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 1-800-370-5792 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 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?	$1,000 per person; $2,750 per family. In-Network and Out-of-Network combined.	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. Supplemental Accident Expenses, In-Network primary care physician office setting, and In-Network preventive care.	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?	Yes. Pharmacy Deductible $100 person.	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: $3,000 per person; $8,750 per family. Out-of-Network: Unlimited. Once the In-Network out-of-pocket limit has been satisfied, In-Network covered charges are paid at 100% and Out-of-Network covered charges are paid at 60%.	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, Out-of-Network durable medical equipment.	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).
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	$25 copay per visit, deductible waived	40% coinsurance	——————none——————
	Specialist visit	20% coinsurance	40% coinsurance	Coverage includes telehealth services by MDLIVE, subject to $10 copay per consultation.
	Preventive care/screening/ immunization	No charge	Not covered	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	Prior authorization 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	$15 copay	Not covered	Pharmacy deductible is $100 per person. Retail supply: up to 34 days for one copay Maintenance supply: up to 100 days for two copays.
	Preferred brand drugs	$55 copay	Not covered	
	Non-preferred brand drugs	$125 copay	Not covered	
	Specialty drugs	*Generic Brand:* $15 copay *Preferred Brand:* $55 copay *Non-Preferred Brand:* $125 copay	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)	20% coinsurance	40% coinsurance	Out-of-Network limited to $500 of allowable charges.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	——————none——————
If you need immediate medical attention	Emergency room care	*True Emergency:* 20% coinsurance *Non-Emergency:* Not covered	*True Emergency:* 20% coinsurance *Non-Emergency:* Not covered	Accident Supplemental benefits must begin within 7 days of accident and up to 90 days maximum; deductible and coinsurance waived. After 90 days subject to deductible and coinsurance.
	Emergency medical transportation	20% coinsurance	40% coinsurance	Ground and water limited to $1,000 per trip. Air limited to $20,000 per trip and one trip per year.
	Urgent care	20% coinsurance	40% coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	The covered person is responsible for obtaining prenotification for Out-of-Network admissions. Penalty for failure to prenotify of an Out-of-Network admission is the covered person's responsibility.
	Physician/surgeon fees	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 mental health, behavioral health, or substance abuse services	Outpatient services	*Office setting:* $25 copay per visit, deductible waived *Other locations:* 20% coinsurance	40% coinsurance	————————none————————
	Inpatient services	20% coinsurance	40% coinsurance	Residential Treatment Centers are not covered. The covered person is responsible for obtaining prenotification for Out-of-Network admissions. Penalty for failure to prenotify an Out-of-Network admission is the covered person's responsibility.
If you are pregnant	Office visits	$25 copay per visit, deductible waived	40% coinsurance	Routine obstetrical ultrasounds limited to one per pregnancy.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	————————none————————
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	————————none————————
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Home Health limited to 40 visits per Calendar Year.
	Rehabilitation services	*Office setting:* $25 copay per visit, deductible waived *Other locations:* 20% coinsurance	40% coinsurance	Chiropractic Services, Physical and Occupational Therapy limited to 30 visits combined per Calendar Year. Speech Therapy limited to 25 visits per Calendar Year.
	Habilitation services	Not covered	Not covered	Habilitation services are not covered.
	Skilled nursing care	20% coinsurance	40% coinsurance	Skilled Nursing limited to 30 days per Calendar Year.
	Durable medical equipment	20% coinsurance	40% coinsurance	————————none————————
	Hospice 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 your child needs dental or eye care	Children's eye exam	*Medical exam:* 20% coinsurance *Routine exam:* No charge. Services limited to children under age six.	*Medical exam:* 40% coinsurance *Routine exam:* Not covered	Additional services may be available under a separate vision benefit plan.
	Children's glasses	Not covered	Not covered	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. 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
- Bariatric surgery
- Cosmetic surgery
- Dental care
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care
- 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.)

- Chiropractic care
- Infertility treatment (limited to $15,000 lifetime)
- Private-duty nursing (limited when combined with Home Health benefits)

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 Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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: Northwest Arkansas Community College, One College Drive, Bentonville, Arkansas, 72712 or by telephone at 1-479-619-3149.

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 1-800-370-5792.
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.

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	$1,000
Specialist	20% coinsurance
Hospital (facility)	20% coinsurance
Other	20% coinsurance

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	$1,000
Copayments	$60
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$3,120

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

The plan's overall deductible	$1,000
Specialist	20% coinsurance
Hospital (facility)	20% coinsurance
Other	20% coinsurance

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	$1,000
Copayments	$1,380
Coinsurance	$430
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$2,870

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

The plan's overall deductible	$1,000
Specialist	20% coinsurance
Hospital (facility)	20% coinsurance
Other	20% coinsurance

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	$1,000
Copayments	$0
Coinsurance	$385
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,385

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