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 1-800-800-4298 or visit us at https://secure.healthadvantage-hmo.com/members/eoclist.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 https://www.healthadvantage-hmo.com/glossary or call 1-800-800-4298 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network provider $0 individual / $0 family ; for out-of-network providers $9,000 individual / $18,000 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 is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. Prescription drugs -- $1,250 / individual or $2,500 / family in-network. There are no other specific deductibles.	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.
What is the out-of-pocket limit for this plan?	For network provider - $7,500 Individual / $15,000 family. For out-of-network providers - $17,000 individual/ $34,000 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 coinsurance, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See https://www.healthadvantage-hmo.com/providerdirectory/trueblueppo or call 1-800-800-4298 for a list of 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.

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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 healthcare provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/visit; deductible does not apply	50% coinsurance	Coverage for 2 free visits before copay applies for in-network primary care office visits. Coinsurance applies after deductible
	Specialist visit	$60 copay/visit and 40% coinsurance for other outpatient services	50% coinsurance	Services and procedures other than consult and eval are paid at 40% coinsurance for network providers; Out-of-network Coinsurance applies after deductible
	Preventive care/screening/ immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$50 copay/lab and 40% coinsurance for other radiology services	50% coinsurance	Out-of-network Coinsurance applies after deductible
	Imaging (CT/PET scans, MRIs)	40% coinsurance	50% coinsurance	Out-of-network Coinsurance applies after deductible; Coverage requires prior approval
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.healthadvantage-hmo.com/ha-formulary-2023	Generic drugs	Retail $25 copay/prescription Mail $50 copay/prescription; deductible does not apply	Not Covered	Covers up to 30-day supply (retail prescriptions); 31-90 day supply (mail order prescription).
	Preferred brand drugs	Retail $40 copay/prescription Mail $80 copay/prescription	Not Covered	Covers up to 30-day supply (retail prescriptions); 31-90 day supply (mail order prescription); Copay applies after deductible
	Non-preferred brand drugs	Retail $100 copay/ prescription Mail $200 copay/prescription	Not Covered	Covers up to 30-day supply (retail prescriptions); 31-90 day supply (mail order prescription); Copay applies after deductible
	Specialty drugs	40% coinsurance	Not Covered	Prior authorization, step therapy or quantity limitations may apply; Coinsurance applies after deductible; Coverage requires prior approval
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% coinsurance	50% coinsurance	Coverage requires prior approval; Out-of-network Coinsurance applies after deductible
	Physician/surgeon fees	40% coinsurance	50% coinsurance	Coverage requires prior approval; Out-of-network Coinsurance applies after deductible

*For more information about limitations and exceptions, see the plan or policy document at https://secure.healthadvantage-hmo.com/members/eoclist.aspx

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 need immediate medical attention	Emergency room care	$350 copay/visit	$350 copay/visit	None
	Emergency medical transportation	40% coinsurance	40% coinsurance	None
	Urgent care	$80 copay/visit	50% coinsurance	Out-of-network Coinsurance applies after deductible
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay/day	50% coinsurance	Coverage requires prior approval; Out-of-network Coinsurance applies after deductible
	Physician/surgeon fees	40% coinsurance	50% coinsurance	Coverage requires prior approval; Out-of-network Coinsurance applies after deductible
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay/visit and 40% coinsurance for other outpatient services	50% coinsurance	Consultation and evaluation only are paid at $30 copay in-network with 2 visits free before copay; Other services and procedures are paid at 40% coinsurance in-network; Out-of-network Coinsurance applies after deductible
	Inpatient services	$500 copay/day	50% coinsurance	Out-of-network Coinsurance applies after deductible; Coverage requires prior approval
If you are pregnant	Office visits	40% coinsurance	50% coinsurance	Coverage for routine ultrasounds limited to 1; Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC; Coverage requires prior notification; Out-of-network Coinsurance applies after deductible
	Childbirth/delivery professional services	40% coinsurance	50% coinsurance	Coverage requires prior notification; Out-of-network Coinsurance applies after deductible
	Childbirth/delivery facility services	40% coinsurance	50% coinsurance	Coverage for out-of-network newborn services is limited to $2,000 per Covered Person for all services first 90 days after birth; Coverage requires prior notification; Out-of-network Coinsurance applies after deductible

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 need help recovering or have other special health needs	Home health care	40% coinsurance	50% coinsurance	Coverage is limited to 50 visits/person/calendar year; Coverage requires prior approval; Out-of-network Coinsurance applies after deductible
	Rehabilitation services	$30 copay/visit and 40% coinsurance	Not Covered	Outpatient services limited to 30 visits/person/ calendar year and paid at $30 copay with 2 visits free before copay in-network; Inpatient services limited to 60 days/person/calendar year and paid at 40% coinsurance in-network
	Habilitation services	$30 copay/visit and 40% coinsurance	Not Covered	Developmental services limited to 180 units/person/calendar year and paid at 40% coinsurance in-network; Outpatient services limited to 30 visits/person/calendar year and paid at $30 copay in-network with 2 visits free before copay
	Skilled nursing care	$500 copay/day	50% coinsurance	Limited to 60 days/person/calendar year; Coverage requires prior approval; Out-of-network Coinsurance applies after deductible
	Durable medical equipment	50% coinsurance	50% coinsurance	Prior approval is required for DME costs which exceeds $500; Out-of-network Coinsurance applies after deductible
	Hospice services	40% coinsurance	50% coinsurance	Hospice care must be certified by a physician as having a life expectancy of six months or less; Coverage requires prior approval; Out-of-network Coinsurance applies after deductible
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	Limited to one exam per child per calendar year
	Children's glasses	40% coinsurance	50% coinsurance	Limited to one pair of glasses with lenses or contacts per child per calendar year; Out-of-network Coinsurance applies after deductible
	Children's dental check-up	Not Covered	Not Covered	None

*For more information about limitations and exceptions, see the plan or policy document at https://secure.healthadvantage-hmo.com/members/eoclist.aspx

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.)

- Abortions are not covered. Pregnancy terminations under the direction of a physician are covered but only when performed in an in-network or outpatient hospital setting.
- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care
- Infertility treatment
- Long term care
- Non-emergency care when traveling outside of U.S. (Subject to discretion of the company)
- Private-duty nursing
- Weight loss programs

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

- Chiropractic care (Limited to 30 visits/person/ calendar year)
- Hearing aids ($1,400/ear/person)
- Routine foot care is covered for podiatric conditions
- Routine Eye Care (Adult) (1 Visit/person every 2 years)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Arkansas Insurance Department at 1-800-852-5494, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol.gov/ebsa/healthreform or contact the **plan** at 1-800-800-4298. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance **Marketplace**. For more information about the **Marketplace**, visit **www.HealthCare.gov** or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your **plan** for a denial of a **claim**. This complaint is called **grievance** or **appeal**. For more information about your rights, look at the explanation of benefits you will receive for that medical **claim**. Your **plan** documents also provide complete information to submit a **claim**, **appeal** or a **grievance** for any reason to your **plan**. For more information about your rights, this notice, or assistance, contact the Arkansas Insurance Department, Consumer Services Division. Additionally, a consumer assistance program can help you file your **appeal**. The contact information is:

Arkansas Insurance Department, Consumer Services Division
1 Commerce Way, Suite 102, Little Rock, Arkansas 72202
Telephone 1-800-852-5494, Email address: insurance.consumers@arkansas.gov

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 Minimum Value Standards? Not Applicable.
If your **plan** doesn't meet the **Minimum Value Standards**, you may be eligible for a **premium tax credit** to help you pay for a **plan** through the **Marketplace**.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-844-662-2276.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-662-2276.
Chinese (中文): 如果需要中文的**帮助**，请拨打这个号码 1-844-662-2276.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-662-2276.

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

About These Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this **plan** might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your **providers** charge, and many other factors. Focus on the **cost sharing** amounts (**deductibles**, **copayments** and **coinsurance**) and **excluded services** under the **plan**. Use this information to compare the portion of costs you might pay under different health **plans**. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist copayment	$60
Hospital (facility) copayment	$500
Other coinsurance	40%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$40
Copayments	$0
Coinsurance	$5,100
What isn't covered	
Limits or exclusions	$40
The total Peg would pay is	**$5,180**

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

The plan's overall deductible	$0
Specialist copayment	$60
Hospital (facility) copayment	$500
Other coinsurance	40%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,300
Copayments	$800
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
Total Example Cost	**$3,160**

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

The plan's overall deductible	$0
Specialist copayment	$60
Hospital (facility) copayment	$500
Other coinsurance	40%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$700
Coinsurance	$600
What isn't covered	
Limits or exclusions	$0
Total Example Cost	**$1,300**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.