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.novasyshealth.com or by calling 1-877-362-9003. 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 1-877-267-2323 x61565 or www.cciio.coms.gov.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$ 950 per person/ $1900 for family aggregate for participating providers $1900 per person/$3800 per family aggregate for non participating providers. Does not apply to preventative 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 1st). 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?	No	None
Is there an out–of–pocket limit on my expenses?	Yes, $2000 for participating providers and $4000 for non participating providers, this does not include the deductible.	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?	Deductibles, Cost containment penalties, copayments, balance billed charges, and health care this plan does not cover.	Even though you pay these expenses, they do not 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 specific covered services, such as office visits.
Does this plan use a network of providers?	Yes, for a list of participating providers, see www.novasyshealth.com	If you use a participating provider, this plan will pay some or all of the costs of covered services. Be aware, your participating provider may use an out of network provider for some services. 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 does not cover are listed on page 11. See your policy or plan document for additional information about excluded services.

- 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 NOVASYS HEALTH 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	$30/visit	40% after out of network deductible	None
	Specialist visit	20% after in network deductible	40% after out of network deductible	None
	Other practitioner office visit	20% after in network deductible for acupuncture or chiropractor	40% after out of network deductible	None
	Preventive care/screenings/immunizations for Adults, Well Child care and Well Newborn services	$0	40% after out of network deductible	Includes routine physical office visit, routine gynecological exam, eye exam, screenings, mammogram, prostate screening, colorectal screening (not a colonoscopy) x-rays, immunizations, laboratory tests

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

Corrected on May 11, 2012

	Colonoscopy (Routine or Medically Necessary)	20% after in network deductible	20% after in network deductible	Regardless of the diagnosis this is considered under the normal medical benefit structure and not a part of a routine physical
If you have a test	Diagnostic test (x-ray, blood work)	20% after in network deductible	40% after out of network deductible	None
	Sleep Study	20% after in network deductible	40% after out of network deductible	Initial test is covered.
	Imaging (CT/PET scans, MRIs)	20% after in network deductible	40% after out of network deductible	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.pti-nps.com	Generic drugs	$5/prescription		
	Preferred brand drugs	$30/prescription		
	Non-preferred brand drugs	$50/prescription		
	3 month maintenance drugs for 2 copays at 3 local pharmacies Specialty drugs: OTC Claritin and Prilosec with prescription from physician	$10/$60/$100 $0		**Authorized local pharmacies are:** **Baker Drugs–Front Street, 329-5625** **The Medicine Shoppe–College Avenue, 327-8088** **The Medicine Shoppe – Dave Ward Drive, 329-3777**
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% after in network deductible	40% after out of network deductible	None
	Physician/surgeon fees	20% after in network deductible	40% after out of network deductible	None
If you need immediate medical attention	Emergency room services	20% after in network deductible	40% after out of network deductible	none

	Supplemental Accident Benefit	$0 up to first $500 then 20% after in network deductible	$0 up to $500 then 20% after in network deductible	If services are used due to an accident, the first $500 of expenses are covered at 100%
	Emergency Room	20% after in network	20% after in network deductible	None
	Emergency medical transportation	20% after in network deductible	20% after in network deductible	None
	Urgent care	20% after in network deductible	20% after in network deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% after in network deductible	40% after out of network deductible	None
	Physician/surgeon fee	20% after in network deductible	40% after out of network deductible	None
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% after in network deductible	40% after out of network deductible	None
	Mental/Behavioral health inpatient services	20% after in network deductible	40% after out of network deductible	None
	Substance use disorder outpatient services	20% after in network deductible	40% after out of network deductible	None
	Substance use disorder inpatient services	20% after in network deductible	40% after out of network deductible	None
If you are pregnant	Prenatal and postnatal all physician charges and out patient facility charges	$0	40% after out of network deductible	None

	Inpatient Facility charges	20% after in network deductible	40% after out of network deductible	None
	1st Ultrasound for pregnancy 2nd Ultrasound for pregnancy and any additional ultrasounds	$0 20% after in network deductible	40% after out of network deductible	
	Birthing Centers	$0	$0	Must be licensed facility and licensed mid wife
	Sterilization Procedures	20% after in network deductible	40% after out of network deductible	Reversals are not a covered benefit
	Durable Medical Equipment	20% after in network deductible	40% after out of network deductible	Pay rental fee up to purchase price of equipment must be deemed medically necessary

If you need help recovering or have other special health needs	Home health care	20% after in network deductible	40% after out of network deductible	None
	Outpatient Private Duty Nursing	20% after in network deductible	40% after out of network deductible	None
	Rehabilitation services	20% after in network deductible	40% after out of network deductible	None
	Habilitation services	20% after in network deductible	40% after out of network deductible	None
	Skilled nursing care	20% after in network deductible	40% after out of network deductible	Must be within 7 days of a day inpatient.
	Durable medical equipment	20% after in network deductible	40% after out of network deductible	None
	Hospice service	20% after in network deductible	40% after out of network deductible	None
	Bariatric Surgery	20% after in network deductible	40% after out of network deductible	Benefits will be available on a case by case basis. Documentation of medically necessity must be submitted prior to surgery.
	Speech, Occupational and Physical Therapy	20% after in network deductible	40% after out of network deductible	Therapy must be ordered by a physician. Services must be provided by a licensed speech, occupational or physical therapist.
	Allergy testing , serum and injections	0% after $30 office visit copayment	40% after out of network deductible	None

	Prosthetic and Orthotics	20% after in network deductible	40% after out of network deductible	The initial purchase, fitting and repair of fitted prosthetic devices which replace body parts
	Hearing Aids	$0	$0	Maximum of $1,400 for each ear every three years
	Infertility Treatment	20% after in network deductible	40% after out of network deductible	$15,000 lifetime maximum for in and out of network. Includes diagnosis care and treatment of infertility
	Organ Transplants	20% after in network deductible	40% after out of network deductible	Charges for obtaining donor organs or tissues are covered charges under the plan when the recipient is a covered member. When the donor has medical coverage, his or her plan will first. All services must be reviewed by Case Management Team prior to transplant
	Dental care for Adults	20% after in network deductible	20% after in network deductible	Only removal of impacted wisdom teeth are covered. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth. Emergency repair due to Injury to sound natural teeth. Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth. Excision of benign bony growths of the jaw and hard palate. External incision and drainage of cellulites. Incision of sensory sinuses, salivary glands or ducts.
Routine Physicals	Routine physical office visits, mammograms lab work, immunizations, pap smears, prostate screening tests, x rays, screenings	$0	$0	None

If your child needs dental or eye care	Eye exam	$0	$0	Covered one time per year under routine physical benefit
	Glasses	100%	100%	Separate vision coverage through Met Life
	Dental check-up	100%	100%	Separate dental coverage through Met Life

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.)

- Cosmetic Surgery(Unless deemed medically necessary)
- Dental Care (Adult)
- Long-term Care
- Non-emergency care when traveling outside the United States
- Routine Foot Care
- Weight Loss Programs (Unless deemed medically necessary)

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.)

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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 right may be limited in duration and will require paying a premium, which may be significantly higher then the premium you pay while covered under the 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 501-450-1494. 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 1-877-267-2323 x61565 or www.cciio.coms.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: Human Resources-Hendrix College-501-450-1494, NovaSys Health-877-362-9003, The State of Arkansas Insurance Department-501-371-2800 or The Department of Labor in Arkansas-501-682-4500.

Language Access Services:

[Spanish (Espanola): Para oftener assistance en Espanola, llama al 877-362-9003

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 877-362-9003

[Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** 877-362-9003

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 877-362-9003

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

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 $5,740
- Patient pays $ 1,800

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	$950
Co pays	$0
Coinsurance	$850
Limits or exclusions	$0
Total	$1,800

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

- Amount owed to providers: $5,400
- Plan pays $4,270
- Patient pays $ 1,130

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	$950
Co pays	$30/visit
Coinsurance	$180
Limits or exclusions	$0
Total	$1,160

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.