>                             | —————none—————                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|                                                                                                                                                                                                                   | Imaging (CT/PET scans, MRIs)                     | 20% <u>coinsurance</u>                                | 40% <u>coinsurance</u>                             | Prior authorization required.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| If you need drugs to treat your illness or condition<br>More information about <u>prescription drug coverage</u> is available at <a href="http://www.blueadvantagearkansas.com">www.blueadvantagearkansas.com</a> | Generic drugs                                    | \$15 <u>copay</u>                                     | Not covered                                        | Pharmacy <u>deductible</u> is \$100 per person.<br><br>Retail supply: up to 34 days for one <u>copay</u><br>Maintenance supply: up to 100 days for two <u>copays</u> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|                                                                                                                                                                                                                   | Preferred brand drugs                            | \$55 <u>copay</u>                                     | Not covered                                        | <b>Specialty Drugs.</b> Coverage of Specialty Drugs is limited to a 30-day supply per fill. Specialty                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|                                                                                                                                                                                                                   | Non-preferred brand drugs                        | \$125 <u>copay</u>                                    | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |

| Common Medical Event                    | Services You May Need                            | What You Will Pay                                                                  |                                                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                              |
|-----------------------------------------|--------------------------------------------------|------------------------------------------------------------------------------------|------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                         |                                                  | Network Provider<br>(You will pay the least)                                       | Out-of-Network Provider<br>(You will pay the most)                                 |                                                                                                                                                                                                                     |
|                                         | <a href="#">Specialty drugs</a>                  | \$250 <u>copay</u>                                                                 | Not covered                                                                        | Drugs must be purchased through the CVS Specialty Pharmacy Network. Prior approval is required.                                                                                                                     |
| If you have outpatient surgery          | Facility fee (e.g., ambulatory surgery center)   | 20% <u>coinsurance</u>                                                             | 40% <u>coinsurance</u>                                                             | Out-of-Network limited to \$500 of allowable charges.                                                                                                                                                               |
|                                         | Physician/surgeon fees                           | 20% <u>coinsurance</u>                                                             | 40% <u>coinsurance</u>                                                             | —————none—————                                                                                                                                                                                                      |
| If you need immediate medical attention | <a href="#">Emergency room care</a>              | <i>True Emergency:</i> 20% <u>coinsurance</u><br><i>Non-Emergency:</i> Not covered | <i>True Emergency:</i> 20% <u>coinsurance</u><br><i>Non-Emergency:</i> Not covered | Accident Supplemental benefits must begin within 7 days of accident and up to 90 days maximum; <u>deductible</u> and <u>coinsurance</u> waived. After 90 days subject to <u>deductible</u> and <u>coinsurance</u> . |
|                                         | <a href="#">Emergency medical transportation</a> | 20% <u>coinsurance</u>                                                             | 40% <u>coinsurance</u>                                                             | Ground and water limited to \$1,000 per trip. Air limited to \$20,000 per trip and one trip per year.                                                                                                               |
|                                         | <a href="#">Urgent care</a>                      | 20% <u>coinsurance</u>                                                             | 40% <u>coinsurance</u>                                                             | —————none—————                                                                                                                                                                                                      |
| If you have a hospital stay             | Facility fee (e.g., hospital room)               | 20% <u>coinsurance</u>                                                             | 40% <u>coinsurance</u>                                                             | The covered person is responsible for obtaining prenotification for Out-of-Network admissions. Penalty for failure to prenotify of an Out-of-Network admission is the covered person's responsibility.              |
|                                         | Physician/surgeon fees                           | 20% <u>coinsurance</u>                                                             | 40% <u>coinsurance</u>                                                             | —————none—————                                                                                                                                                                                                      |

| Common Medical Event                                                             | Services You May Need                     | What You Will Pay                                                                                                    |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                             |
|----------------------------------------------------------------------------------|-------------------------------------------|----------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                  |                                           | Network Provider<br>(You will pay the least)                                                                         | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                    |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                       | Office setting: \$25 <u>copay</u> per visit, <u>deductible</u> waived<br><br>Other locations: 20% <u>coinsurance</u> | 40% <u>coinsurance</u>                             | _____none_____                                                                                                                                                                                                                                     |
|                                                                                  | Inpatient services                        | 20% <u>coinsurance</u>                                                                                               | 40% <u>coinsurance</u>                             | Residential Treatment Centers are not covered. The covered person is responsible for obtaining prenotification for Out-of-Network admissions. Penalty for failure to prenotify an Out-of-Network admission is the covered person's responsibility. |
| <b>If you are pregnant</b>                                                       | Office visits                             | \$25 <u>copay</u> per visit, <u>deductible</u> waived                                                                | 40% <u>coinsurance</u>                             | Routine obstetrical ultrasounds limited to one per pregnancy.                                                                                                                                                                                      |
|                                                                                  | Childbirth/delivery professional services | 20% <u>coinsurance</u>                                                                                               | 40% <u>coinsurance</u>                             | _____none_____                                                                                                                                                                                                                                     |
|                                                                                  | Childbirth/delivery facility services     | 20% <u>coinsurance</u>                                                                                               | 40% <u>coinsurance</u>                             | _____none_____                                                                                                                                                                                                                                     |
| <b>If you need help recovering or have other special health needs</b>            | <a href="#">Home health care</a>          | 20% <u>coinsurance</u>                                                                                               | 40% <u>coinsurance</u>                             | Home Health limited to 40 visits per Calendar Year.                                                                                                                                                                                                |
|                                                                                  | <a href="#">Rehabilitation services</a>   | Office setting: \$25 <u>copay</u> per visit, <u>deductible</u> waived<br><br>Other locations: 20% <u>coinsurance</u> | 40% <u>coinsurance</u>                             | Chiropractic Services, Physical and Occupational Therapy limited to 30 visits combined per Calendar Year. Speech Therapy limited to 25 visits per Calendar Year.                                                                                   |
|                                                                                  | <a href="#">Habilitation services</a>     | Not covered                                                                                                          | Not covered                                        | Habilitation services are not covered.                                                                                                                                                                                                             |
|                                                                                  | <a href="#">Skilled nursing care</a>      | 20% <u>coinsurance</u>                                                                                               | 40% <u>coinsurance</u>                             | Skilled Nursing limited to 30 days per Calendar Year.                                                                                                                                                                                              |
|                                                                                  | <a href="#">Durable medical equipment</a> | 20% <u>coinsurance</u>                                                                                               | 40% <u>coinsurance</u>                             | _____none_____                                                                                                                                                                                                                                     |
|                                                                                  | <a href="#">Hospice services</a>          | 20% <u>coinsurance</u>                                                                                               | 40% <u>coinsurance</u>                             | _____none_____                                                                                                                                                                                                                                     |

| Common Medical Event                   | Services You May Need      | What You Will Pay                                                                                     |                                                            | Limitations, Exceptions, & Other Important Information                                                                                  |
|----------------------------------------|----------------------------|-------------------------------------------------------------------------------------------------------|------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|
|                                        |                            | Network Provider<br>(You will pay the least)                                                          | Out-of-Network Provider<br>(You will pay the most)         |                                                                                                                                         |
| If your child needs dental or eye care | Children's eye exam        | Medical exam: 20% coinsurance<br>Routine exam: No charge. Services limited to children under age six. | Medical exam: 40% coinsurance<br>Routine exam: Not covered | Additional services may be available under a separate vision benefit plan.                                                              |
|                                        | Children's glasses         | Not covered                                                                                           | Not covered                                                | Additional services may be available under a separate vision benefit plan.                                                              |
|                                        | Children's dental check-up | Not covered                                                                                           | Not covered                                                | No coverage for dental check-ups under Medical Benefit Plan. Additional services may be available under a separate dental benefit plan. |

#### 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](#).)

- |                                                                                                                                                 |                                                                                                                                                          |                                                                                                                                   |
|-------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Bariatric surgery</li> <li>• Cosmetic surgery</li> <li>• Dental care</li> </ul> | <ul style="list-style-type: none"> <li>• Hearing aids</li> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>• Routine eye care</li> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul> |
|-------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------|

##### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- |                                                                       |                                                                                                          |                                                                                                                             |
|-----------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Chiropractic care</li> </ul> | <ul style="list-style-type: none"> <li>• Infertility treatment (limited to \$15,000 lifetime)</li> </ul> | <ul style="list-style-type: none"> <li>• Private-duty nursing ( limited when combined with Home Health benefits)</li> </ul> |
|-----------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|

**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: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). 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](http://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 a [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: Northwest Arkansas Community College, One College Drive, Bentonville, Arkansas, 72712 or by telephone at 1-479-619-3149.

**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 the 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 1-800-370-5792.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-370-5792.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-370-5792.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-370-5792.

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*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

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## 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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$1,000                         |
| ■ <a href="#">Specialist</a>                                    | 20% <a href="#">coinsurance</a> |
| ■ Hospital (facility)                                           | 20% <a href="#">coinsurance</a> |
| ■ Other                                                         | 20% <a href="#">coinsurance</a> |

#### 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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,840</b> |
|---------------------------|-----------------|

#### In this example, Peg would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| Deductibles                       | \$1,000        |
| Copayments                        | \$60           |
| Coinsurance                       | \$2,000        |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$3,120</b> |

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

|                                                                 |                                 |
|-----------------------------------------------------------------|---------------------------------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$1,000                         |
| ■ <a href="#">Specialist</a>                                    | 20% <a href="#">coinsurance</a> |
| ■ Hospital (facility)                                           | 20% <a href="#">coinsurance</a> |
| ■ Other                                                         | 20% <a href="#">coinsurance</a> |

#### 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$7,460</b> |
|---------------------------|----------------|

#### In this example, Joe would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| Deductibles                       | \$1,000        |
| Copayments                        | \$1,380        |
| Coinsurance                       | \$430          |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Joe would pay is</b> | <b>\$2,870</b> |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

|                                                                 |                                 |
|-----------------------------------------------------------------|---------------------------------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$1,000                         |
| ■ <a href="#">Specialist</a>                                    | 20% <a href="#">coinsurance</a> |
| ■ Hospital (facility)                                           | 20% <a href="#">coinsurance</a> |
| ■ Other                                                         | 20% <a href="#">coinsurance</a> |

#### This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,010</b> |
|---------------------------|----------------|

#### In this example, Mia would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| Deductibles                       | \$1,000        |
| Copayments                        | \$0            |
| Coinsurance                       | \$385          |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,385</b> |