

Washington County: Health Benefit Plan

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2016-12/31/2016

Coverage for: Individual/Family | Plan Type: POS



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.blueadvantagearkansas.com or by calling 1-800-370-5792.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$345 person/ \$600 family. Does not apply to accident related expenses or in-network preventive care.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1 st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other deductibles for specific services?	Yes, \$25 for dental expenses. There are no other specific deductibles .	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.
Is there an out-of-pocket limit on my expenses?	\$1,000 person/ \$2,000 family in-network and \$4,000 person/ \$8,000 family out-of-network	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, health care this plan doesn't cover, calendar year deductibles, cost containment penalties, obesity and per visit copayments.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of preferred providers , see www.blueadvantagearkansas.com or call 1-800-370-5792	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a specialist?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services .

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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$25 co-pay/visit	40% co-insurance	—————none—————
	Specialist visit	20% co-insurance	40% co-insurance	—————none—————
	Other practitioner office visit	20% co-insurance	40% co-insurance	Chiropractic services limited to 30 visits per calendar year.
	Preventive care/screening/immunization	No charge	20% co-insurance, deductible waived	Routine well adult care limited to \$750 calendar year maximum. Routine colonoscopies are covered once every five years for individuals 50 and over and are reimbursed at 80%, deductible waived, in-network and 60%, after deductible, out-of-network. Routine colonoscopies for individuals 50 and over, prostate cancer screenings for men 40 and older and routine well child care, birth to age 18, are not subject to calendar year maximum.
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance	40% co-insurance	—————none—————
	Imaging (CT/PET scans, MRIs)	20% co-insurance	40% co-insurance	—————none—————

Blue Advantage Administrators of Arkansas
 Snapshot Count Report

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If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.blueadvantagearkansas.com	Generic drugs	\$10 co-pay/prescription	\$10 co-pay/prescription	Prescriptions over \$500 are subject to 20% co-insurance rather than copay
	Preferred brand drugs	\$30 co-pay/prescription	\$30 co-pay/prescription	Prescriptions over \$500 are subject to 20% co-insurance rather than copay
	Non-preferred brand drugs	\$55 co-pay/prescription	\$55 co-pay/prescription	Prescriptions over \$500 are subject to 20% co-insurance rather than copay
	Specialty drugs	Generic: \$10 co-pay/prescription Preferred brand drugs: \$30 co-pay/prescription Non-preferred brand drugs: \$55 co-pay/prescription	Generic: \$10 co-pay/prescription Preferred brand drugs: \$30 co-pay/prescription Non-preferred brand drugs: \$55 co-pay/prescription	Prescriptions over \$500 are subject to 20% co-insurance rather than copay
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance	40% co-insurance	—————none—————
	Physician/surgeon fees	20% co-insurance	40% co-insurance	—————none—————
If you need immediate medical attention	Emergency room services	20% co-insurance	20% co-insurance	—————none—————
	Emergency medical transportation	20% co-insurance	40% co-insurance	Coverage is limited to \$500 per trip maximum, ground ambulance; \$1,000 per trip maximum, air ambulance.
	Urgent care	\$20 co-pay/visit	40% co-insurance	In-network Specialist provider specialty will be subject to 20% co-insurance.

Blue Advantage Administrators of Arkansas
Snapshot Count Report

Transitional Reinsurance Enrollment

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If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance	40% co-insurance	The covered person is responsible for obtaining prenotification for Out-of-Network admissions. Penalty for failure to prenotify an Out-of-Network admission is \$200
	Physician/surgeon fee	20% co-insurance	40% co-insurance	—————none—————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% co-insurance	40% co-insurance	—————none—————
	Mental/Behavioral health inpatient services	20% co-insurance	40% co-insurance	The covered person is responsible for obtaining prenotification for Out-of-Network admissions. Penalty for failure to prenotify an Out-of-Network admission is \$200
	Substance use disorder outpatient services	20% co-insurance	40% co-insurance	—————none—————
	Substance use disorder inpatient services	20% co-insurance	40% co-insurance	The covered person is responsible for obtaining prenotification for Out-of-Network admissions. Penalty for failure to prenotify an Out-of-Network admission is \$200
If you are pregnant	Prenatal and postnatal care	20% co-insurance	40% co-insurance	Coverage for obstetrical ultrasound is limited to one per pregnancy
	Delivery and all inpatient services	20% co-insurance	40% co-insurance	—————none—————

Blue Advantage Administrators of Arkansas
Snapshot Count Report
Transitional Reinsurance Contribution Enrollees

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If you need help recovering or have other special health needs	Home health care	20% co-insurance	40% co-insurance	Coverage is limited to 40 visits per calendar year
	Rehabilitation services	20% co-insurance	40% co-insurance	Coverage for physical and occupational therapy is limited to 45 visits combined per calendar year. Coverage for speech therapy is limited to 30 visits per year
	Habilitation services	Not covered	Not covered	No coverage for habilitation services
	Skilled nursing care	20% co-insurance	40% co-insurance	Coverage is limited to 30 visits per calendar year
	Durable medical equipment	20% co-insurance	40% co-insurance	—————none—————
	Hospice service	20% co-insurance	40% co-insurance	—————none—————
If your child needs dental or eye care	Eye exam	No coverage	No coverage	No coverage for eye exam
	Glasses	No coverage	No coverage	No coverage for glasses
	Dental check-up	20% co-insurance	20% co-insurance	Coverage is limited to \$1,500 calendar year maximum

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
Acupuncture	• Hearing aids	• Routine eye care
Cosmetic surgery	• Infertility treatment	• Routine foot care
Glasses	• Long-term care	• Weight loss programs
Habilitation services	• Non-emergency care when traveling outside the U.S.	

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
Bariatric surgery	• Chiropractic care	• Private-duty nursing when combined with Home Health Care

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Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under this plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-479-444-1643. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-237-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the plan administrator in writing at Washington County 280 North College, Ste 510, Fayetteville, Ar. 72701 or by phone at 1-479-444-1643. You may also contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services at 1-877-267-2323 x 61565 or www.cciio.cms.gov.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-370-5792.

————— *To see examples of how this plan might cover costs for a sample medical situation, see the next page.* —————

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

Amount owed to providers: \$7,540

- Plan pays \$6,045
- Patient pays \$1,495

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$345
Copays	\$0
Coinsurance	\$1,000
Limits or exclusions	\$150
Total	\$1,495

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

Amount owed to providers: \$5,400

- Plan pays \$3,915
- Patient pays \$1,485

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$345
Copays	\$720
Coinsurance	\$260
Limits or exclusions	\$160
Total	\$1,485

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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