**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?** | $0 | See the Common Medical Events chart below for your costs for services this plan covers. |
| **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?** | No. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | Not Applicable. | This plan does not have an out-of-pocket limit on your expenses. |
| **What is not included in the out-of-pocket limit?** | Not Applicable. | This plan does not have an out-of-pocket limit on your expenses. |
| **Will you pay less if you use a network provider?** | Yes. See https://secure.healthadvantage-hmo.com/providerdirectory/trueblueppo.aspx 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. |

SBC #: 60028 31-37-B SBC-13262AR0230006-02
07/31/23

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 | No Charge | No Charge | None |
| | Specialist visit | No Charge | No Charge | None |
| | 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) | No Charge | No Charge | None |
| | Imaging (CT/PET scans, MRIs) | No Charge | No Charge | None |
| **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-2024 | Generic drugs | No Charge | Not Covered | Covers up to 30-day supply (retail prescriptions); 31-90 day supply (mail order prescription); |
| | Preferred brand drugs | No Charge | Not Covered | Covers up to 30-day supply (retail prescriptions); 31-90 day supply (mail order prescription) |
| | Non-preferred brand drugs | No Charge | Not Covered | Covers up to 30-day supply (retail prescriptions); 31-90 day supply (mail order prescription) |
| | Specialty drugs | No Charge | Not Covered | Prior authorization, step therapy or quantity limitations may apply. Coverage requires prior approval. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | No Charge | No Charge | None |
| | Physician/surgeon fees | No Charge | No Charge | None |

| 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 | No Charge | No Charge | None |
| | Emergency medical transportation | No Charge | No Charge | None |
| | Urgent care | No Charge | No Charge | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | No Charge | No Charge | None |
| | Physician/surgeon fees | No Charge | No Charge | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | No Charge | No Charge | None |
| | Inpatient services | No Charge | No Charge | None |
| **If you are pregnant** | Office visits | No Charge | No Charge | Coverage for routine ultrasounds limited to 1; Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC; Coverage requires prior notification |
| | Childbirth/delivery professional services | No Charge | No Charge | Coverage requires prior notification |
| | Childbirth/delivery facility services | No Charge | No Charge | 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 |

| 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 | No Charge | No Charge | None |
| | Rehabilitation services | No Charge | Not Covered | Outpatient services limited to 30 visits/person/calendar year; Inpatient services limited to 60 days/person/calendar year |
| | Habilitation services | No Charge | Not Covered | Developmental services limited to 180 units/person/calendar year; Outpatient services limited to 30 visits/person/calendar year; |
| | Skilled nursing care | No Charge | No Charge | None |
| | Durable medical equipment | No Charge | No Charge | None |
| | Hospice services | No Charge | No Charge | Hospice care must be certified by a physician as having a life expectancy of six months or less; |
| **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 | No Charge | No Charge | Limited to one pair of glasses with lenses or contacts per child per calendar year |
| | 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.)**

- 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
- Adult Routine Eye Care
- 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 | $0 |
| Hospital (facility) coinsurance | 0% |
| Other coinsurance | 0% |

**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 | $0 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Peg would pay is** | **$0** |

### 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 | $0 |
| Hospital (facility) coinsurance | 0% |
| Other coinsurance | 0% |

**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 | $0 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **Total Example Cost** | **$60** |

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

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist copayment | $0 |
| Hospital (facility) coinsurance | 0% |
| Other coinsurance | 0% |

**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 | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **Total Example Cost** | **$0** |

**Note: These numbers assume the patient received care from an IHCP provider or with IHCP referral at a non-IHCP. If you receive care from a non-IHCP provider without a referral from an IHCP your costs may be higher**

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