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: $400 per person; $800 per family. Out-of-Network: $2,500 per person; $5,000 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 PCP Office services and the following services when rendered by an In-Network provider: preventive care, chemotherapy and radiation therapy, chiropractic services, dialysis treatment, infusion therapy, physical therapy, occupational therapy, and speech therapy.	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: $2,200 per person; $4,400 family. Out-of-Network: $4,400 per person; $8,800 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	$20 copay	40% coinsurance	--------none--------
	Specialist visit	$40 copay	40% coinsurance	--------none--------
	Preventive care/screening/ immunization	No charge	40% 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. 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)	20% coinsurance	40% coinsurance	--------none--------
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	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	Retail: $10 copay Mail Order: $25 copay	Retail: $10 copay Mail Order: Not covered	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	Retail: $30 copay Mail Order: $75 copay	Retail: $30 copay Mail Order: Not covered	
	Non-preferred brand drugs	Retail: $60 copay Mail Order: $150 copay	Retail: $60 copay Mail Order: Not covered	
	Specialty drugs	Generic drugs: Retail, $10 copay; Mail Order, $25 copay. Preferred drugs: Retail, $30 copay; Mail Order, $75 copay. Non-preferred drugs: Retail, $60 copay; Mail Order, $150 copay.	Generic drugs: Retail, $10 copay Preferred drugs: Retail, $30 copay Non-preferred drugs: Retail, $60 copay Mail order: Not covered	
If you have outpatient	Facility fee (e.g., ambulatory	20% coinsurance	40% coinsurance	--------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)	
surgery	surgery center)			
	Physician/surgeon fees	20% coinsurance	40% coinsurance	--------none--------
If you need immediate medical attention	Emergency room care	$150 copay 20% coinsurance	$150 copay 20% coinsurance	--------none--------
	Emergency medical transportation	20% coinsurance	20% coinsurance	--------none--------
	Urgent care	$50 copay	40% coinsurance	--------none--------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization is required.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	--------none--------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	--------none--------
	Inpatient services	20% coinsurance	40% coinsurance	Preauthorization is required.
If you are pregnant	Office visits	No charge, prenatal; 20% coinsurance, postnatal	40% coinsurance	--------none--------
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	--------none--------
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	--------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 help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Limited to 120 visits per year
	Rehabilitation services	$40 copay	40% coinsurance	Chiropractic services limited to 30 visits per year.
	Habilitation services	$40 copay	40% coinsurance	--------none--------
	Skilled nursing care	20% coinsurance	40% coinsurance	Limited to 120 visits per year. Preauthorization is required.
	Durable medical equipment	20% coinsurance	40% coinsurance	--------none--------
	Hospice services	20% coinsurance	40% coinsurance	--------none--------
If your child needs dental or eye care	Children's eye exam	No charge	40% coinsurance	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.)

- Cosmetic surgery
- Dental care
- Long-term care
- Non-emergency care when traveling outside the United States
- Routine eye care (Adult)
- 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.)

- Acupuncture, limited to 12 visits per year
- Bariatric surgery, limited to one surgery per lifetime
- 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
- Private duty nursing, when billed by a home health care agency

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, kwiijigo 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	$400
Specialist	20%
Hospital (facility)	20%
Other	20%

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:

Cost Sharing	
Deductibles	$400
Copayments	$40
Coinsurance	$1,760
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$2,260

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

The plan's overall deductible	$400
Specialist	20%
Hospital (facility)	20%
Other	20%

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:

Cost Sharing	
Deductibles	$400
Copayments	$1,160
Coinsurance	$640
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$2,260

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

The plan's overall deductible	$400
Specialist	20%
Hospital (facility)	20%
Other	20%

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:

Cost Sharing	
Deductibles	$400
Copayments	$190
Coinsurance	$280
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$870

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