This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.blueadvantagearkansas.com or by calling 1-888-898-8145.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$750 per person. $1,500 per family. Waived for In-Network PCP office services, In-Network preventive care, In-Network diabetes self-management training, accident-related services.	You must pay all the costs up to the deductible amount before this health insurance plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart titled Common Medical Event for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	No.	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.
Is there an out-of-pocket limit on my expenses?	In-Network $2,750 per person; $5,500 per family. Out-of-Network: $16,000 per person; $32,000 per family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Out-of-Network charges for weight loss surgery and DME, premiums, amounts over allowed amount, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Is there an overall annual limit on what the insurer pays?	No.	The chart titled Common Medical Event describes *specific* coverage limits such as limits on the number of office visits.
Does this plan use a network of providers?	Yes. For a list of In-Network Providers, see www.blueadvantagearkansas.com	If you use a Network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Beware, your Network provider may use an out-of-Network provider for some services. Plans use the term panel, in-network, preferred, or participating for providers in their network. See the chart titled Common Medical Event for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed in the box titled Services Your Plan Does Not Cover. See your policy or plan document for information about excluded services.

- Copayments are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- Coinsurance is *your* share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is $1,000, your coinsurance payment of 20% would be $200. This may change if you haven't met your deductible.
- The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
- This plan may encourage you to use Network providers by charging you lower deductibles, copayments and coinsurance amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 copay	40% coinsurance	---------- none ----------
	Specialist visit	20% coinsurance	40% coinsurance	---------- none ----------
	Other practitioner office visit	20% coinsurance	40% coinsurance	Chiropractor charges are subject to a 30-visit limit combined with physical and occupational therapy.
	Preventive care / screening / immunization	No charge	20% coinsurance	Out-of-Network preventive services are not covered. At all times, this Plan will comply with the Patient Protection and Affordable Care Act (the Affordable Care Act). A complete listing of Affordable Care Act preventative care services can be accessed at www.HealthCare.gov/center/regulations/prevention.html and www.cdc.gov/vaccines/recs/acip/.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	---------- none ----------
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	---------- none ----------

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.blueadvantagearkansas.com	Generic drugs	$15 copay	$15 copay	Copays amounts apply to a 34-day supply of drugs from a retail pharmacy.
	Preferred brand drugs	$45 copay	$45 copay	
	Non-preferred brand drugs	$65 copay	$65 copay	
	Specialty drugs	Generic drugs: $15 copay. Preferred brand drugs: $45 copay. Non-preferred brand drugs: $65 copay.	Generic drugs: $15 copay. Preferred brand drugs: $45 copay. Non-preferred brand drugs: $65 copay.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	---------- none ----------
	Physician/surgeon fees	20% coinsurance	40% coinsurance	---------- none ----------
If you need immediate medical attention	Emergency room services	20% coinsurance	20% coinsurance	Deductible waived for accident-related charges if treatment is received within 90 days of accident.
	Emergency medical transportation	20% coinsurance	40% coinsurance	Ground and water transport limited to $1,000 per trip. Air transport limited to $5,000 per trip.
	Urgent care	20% coinsurance	40% coinsurance	---------- none ----------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	The covered person is responsible for obtaining precertification for Out-of-Network admissions.
	Physician/surgeon fee	20% coinsurance	40% coinsurance	---------- none ----------
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health Outpatient services	20% coinsurance	40% coinsurance	---------- none ----------
	Mental/Behavioral health Inpatient services	20% coinsurance	40% coinsurance	The covered person is responsible for obtaining precertification for Out-of-Network admissions.
	Substance use disorder Outpatient services	20% coinsurance	40% coinsurance	---------- none ----------
	Substance use disorder Inpatient services	20% coinsurance	40% coinsurance	The covered person is responsible for obtaining precertification for Out-of-Network admissions.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	20% coinsurance	40% coinsurance	Routine obstetrical ultrasounds are limited to one per pregnancy.
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	---------- none ----------
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Limited to 40 visits per year. Coinsurance continues to apply to out-of-network services, even after out-of-pocket limit is met.
	Rehabilitation services	20% coinsurance	40% coinsurance	Chiropractor, physical therapy, and occupational therapy is subject to a combined 30-visit limit per calendar year. Speech therapy is limited to 25 visits per year and the coinsurance continues to apply to out-of-network services, even after the out-of-pocket limit is met.
	Habilitation services	100% coinsurance	100% coinsurance	There is no coverage for habilitation services.
	Skilled nursing care	20% coinsurance	40% coinsurance	Limited to 30 inpatient days per year. Coinsurance continues to apply to out-of-network services, even after out-of-pocket limit is met.
	Durable medical equipment	20% coinsurance	40% coinsurance	Out-of-Network charges for DME do not contribute to the Out-of-Pocket limit and coinsurance will always apply, even if the out-of-pocket limit is met.
	Hospice service	20% coinsurance	40% coinsurance	---------- none ----------
If your child needs dental or eye care	Eye exam	No charge	40% coinsurance	Coverage is limited to eye exams for children under age six.
	Glasses	20% coinsurance	40% coinsurance	Coverage is limited to glasses following an injury or illness.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Dental check-up	100% coinsurance	100% coinsurance	There is no coverage for dental services under the medical plan. Additional coverage may be available under a separate dental benefit plan.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care
- Long-term care
- Routine foot care
- Private duty nursing
- Routine eye care (age six and older)
- Non-emergency care when traveling outside the U.S. if travel is for the sole purpose of obtaining medical services.

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Hearing aids
- Infertility treatment
- Urgent care

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.
For more information on your rights to continue coverage, contact the plan at 1-479-474-5736. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: the plan sponsor at 1-479-474-5736 or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- Amount owed to providers: $7,540
- Plan pays: $5,400
- Patient pays $2,140

Sample care costs:

Hospital charges (mother)	$2700
Routine obstetric care	$2100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	$7,540

Patient pays:

Deductibles	$750
Copays	$20
Coinsurance	$1,220
Limits or exclusions	$150
Total	$2,140

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- Amount owed to providers: $5,400
- Plan pays $3,470
- Patient pays $1,930

Sample care costs:

Prescriptions	$2900
Medical Equipment & Supplies	$1300
Office visits & Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	$5,400

Patient pays:

Deductibles	$750
Copays	$890
Coinsurance	$210
Limits or exclusions	$80
Total	$1,930

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ No. Treatments shown are just examples. The care you would receive for this condition could be different, based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box for each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.