



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? | \$ 1000 per person/ \$2000 for family aggregate for participating providers \$2000 per person/\$4000 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 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? | No | None |
| Is there an <u>out-of-pocket limit</u> on my expenses? | Yes, \$4000 for participating providers and \$8000 for non participating providers, this does 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 includes your office visit and pharmacy copayments. This limit helps you plan for health care expenses. |
| What is not included in the <u>out-of-pocket limit</u>? | Cost containment penalties, 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 <u>network of providers</u>? | 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 <u>specialist</u>? | No | You can see the specialist you choose without permission from this plan. |

Questions: Call 1-877-362-9003 or visit us at www.novasyshealth.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.novasyshealth.com or call 1-877-362-9003 to request a copy.

Summary of Benefits and Coverage: What this Plan Covers & What it Costs Coverage for: Individual & Family Plan Type: HD

| | | |
|---|-----|---|
| 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 <u>provider's</u> 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 | 0% after out of network deductible | Includes routine physical office visit, routine gynecological exam, eye exam, screenings, mammogram, prostate screening, colorectal screening, colonoscopy's, x-rays, immunizations, laboratory tests |
| | Non Routine Colonoscopy | 20% after in network deductible | 20% after in network deductible | |

Questions: Call 1-877-362-9003 or visit us at www.novasyshealth.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.novasyshealth.com or call 1-877-362-9003 to request a copy.

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

Coverage for: Individual & Family Plan Type: HD

| | | | | |
|---|---|---|--|--|
| 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 <u>prescription drug coverage</u> 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 Mail Order- OTC Claritin and Prilosec with prescription from physician | \$10/\$60/\$100 \$100 \$10/\$20/\$90 \$0 | | Authorized local pharmacies are: Baker Drive-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 |

Questions: Call 1-877-362-9003 or visit us at www.novasyshealth.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.novasyshealth.com or call 1-877-362-9003 to request a copy.

Summary of Benefits and Coverage: What this Plan Covers & What it Costs Coverage for: Individual & Family Plan Type: HD

| | | | | |
|---|--|--|-------------------------------------|------|
| | 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 50 visits per year | 20% after in network deductible | 20% after in network deductible | None |
| | Mental/Behavioral health inpatient services 10 visits per year (2 admissions per lifetime for alcohol admissions) does not apply to Stop Loss | 20% after in network deductible | 20% after in network deductible | None |
| | Substance use disorder outpatient services 50 visits per year | 20% after in network deductible | 20% after in network deductible | None |
| | Substance use disorder inpatient services 10 visits per year | 20% after in network deductible | 20% after in 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 |
| | 1 st Ultrasound for pregnancy 2 nd Ultrasound for pregnancy and any additional ultrasounds | \$0 20% after in network deductible | 40% after out of network deductible | |

Questions: Call 1-877-362-9003 or visit us at www.novasyshealth.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.novasyshealth.com or call 1-877-362-9003 to request a copy.

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for: Individual & Family Plan Type: HD**

| | | | | |
|--|---------------------------|---------------------------------|-------------------------------------|---|
| | Birth 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 |

Questions: Call 1-877-362-9003 or visit us at www.novasyshealth.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.novasyshealth.com or call 1-877-362-9003 to request a copy.

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

Coverage for: Individual & Family Plan Type: HD

| | | | | |
|--|---|--------------------------------------|-------------------------------------|--|
| 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 |

Questions: Call 1-877-362-9003 or visit us at www.novasyshealth.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.novasyshealth.com or call 1-877-362-9003 to request a copy.

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for: Individual & Family Plan Type: HD**

| | | | | |
|---|--|---------------------------------|-------------------------------------|--|
| | 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 VSP |
| | Dental check-up | 100% | 100% | Separate dental coverage through BCBS |

Questions: Call 1-877-362-9003 or visit us at www.novasyshealth.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.novasyshealth.com or call 1-877-362-9003 to request a copy.

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.)

- Breast Pumps

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 than 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:

Questions: Call 1-877-362-9003 or visit us at www.novasyshealth.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.novasyshealth.com or call 1-877-362-9003 to request a copy.

Summary of Benefits and Coverage: What this Plan Covers & What it Costs Coverage for: Individual & Family Plan Type: HD

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.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires employers to have health care coverage that qualifies as “minimum essential coverage.” This plan does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

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

Language Access Services:

[Spanish (Espanola): Para obtener 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, kwijigo holne' 877-362-9003

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

Questions: Call 1-877-362-9003 or visit us at www.novasyshealth.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.novasyshealth.com or call 1-877-362-9003 to request a copy.

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 \$5,690
- Patient pays \$ 1,850

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 | \$1000 |
| 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 \$4,220
- Patient pays \$ 1,180

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 | \$1000 |
| Co pays | \$30/visit |
| Coinsurance | \$180 |
| Limits or exclusions | \$0 |
| Total | \$1,160 |

Questions: Call 1-877-362-9003 or visit us at www.novasyshealth.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.novasyshealth.com or call 1-877-362-9003 to request a copy.

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.

Questions: Call 1-877-362-9003 or visit us at www.novasyshealth.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.novasyshealth.com or call 1-877-362-9003 to request a copy.