
 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 1-844-662-2279 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 <https://www.healthcare.gov/sbc-glossary> or call 1-844-662-2279 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	In-Network: \$6,550 per person; \$13,100 per family. Out-of-Network: \$13,100 per person; \$26,200 per 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 ?	In-Network preventive service	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 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 ?	In-Network: \$6,550 per person; \$13,100 per family. Out-of-Network: \$13,100 per person; \$26,200 per 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 , 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, health care this plan doesn't cover, and cost containment penalties.	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 1-844-662-2279 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).
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
		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	0% coinsurance after deductible	0% coinsurance after deductible	-----none-----
	Specialist visit	0% coinsurance after deductible	0% coinsurance after deductible	-----none-----
	Preventive care/screening/immunization	No charge	0% coinsurance after deductible	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. A current listing of required preventive care can be accessed at: www.HealthCare.gov/center/regulations/prevention.html and www.cdc.gov/vaccines/recs/acip .
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance after deductible	0% coinsurance after deductible	-----none-----
	Imaging (CT/PET scans, MRIs)	0% coinsurance after deductible	0% coinsurance after deductible	Preauthorization is required.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com	Generic drugs	0% coinsurance after deductible	0% coinsurance after deductible	Express Scripts' Preventive Medication program supports consumer directed healthcare (CDH) plans. The program allows certain drugs to bypass the deductible in accordance with the U.S. Internal Revenue Service's "safe harbor" provision for preventive medications. Your plan offers a number of preventive medications for just a coinsurance payment. 30-day supply (retail); 90-day supply (mail order and at Walgreens locations). Mail order mandatory for maintenance drugs after 2 retail fills. No coverage for out-of-network mail order. Using the Express Advantage preferred network will help you get your Rx at the lowest cost. Specialty 30-day supply. Requires Accredo delivery after 1 retail fill. Some drugs require prior authorization or step therapy. If necessary authorization is not obtained, the drug may not be covered.
	Preferred brand drugs	0% coinsurance after deductible	0% coinsurance after deductible	
	Non-preferred brand drugs	0% coinsurance after deductible	0% coinsurance after deductible	
	Specialty drugs	0% coinsurance after deductible	0% coinsurance after deductible	

* For more information about limitations and exceptions, see the plan or policy document at www.blueadvantagearkansas.com.

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance after deductible	0% coinsurance after deductible	-----none-----
	Physician/surgeon fees	0% coinsurance after deductible	0% coinsurance after deductible	-----none-----
If you need immediate medical attention	Emergency room care	0% coinsurance after deductible	0% coinsurance after deductible	-----none-----
	Emergency medical transportation	0% coinsurance after deductible	0% coinsurance after deductible	-----none-----
	Urgent care	0% coinsurance after deductible	0% coinsurance after deductible	-----none-----
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance after deductible	0% coinsurance after deductible	Preauthorization is required.
	Physician/surgeon fees	0% coinsurance after deductible	0% coinsurance after deductible	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance after deductible	0% coinsurance after deductible	-----none-----
	Inpatient services	0% coinsurance after deductible	0% coinsurance after deductible	Preauthorization is required.
If you are pregnant	Office visits	0% coinsurance after deductible	0% coinsurance after deductible	-----none-----
	Childbirth/delivery professional services	0% coinsurance after deductible	0% coinsurance after deductible	-----none-----
	Childbirth/delivery facility services	0% coinsurance after deductible	0% coinsurance after deductible	-----none-----

* For more information about limitations and exceptions, see the plan or policy document at www.blueadvantagearkansas.com .

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	0% coinsurance after deductible	0% coinsurance after deductible	Limited to 120 visits per year
	Rehabilitation services	0% coinsurance after deductible	0% coinsurance after deductible	-----none-----
	Habilitation services	0% coinsurance after deductible	0% coinsurance after deductible	-----none-----
	Skilled nursing care	0% coinsurance after deductible	0% coinsurance after deductible	Limited to 120 visits per year. Preauthorization is required.
	Durable medical equipment	0% coinsurance after deductible	0% coinsurance after deductible	-----none-----
	Hospice services	0% coinsurance after deductible	0% coinsurance after deductible	-----none-----
If your child needs dental or eye care	Children's eye exam	No charge	0% coinsurance after deductible	Coverage is limited to eligible preventive services for children under age six.
	Children's glasses	Not covered	Not covered	No coverage for eyeglasses under the medical benefit plan. Coverage 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 the 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](#).)

- | | | |
|---|---|---|
| <ul style="list-style-type: none"> • Cosmetic surgery • Dental care • Long-term care | <ul style="list-style-type: none"> • Non-emergency care when traveling outside the United States • Routine eye care (Adult) | <ul style="list-style-type: none"> • 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.)

- | | | |
|--|--|--|
| <ul style="list-style-type: none"> • Acupuncture, limited to 12 visits per year • Bariatric surgery, limited to one surgery per lifetime | <ul style="list-style-type: none"> • Chiropractic care, limited to 30 visits per year • Hearing aids, limited to \$1,000 per ear per year • Infertility treatment, limited to \$15,000 per lifetime | <ul style="list-style-type: none"> • Private duty nursing, when billed by a home health care agency |
|--|--|--|

* For more information about limitations and exceptions, see the plan or policy document at www.blueadvantagearkansas.com .

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 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 Windstream Services LLC in writing at 4001 Rodney Parham Road, Little Rock, Arkansas 72212 or by phone at 501-748-7000 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

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 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 1-844-662-2279.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-662-2279.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-844-662-2279.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-844-662-2279.

-----*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](#) \$6,550
- [Specialist](#) 0%
- Hospital (facility) 0%
- Other 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	\$12,840
---------------------------	-----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$6,550
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$6,610

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

- The [plan's](#) overall [deductible](#) \$6,550
- [Specialist](#) 0%
- Hospital (facility) 0%
- Other 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	\$7,460
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$6550
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$6,610

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

- The [plan's](#) overall [deductible](#) \$6,550
- [Specialist](#) 0%
- Hospital (facility) 0%
- Other 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	\$2,010
---------------------------	----------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,010
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,010