
 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](http://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 \$1,000 individual / \$3,000 family ; for out-of-network providers \$3,000 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 policy, the overall family deductible must be met before the plan begins to pay.
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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
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 / \$9,000 family. For out-of-network providers - \$8,000 individual/ \$24,000 family.	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, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Out-of-network Deductibles, 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 <a href="https://secure.healthadvantage-hmo.com/providerdirectory/default.aspx">https://secure.healthadvantage-hmo.com/providerdirectory/default.aspx</a> 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)	
<b>If you visit a healthcare provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$25 <u>copay</u> /visit	40% <u>coinsurance</u>	---none---
	<u>Specialist</u> visit	\$35 <u>copay</u> /visit and 20% <u>coinsurance</u>	40% <u>coinsurance</u>	---none---
	<u>Preventive care/screening/immunization</u>	No Charge	20% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	Applicable <u>copay</u> and 20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Coinsurance</u> applies to services and procedures other than consultation and evaluation in-network
	Imaging (CT/PET scans, MRIs)	Applicable <u>copay</u> and 20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Coinsurance</u> applies to services and procedures other than consult and eval in-network; Coverage requires prior authorization
<b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at <a href="http://www.healthadvantage-hmo.com">www.healthadvantage-hmo.com</a> .	Generic drugs	Retail \$10 <u>copay</u> /prescription	Not Covered	Covers up to a 30-day supply (retail subscription) Mail order is not covered
	Preferred brand drugs	Retail \$40 <u>copay</u> /prescription	Not Covered	Covers up to a 30-day supply (retail subscription) Mail order is not covered
	Non-preferred brand drugs	Retail \$60 <u>copay</u> /prescription	Not Covered	Covers up to a 30-day supply (retail subscription) Mail order is not covered
	<u>Specialty drugs</u>	Retail \$60 <u>copay</u> /prescription	Retail 40% <u>coinsurance</u>	Prior authorization, step therapy or quantity limitations may apply
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$100 <u>copay</u> /visit and 20% <u>coinsurance</u>	40% <u>coinsurance</u>	---none---
	Physician/surgeon fees	\$100 <u>copay</u> /visit and 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
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	\$100 <u>copay</u> /visit and 20% <u>coinsurance</u>	\$100 <u>copay</u> /visit and 20% <u>coinsurance</u>	---none---
	<u>Emergency medical transportation</u>	50% <u>coinsurance</u>	50% <u>coinsurance</u>	Coverage is limited to \$1,000/trip (ground or water) and \$5,000/trip (air)
	<u>Urgent care</u>	\$35 <u>copay</u> /visit and 20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Coinsurance</u> applies to services and procedure other than consultation and evaluation in-network
If you have a hospital stay	Facility fee (e.g., hospital room)	\$200 <u>copay</u> /admission and 20% <u>coinsurance</u>	\$100 <u>copay</u> /admission and 40% <u>coinsurance</u>	<u>Copay</u> applies per admission and <u>coinsurance</u> applies after <u>deductible</u> and <u>copayment</u>
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	---none---
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 <u>copay</u> /visit and 20% <u>coinsurance</u>	40% <u>coinsurance</u>	In-network <u>copay</u> applies to consultation and evaluation services only; In-network <u>coinsurance</u> applies to all other outpatient services and procedures
	Inpatient services	\$200 <u>copay</u> /admission and 20% <u>coinsurance</u>	\$100 <u>copay</u> /admission and 40% <u>coinsurance</u>	Coverage is limited to 7 days/contract year; Substance use disorder limited to 2 admissions
If you are pregnant	Office visits	1st office visit \$35 specialist <u>copay</u> and 20% <u>coinsurance</u>	40% <u>coinsurance</u>	Coverage for routine ultrasounds limited to 1; <u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> or <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC; <u>Copay</u> applies only to the 1st office visit with no <u>coinsurance</u> in-network
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	---none---
	Childbirth/delivery facility services	\$200 <u>copay</u> /admission and 20% <u>coinsurance</u>	\$100 <u>copay</u> /visit and 40% <u>coinsurance</u>	Coverage for Out of Network newborn services is limited to \$2000 per member for all services first 90 days after birth

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)	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Coverage is limited to 50 visits/contract year
	<u>Rehabilitation services</u>	\$200 <u>copay</u> /admission and 20% <u>coinsurance</u> inpatient services; \$25 <u>copay</u> /visit outpatient services	Not Covered	<u>Copay</u> applies per admission and Inpatient services limited to 60 days/member/contract year in-network; Outpatient services limited to 30 visits/member/contract year and paid as a \$25 copay in-network. <u>Coinsurance</u> applies after <u>deductible</u> .
	<u>Habilitation services</u>	Not Covered	Not Covered	None
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 60 days/contract year; Prior authorization required
	<u>Durable medical equipment</u>	50% <u>copayment</u>	50% <u>copayment</u>	Does not contribute to out-of-pocket limit
	<u>Hospice services</u>	20% <u>coinsurance</u>	Not Covered	Must be certified by a physician as having a life expectancy of six months or less; Prior authorization required
<b>If your child needs dental or eye care</b>	Children's eye exam	\$0 <u>copay</u> /visit	40% <u>coinsurance</u>	Limited to 1 exam every 2 years
	Children's glasses	Not Covered	Not Covered	None
	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       | • Habilitation services | • Routine foot care    |
| • Bariatric Surgery | • Hearing aids          | • Weight loss programs |
| • Cosmetic Surgery  | • Infertility treatment |                        |
| • Dental Care       | • Long term care        |                        |
| • Glasses           | • Private-duty nursing  |                        |

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

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|--|--|
| • Chiropractic care (Outpatient rehabilitation services limited to 30 visits/member/contract year) | • Non-emergency care when traveling outside of U.S. (Subject to discretion of the company) |
|  | • Routine Eye Care   |

**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](http://www.dol.gov/ebsa/healthreform) 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](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 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](http://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](mailto: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, kwijijigo 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 <b>plan's</b> overall <b>deductible</b>	\$1,000
■ <b>Specialist coinsurance</b>	20%
■ <b>Hospital (facility) coinsurance</b>	20%
■ <b>Other <u>coinsurance</u></b>	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>\$12,800</b>
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#### In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$300
Coinsurance	\$1,700
<i>What isn't covered</i>	
Limits or exclusions	\$70
<b>The total Peg would pay is</b>	<b>\$3,070</b>

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

■ The <b>plan's</b> overall <b>deductible</b>	\$1,000
■ <b>Specialist coinsurance</b>	20%
■ <b>Hospital (facility) coinsurance</b>	20%
■ <b>Other <u>coinsurance</u></b>	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>\$7,400</b>
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#### In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$1,700
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$2,960</b>

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

■ The <b>plan's</b> overall <b>deductible</b>	\$1,000
■ <b>Specialist coinsurance</b>	20%
■ <b>Hospital (facility) coinsurance</b>	20%
■ <b>Other <u>coinsurance</u></b>	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>\$1,900</b>
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#### In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$200
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,300</b>

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>.

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**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 مجاناً. 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 مجاناً بالنسبة لك. يرجى الاتصال 1-844-662-2276

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિઃશુલ્ક 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.

**انتباه:** 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, ໂດຍບໍ່ສົ່ຄາ, ແມ່ນມີອ້າງໃຫ້ທ່ານ. ໂທ 1-844-662-2276.

**LALE:** Ñe kwōj kōnono Kajin Mājōl, kwomaroñ bōk jermal in jipañ ilo kajin ñe aṃ ejjelok wōñāān. Kaalok 1-844-662-2276