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, contact the claims administrator at 1-800-370-5790 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 1-800-370-5790 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	ACMC Network physician services: $200 person/$400 family. PPO Network physician services: $700 person/$1,400 family. Out-of-Network physician services: $1,400 person/$2,800 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. Deductible is waived for accident benefits, prescription drug charges, outpatient and inpatient facility services rendered at ACMC, preventive care rendered at ACMC and PPO In-Network.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply
Are there other deductibles for specific services?	PPO Network: outpatient facility service $350 per person; inpatient facility services: $350 up to three separate family members. Out-of-Network: outpatient facility services $1,400 per person; inpatient facility $1,400 up to three separate family members.	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?	ACMC Network physician services: $1,400 per person; ACMC Network facility services: $0 per person. PPO Network: physician services: $3,600 per person. PPO Network: outpatient facility $2,200 per person; inpatient facility services: $2,200 per person up to three separate family members. Out-of-Network: 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-billed charges, health care this plan doesn't cover, deductibles, copays, precertification penalties, and out-of-network services.	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 1-800-370-5790 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 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
		ACMC Network Provider (You will pay the least)	In-Network PPO Provider	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	10% coinsurance	20% coinsurance	50% coinsurance	——————none——————
	Specialist visit	10% coinsurance	20% coinsurance	50% coinsurance	——————none——————
	Preventive care/screening/ immunization	$15 copay	$25 copay	Not covered	**Well adult care** limited to one per year of each of the following services: physical exams, pap smear, mammogram, PSA exam, rectal exam. Routine immunizations are also included. **Well child care** limited to physical exams, lab services, vision and hearing screenings, immunizations.
If you have a test	Diagnostic test (x-ray, blood work)	**Facility services:** No charge **Professional services**: 10% coinsurance	20% coinsurance	50% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	**Facility services:** No charge **Professional services:** 10% coinsurance	20% coinsurance	50% coinsurance	——————none——————

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		ACMC Network Provider (You will pay the least)	In-Network PPO Provider	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.blueadvantagearkansascom.	Generic drugs	ACMC Pharmacy $10 copay	$15 copay	Not covered	none
	Preferred brand drugs	ACMC Pharmacy $25 copay	$40 copay	Not covered	none
	Non-preferred brand drugs	ACMC Pharmacy $25 copay	$70 copay	Not covered	none
	Specialty drugs	Specialty drugs and narcotics are not available at the ACMC Pharmacy.	**Generic** $15 copay **Preferred brand** $40 copay **Non-preferred brand** $70 copay	Not covered	none
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance	20% coinsurance	none
	Physician/surgeon fees	10% coinsurance	20% coinsurance	50% coinsurance	none
If you need immediate medical attention	Emergency room care	**True Emergency**: No Charge **Non-emergency**: $50 copay 0% coinsurance	**True Emergency:** 20% coinsurance **Non-emergency:** $50 copay plus 20% coinsurance	**True Emergency:** 20% coinsurance **Non-emergency:** $50 copay plus 50% coinsurance	Accident related services deductible and coinsurance waived up to $500. Accident expenses in excess of $500 or more than 90 days after the date of accident are subject to standard reimbursement.
	Emergency medical transportation	20% coinsurance	20% coinsurance	20% coinsurance	none

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		ACMC Network Provider (You will pay the least)	In-Network PPO Provider	Out-of-Network Provider (You will pay the most)	
	Urgent care	**True Emergency:** 20% coinsurance **Non-emergency:** 20% coinsurance	**True Emergency:** 20% coinsurance **Non-emergency:** 20% coinsurance	**True Emergency:** 20% coinsurance **Non-emergency:** 50% coinsurance	none
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% coinsurance	50% coinsurance	The covered person is responsible for obtaining precertification for Out-of-Network admissions. Penalty for failure to precertify an Out-of-Network admission is a 25% reduction in benefits, up to $5,000.
	Physician/surgeon fees	10% coinsurance	20% coinsurance	50% coinsurance	none
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	20% coinsurance	50% coinsurance	none
	Inpatient services	10% coinsurance	20% coinsurance	50% coinsurance	The covered person is responsible for obtaining precertification for Out-of-Network admissions. Penalty for failure to precertify an Out-of-Network admission is a 25% reduction in benefits, up to $5,000.
If you are pregnant	Office visits	10% coinsurance	20% coinsurance	50% coinsurance	Routine obstetrical ultrasounds limited to one per pregnancy.
	Childbirth/delivery professional services	10% coinsurance	20% coinsurance	50% coinsurance	none

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		ACMC Network Provider (You will pay the least)	In-Network PPO Provider	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery facility services	10% coinsurance	20% coinsurance	50% coinsurance	none
If you need help recovering or have other special health needs	Home health care	**Facility services:** No charge **Professional services:** 10% coinsurance	20% coinsurance	50% coinsurance	none
	Rehabilitation services	**Facility services:** No Charge **Professional services:** 10% coinsurance	20% coinsurance	50% coinsurance	none
	Habilitation services	Not covered	Not covered	Not covered	Habilitation services are not covered.
	Skilled nursing care	10% coinsurance	20% coinsurance	50% coinsurance	Skilled nursing care is limited to 30 inpatient days per calendar year.
	Durable medical equipment	10% coinsurance	20% coinsurance	50% coinsurance	none
	Hospice services	10% coinsurance	20% coinsurance	50% coinsurance	none
If your child needs dental or eye care	Children's eye exam	Routine vision exam: $15 copay	Routine vision exam: $25 copay	Routine vision exam: Not covered	none
	Children's glasses	10% coinsurance	20% coinsurance	50% coinsurance	Limited to eyeglasses required following an injury.
	Children's dental check-up	Not covered	Not covered	Not covered	No coverage for dental check-ups.

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
- Chiropractic care
- Dental care
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when travelling outside the United States.
- Routine eye care for adults
- Routine foot care
- 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 (Lifetime limit of $15,000)
- Private duty nursing (Limited to $5,000 per calendar year for Inpatient 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: Ashley County Medical Center, P.O. Box 400, Crossett, Arkansas, 71653 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 1-800-370-5790.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-370-5790.
Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-370-5790.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-370-5790.

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	$200
Specialist coinsurance	10%
Hospital (facility) coinsurance	0%
Other coinsurance	10%

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	$200
Copayments	$40
Coinsurance	$400
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$700**

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

The plan's overall deductible	$200
Specialist coinsurance	10%
Hospital (facility) coinsurance	0%
Other coinsurance	10%

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	$200
Copayments	$400
Coinsurance	$200
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$820**

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

The plan's overall deductible	$200
Specialist coinsurance	10%
Hospital (facility) coinsurance	0%
Other coinsurance	10%

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	$200
Copayments	$10
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$410**

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