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. 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:
What is the overall deductible?	In-Network providers $3,200 individual / $6,000 family Out-of-network providers $6,000 individual / $12,000 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 plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. MDLIVE consultations, generic and non-preferred prescription drugs, In-Network: Standard Preventive care, office/telehealth visit and prescription drugs with the exception of specialty 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 https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles or specific services.
What is the out-of-pocket limit for this plan?	In-Network providers $8,000 individual / $16,000 family Out-of-network providers Unlimited	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, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, prior approval penalties, certain specialty drugs that are considered non-essential health benefits and fall outside the out-of-pocket limits, out-of-network services, 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 www.blueadvantagearkansas.com or call 1-800-370-5792 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.

Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist?	No.	You can see a specialist 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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 copay/office and telehealth visit; deductible is waived Office related services: No charge	50% coinsurance	Chiropractic services are limited to 10visits per Calendar Year. MDLIVE: $10 copay per consultation; deductible is waived.
	Specialist visit	$65 copay/office and telehealth visit; deductible is waived Office related services: No charge	50% coinsurance	
	Preventive care/screening/ immunization	No charge	50% coinsurance	At all times this plan will comply with the Patient Protection and Affordable Care Act. The list of services included as standard preventive care may change from time to time depending upon government guidelines. 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)	Office related services: No charge Other locations: 30% coinsurance	50% coinsurance	Laboratory and radiology related to in-network preventive care will be reimbursed (paid) at 100%.

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)	
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	Prior approval required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.blueadvantagearkansas.com.	Generic drugs	Retail: The less of $25 copay or the actual cost of the medication deductible waived; Mail order: $50 copay deductible waived.	Not covered	
	Preferred brand drugs	Retail:.25% coinsurance; Mail order: 20% coinsurance deductible waived.	Not covered	
	Non-preferred brand drugs	Retail:.25% coinsurance; Mail order: 20% coinsurance deductible waived.	Not covered	

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)	
	Specialty drugs	Specialty drugs not available under the PrudentRx Copay Program Retail/Mail Order: 20% coinsurance after deductible Specialty drugs enrolled in the PrudentRx Copay Program: No charge Opt out of enrollment in the PrudentRX Copay Program: 30% coinsurance after deductible	Not covered	**Specialty Drugs:** Specialty drugs are limited to a 30-day supply per fill and require prior approval. Specialty drugs must be purchased through CVS Caremark Specialty Pharmacy. This may not apply to limited distribution specialty drugs. Some Specialty drugs may qualify for third party copayment assistance programs which could lower your out-of-pocket costs for those products. For any such Specialty drugs where third-party copayment assistance is used, you shall not receive credit toward their out-of-pocket limit or deductible for any copayment amounts or coinsurance amounts that are applied from a manufacturer coupon or rebate. PrudentRx can be reached at 1-800-578-4403 to address any questions regarding the PrudentRx Copay Program.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	————————none————————
	Physician/surgeon fees	30% coinsurance	50% coinsurance	————————none————————
If you need immediate medical attention	Emergency room care	Medical Emergency: $50 copay, then 30% coinsurance Non-emergency: 50% coinsurance	Medical Emergency: $50 copay, then 30% coinsurance Non-emergency: 50% coinsurance	————————none————————
	Emergency medical transportation	30% coinsurance	30% coinsurance	Water and land ambulance services are limited to $1,000 per trip. Air ambulance services are limited to $5,000 per trip.

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)	
	Urgent care	PCP: $50 copay/visit Specialist: 30% coinsurance	50% coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	The covered person is responsible for obtaining prior approval for all out-of-network provider inpatient admissions. Failure to obtain prior approval will result in a reduction of $500 and benefits are at a reduced rate of 50%.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	——————none——————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office and telehealth visit: $35 copay; deductible is waived. Office related services: No charge Outpatient services: 30% coinsurance	50% coinsurance	Substance abuse treatment is not covered. The covered person is responsible for obtaining prior approval for all out-of-network provider inpatient admissions. Failure to obtain prior approval will result in a reduction of $500 and benefits are at a reduced rate of 50%.
	Inpatient services	30% coinsurance	50% coinsurance	
If you are pregnant	Office visits	$35 copay/visit; deductible is waived. Office related services: No charge	50% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Routine obstetrical ultrasounds limited to one per pregnancy. Maternity care for dependent daughter is not covered; however, any pre-natal, post-natal, or maternity care that is required as Standard Preventive Care will be covered.
	Childbirth/delivery professional services	30% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	30% coinsurance.	50% coinsurance	

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	30% coinsurance	50% coinsurance	Home health care is limited to 40 visits per calendar year.
	Rehabilitation services	30% coinsurance	50% coinsurance	Occupational, Physical, Speech and Respiratory Therapy combined limit of 45 visits per calendar year in an office or outpatient setting.
	Habilitation services	Not covered	Not covered	Habilitation services are not covered.
	Skilled nursing care	30% coinsurance	50% coinsurance	Skilled nursing care is limited to30 days per calendar year.
	Durable medical equipment	30% coinsurance	50% coinsurance	————————none————————
	Hospice services	30% coinsurance	50% coinsurance	Hospice services is limited to 180-days per lifetime.
If your child needs dental or eye care	Children's eye exam	**Routine exam:** No charge **Outpatient Exam for Illness/Injury:** 20% coinsurance	**Routine exam:** 50% coinsurance **Exam for Illness/Injury:** 50% coinsurance	Children's eye exams are limited under the age of six. Additional services may be available under a separate vision benefit plan.
	Children's glasses	Not covered	Not covered	No coverage for glasses under the Medical Benefit Plan. Additional services may be available under a separate vision benefit plan.
	Children's dental check-up	Not covered	Not covered	No coverage for dental check-ups under Medical Benefit Plan. No coverage for dental check-ups under Medical Benefit Plan. Additional services may be available under a separate dental benefit plan.

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
- Glasses
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (age six and older
- Routine foot care
- Substance Abuse Treatment
- Weight loss programs

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

- Bariatric surgery (50% coinsurance for morbid obesity services. Bariatric surgery is limited to $4,000 per calendar year; prior approval required.)
- Chiropractic care (limited to 10 visits per calendar year.)
- Private-duty nursing (when provided in a home setting and combined with Home Health Care Services.)

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 Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 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 on how 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: P.A.M. Transport 297 W. Henri De Tonti Blvd, Tontitown, Arkansas, 72770 or by telephone at 1-800-390-7330 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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, kwiijigo holne' 1-800-370-5792.Na

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.

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** **$3,200**
- **Specialist copay** **$65**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **30%**

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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,200
Copayments	$10
Coinsurance	$2,400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,670**

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

- **The plan's overall deductible** **$3,200**
- **Specialist copay** **3$65**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **30%**

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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$800
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,720**

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

- **The plan's overall deductible** **$3,200**
- **Specialist copay** **$65**
- **Hospital (facility) copay and coinsurance** **$50 copay +30%**
- **Other coinsurance** **30%**

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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,300
Copayments	$250
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,550**

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