




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, 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 at <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>	<a href="#">Network providers</a> \$1,500 individual / \$3,000 family <a href="#">Out-of-network providers</a> \$6,000 individual / \$12,000 family	Generally, you must pay all of the costs from providers 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. MDLIVE medical telehealth consultations and In- <a href="#">Network</a> : Standard <a href="#">Preventive care</a> , primary care physician and <a href="#">specialist</a> office visits, chiropractic services, and urgent care visits are covered before you meet your <a href="#">deductible</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>	No.	You don't have to meet <a href="#">deductibles</a> or specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	<a href="#">Network providers</a> \$6,500 individual / \$13,000 family <a href="#">Out-of-network providers</a> \$13,000 individual / \$26,000 family	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>	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, prior approval penalties, certain specialty drugs that are considered non-essential health benefits and fall outside the out-of-pocket limits, <a href="#">out-of-network deductible</a> , and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .

Important Questions	Answers	Why This Matters:
Will you pay less if you use a <a href="#">network provider</a> ?	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 <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">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 provider's 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 <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see a <a href="#">specialist</a> 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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$20 <a href="#">copay</a> /visit	50% <a href="#">coinsurance</a>	MDLIVE medical telehealth consultations are available at no charge.
	<a href="#">Specialist</a> visit	\$50 <a href="#">copay</a> /visit	50% <a href="#">coinsurance</a>	Chiropractic services are limited to 12 visits per year and subject to 20% <a href="#">coinsurance deductible</a> is waived.
	<a href="#">Preventive care/screening/immunization</a>	No charge	50% <a href="#">coinsurance</a>	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	—————none—————
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	—————none—————

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.blueadvantagearkansas.com](http://www.blueadvantagearkansas.com).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<p><b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.blueadvantagearkansas.com">www.blueadvantagearkansas.com</a>.</p>	Generic drugs	<p><b>Drugs &lt; \$500 per fill:</b> \$15 <a href="#">copay</a></p> <p><b>Drugs =&gt; \$500 per fill:</b> 20% <a href="#">coinsurance</a>, up to \$250.</p>	Not covered	<p><a href="#">Prescription drugs</a> are limited to one fill in a 30-day period.</p>
	Preferred brand drugs	<p><b>Drugs &lt; \$500 per fill:</b> \$45 <a href="#">copay</a></p> <p><b>Drugs =&gt; \$500 per fill:</b> 20% <a href="#">coinsurance</a>, up to \$250.</p>	Not covered	
	Non-preferred brand drugs	<p><b>Drugs &lt; \$500 per fill:</b> \$65 <a href="#">copay</a></p> <p><b>Drugs =&gt; \$500 per fill:</b> 20% <a href="#">coinsurance</a>, up to \$250.</p>	Not covered	
	<a href="#">Specialty drugs</a>	<p><a href="#">Specialty drugs</a> not available under the PrudentRx Copay Program 20% <a href="#">coinsurance</a>, up to \$250.</p> <p><a href="#">Specialty drugs</a> enrolled in the PrudentRx Copay Program: No charge</p> <p>Opt out of enrollment in the PrudentRX Copay Program: 30% <a href="#">coinsurance</a></p>	Not covered	<p>Coverage of <a href="#">Specialty drugs</a> is limited to a 30-day supply per fill. <a href="#">Specialty drugs</a> must be purchased through the CVS Specialty Pharmacy Network.</p> <p>PrudentRx can be reached at 1-800-578-4403 to address any questions regarding the PrudentRx Copay Program.</p>

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	—————none—————
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	—————none—————
If you need immediate medical attention	<a href="#">Emergency room care</a>	<b>Medical emergency:</b> 20% <a href="#">coinsurance</a>  <b>Non-emergency:</b> \$100 <a href="#">copay</a> , then 20% <a href="#">coinsurance</a>	<b>Medical emergency:</b> 20% <a href="#">coinsurance</a>  <b>Non-emergency:</b> \$100 <a href="#">copay</a> , then 50% <a href="#">coinsurance</a>	—————none—————
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	—————none—————
	<a href="#">Urgent care</a>	<b>Medical emergency and non-emergency:</b> PCP: \$20 <a href="#">copay</a> /visit Specialist: \$75 <a href="#">copay</a> /visit	<b>Medical emergency:</b> PCP: \$20 <a href="#">copay</a> /visit Specialist: \$75 <a href="#">copay</a> /visit  <b>Non-emergency:</b> 50% <a href="#">coinsurance</a>	—————none—————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	The covered person is responsible for obtaining precertification for all <a href="#">out-of-network provider</a> inpatient admissions. Failure to obtain prior approval will result in a \$300 reduction in benefits.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	—————none—————

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	<b>Office setting:</b> \$20 <a href="#">copay</a> /visit <b>Outpatient setting:</b> 20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	—————none—————
	Inpatient services	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	The covered person is responsible for obtaining precertification for all <a href="#">out-of-network provider</a> inpatient admissions. Failure to obtain prior approval will result in a \$300 reduction in benefits.
<b>If you are pregnant</b>	Office visits	\$20 <a href="#">copay</a> /visit	50% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Routine obstetrical ultrasound is limited to one per pregnancy. Dependent daughter is not covered under the <a href="#">plan</a> ; however any prenatal, post-natal or maternity care that is required as Standard <a href="#">Preventive care</a> are covered under the <a href="#">plan</a> .
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Limited to 60 visits per calendar year.
	<a href="#">Rehabilitation services</a>	<b>Office setting:</b> \$20 <a href="#">copay</a> /visit <b>Outpatient setting:</b> 20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	—————none—————
	<a href="#">Habilitation services</a>	Not covered	Not covered	Not covered
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Limited to 60 visits per calendar year.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	—————none—————
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	—————none—————

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.blueadvantagearkansas.com](http://www.blueadvantagearkansas.com).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	<b>Illness/Injury Exam:</b> Office: \$20 <a href="#">copay</a> All other locations: 20% <a href="#">coinsurance</a>  <b>Routine exams, limited to children under age six:</b> No charge	<b>Illness/Injury Exam:</b> 50% <a href="#">coinsurance</a>  <b>Routine exams, limited to children under age six:</b> 50% <a href="#">coinsurance</a>	Children's routine eye exams are limited under the age of six. Additional services may be available under a separate vision benefit <a href="#">plan</a> .
	Children's glasses	Not covered	Not covered	No coverage for glasses under the Medical Benefit <a href="#">Plan</a> . Additional services may be available under a separate vision benefit <a href="#">plan</a> .
	Children's dental check-up	Not covered	Not covered	No coverage for dental check-ups under Medical Benefit <a href="#">Plan</a> . No coverage for dental check-ups under Medical Benefit <a href="#">Plan</a> . Additional services may be available under a separate dental benefit <a href="#">plan</a> .

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## 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
- Cosmetic surgery
- Dental care
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care
- Routine foot care

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

- Bariatric surgery (subject to prior approval; surgical lifetime limit of \$10,000. Bariatric surgery benefits are available after an employee has been employed by Benton County for two continuous years.)
- Chiropractic care (limited to 12 visits/year)
- Infertility treatment (subject to prior approval; lifetime maximum \$15,000.)
- Private-duty nursing
- Weight loss programs

**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: Benton County, State of Arkansas 215 East Central Ave., Bentonville, Arkansas 72712 or by phone at 479-271-1091.

### 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 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.

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

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.blueadvantagearkansas.com](http://www.blueadvantagearkansas.com).

## 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 copay](#) \$50
- 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,500
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$2,200
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,770</b>

### 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 copay](#) \$50
- 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,500
<a href="#">Copayments</a>	\$400
<a href="#">Coinsurance</a>	\$500
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,420</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$1,500
- [Specialist copay](#) \$50
- 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,500
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,900</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.