**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, 1-844-662-2279 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 at 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 providers<br>$4,000 individual / $8,000 family<br>Out-of-network providers<br>$8,000 individual / $16,000 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. In-Network PCP and Specialist office services and the following services when rendered by an In-Network provider: standard Preventive care emergency room, urgent care, chemotherapy and radiation therapy, chiropractic services, dialysis treatment, infusion/physical/occupational/speech therapy 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<br>$6,550 individual / $13,100 family<br>Out-of-network providers<br>$13,100 individual / $26,200 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, preauthorization penalties, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out–of–pocket limit. |

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **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). 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 |
|---|---|---|---|---|
| | | 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 | $40 copay, deductible waived | 50% coinsurance | ——————none—————— |
| | Specialist visit | $80 copay, deductible waived | 50% coinsurance | ——————none—————— |
| | 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. A current listing of required Preventive care can be accessed at: www.HealthCare.gov/center/regulations/prevention.html.<br><br>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. |

* 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 a test** | Diagnostic test (x-ray, blood work) | 30% coinsurance | 50% coinsurance | ——————none—————— |
| | Imaging (CT/PET scans, MRIs) | 30% coinsurance | 50% 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: $20 copay, deductible waived<br>Mail Order: $50 copay, deductible waived copay | Retail: $10 copay, deductible waived<br>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. Specialty medications are required to be filled through Accredo, Express Scripts' Specialty Pharmacy, 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: $60 copay, deductible waived<br>Mail Order: $150 copay, deductible waived | Retail: $30 copay, deductible waived<br>Mail Order: Not covered | |
| | Non-preferred brand drugs | Retail: $120 copay, deductible waived<br>Mail Order: $300 copay, deductible waived | Retail: $60 copay, deductible waived<br>Mail Order: Not covered | |
| | Specialty drugs | *Generic drugs:*<br>Retail: $20 copay, deductible waived<br>Mail Order: $50 copay, deductible waived<br>*Preferred drugs:*<br>Retail: $60 copay, deductible waived<br>Mail Order: $150 copay, deductible waived<br>*Non-preferred drugs:*<br>Retail: $120 copay, deductible waived<br>Mail Order: $300 copay, deductible waived | *Generic drugs:*<br>Retail: $20 copay, deductible waived<br>*Preferred drugs:*<br>Retail: $60 copay, deductible waived<br>*Non-preferred drugs:*<br>Retail: $120 copay, deductible waived<br>Mail order: 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) | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 30% coinsurance | 50% coinsurance | Preauthorization is required for certain services. |
| | Physician/surgeon fees | 30% coinsurance | 50% coinsurance | ————————none———————— |
| **If you need immediate medical attention** | Emergency room care | $300 copay<br>30% coinsurance | $300 copay<br>30% coinsurance | In-Network deductible applies to Out-of-Network emergency room care benefits. Emergency room care copay may be waived if admitted. |
| | Emergency medical transportation | 30% coinsurance | 30% coinsurance | In-Network deductible applies to Out-of-Network emergency medical transportation services. |
| | Urgent care | Medical Emergency and non-emergency:<br>$100 copay, deductible waived | Medical Emergency<br>$100 copay, deductible waived<br>Non-emergency<br>50% coinsurance | ————————none———————— |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 30% coinsurance | 50% coinsurance | Preauthorization is required. |
| | Physician/surgeon fees | 30% coinsurance | 50% coinsurance | ————————none———————— |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Office visit:<br>$40 copay, deductible waived<br>Outpatient services:<br>30% coinsurance | 50% coinsurance | ————————none———————— |
| | Inpatient services | 30% coinsurance | 50% coinsurance | Preauthorization is required. Residential treatment centers are limited to 120 visits per calendar year. |

| 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 are pregnant** | Office visits | Prenatal Care<br>No charge<br><br>Postnatal Care<br>30% coinsurance | 50% coinsurance | Routine obstetrical ultrasound is limited to one ultrasound per pregnancy.<br><br>Depending on the type of services, deductible, copayment or coinsurance may apply.<br><br>Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | 30% coinsurance | 50% coinsurance | |
| | Childbirth/delivery facility services | 30% coinsurance | 50% coinsurance | ————none———— |
| **If you need help recovering or have other special health needs** | Home health care | 30% coinsurance | 50% coinsurance | Preauthorization is required. Limited to 120 visits per calendar year. |
| | Rehabilitation services | $80 copay, deductible waived | 50% coinsurance | ————none———— |
| | Habilitation services | $80 copay, deductible waived | 50% coinsurance | ————none———— |
| | Skilled nursing care | 30% coinsurance | 50% coinsurance | Preauthorization is required. Limited to 120 visits per calendar year. |
| | Durable medical equipment | 30% coinsurance | 50% coinsurance | ————none———— |
| | Hospice services | 30% coinsurance | 50% coinsurance | Preauthorization is required. |
| **If your child needs dental or eye care** | Children's eye exam | No charge | 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.)**

- Cosmetic surgery
- Dental care
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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 calendar year.)
- Bariatric surgery (limited to one surgery per lifetime.)
- Chiropractic care (limited to 30 visits per calendar year.)
- Hearing aids (limited to $1,000 per ear per calendar year.)
- Infertility treatment
- Private-duty nursing (when billed by a home health care agency and limited to 60 visits per calendar year.)

**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: Windstream Services LLC in writing at 4005 N. 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**

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 1-844-662-2279.

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.*

* 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** | **$4,000** |
| **Specialist copay** | **$80** |
| **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 | $4,000 |
| Copayments | $0 |
| Coinsurance | $2,200 |
| *What isn't covered* | |
| Limits or exclusions | $70 |
| **The total Peg would pay is** | **$6,270** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$4,000** |
| **Specialist copay** | **$80** |
| **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 | $400 |
| Copayments | $300 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $4,300 |
| **The total Joe would pay is** | **$5,000** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$4,000** |
| **Specialist copay** | **$80** |
| **Hospital (facility) coinsurance** | **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 | $2,000 |
| Copayments | $500 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $10 |
| **The total Mia would pay is** | **$2,510** |

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