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, 1-800-370-5852 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 1-800-370-5852 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network providers $500 individual / $1,000 family Out-of-network providers $1,000 individual / $2,000 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. standard preventive care accident benefits, and in-network PCP office visit services and select urgent care centers, 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 for specific services.
What is the out-of-pocket limit for this plan?	In-Network providers $5,500 individual / $11,000 family Out-of-network providers $10,000 individual / $20,000 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, prior approval 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.
Will you pay less if you use a network provider?	Yes. See www.blueadvantagearkansas.com or call 1-800-370-5852 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	$20 copay/physician office visit charge; deductible does not apply.	40% coinsurance	——————none——————
	Specialist visit	20% coinsurance	40% coinsurance	——————none——————
	Preventive care/screening/ immunization	No charge	No charge	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. The plan must provide coverage for the USPSTF published recommendations for the plan year that begins on or after the date that is one year after the date the recommendation is published. 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.
If you have a test	Diagnostic test (x-ray, blood work)	Office visit services: PCP: no charge Specialist: 20% coinsurance Outpatient maternity services: No charge All other outpatient 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)	
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	——————none——————
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.magellanrx.com or 1-800-424-0472.	Generic drugs	Retail: $10 copay/prescription; Mail order: $20 copay/prescription; deductible does not apply.		Retail: one copay for up to a 34-day supply. Retail: two copay for up to a 93-day supply. Mail order: up to a 93-day supply. No charge for over-the-counter Claritin and Prilosec (with a prescription from the physician). No charge for certain preventive medications.
	Preferred brand drugs	Retail: $30 copay/prescription; Mail order: $60 copay/prescription; deductible does not apply.		
	Non-preferred brand drugs	Retail: $50 copay/prescription; Mail order: $100 copay/prescription; deductible does not apply.		
	Specialty drugs	20% of prescription cost up to $250 maximum per prescription; deductible does not apply.		Specialty drugs may require prior authorization. Please contact Magellan Rx customer service at 1-800-424-0472.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	——————none——————
	Physician/surgeon fees	20% coinsurance	20% coinsurance	——————none——————
If you need immediate medical attention	Emergency room care	Medical Emergency: 20% coinsurance Non-Medical Emergency: 20% coinsurance	Medical Emergency: 20% coinsurance Non-Medical Emergency: 40% coinsurance	100%, deductible waived up to a maximum of $500 for covered charges when accident related.
	Emergency medical transportation	20% coinsurance	20% 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)	
	Urgent care	Prime Care and Conway Regional Medical Urgent Care Centers: $20 copay/physician office visit charge; deductible does not apply. Other urgent care centers: 20% coinsurance	Medical Emergency: 20% coinsurance Non-Medical Emergency: 40% coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	——————none——————
	Physician/surgeon fees	20% coinsurance	40% coinsurance	——————none——————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/physician office visit charge; deductible does not apply and 20% coinsurance for outpatient services	20% coinsurance	——————none——————
	Inpatient services	20% coinsurance	20% coinsurance	——————none——————
If you are pregnant	Office visits	Office visit: $20 copay/physician office visit charge; deductible does not apply. No charge for outpatient facility and professional services.	40% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Routine obstetrical ultrasound is limited to one per pregnancy, subject to the applicable deductible and coinsurance amounts.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	——————none——————
	Childbirth/delivery facility 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 you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	——————none——————
	Rehabilitation services	Outpatient services: 20% coinsurance	40% coinsurance	——————none——————
	Habilitation services	Outpatient services: 20% coinsurance	40% coinsurance	——————none——————
	Skilled nursing care	20% coinsurance	40% coinsurance	——————none——————
	Durable medical equipment	Outpatient services: 20% coinsurance	40% coinsurance	——————none——————
	Hospice services	20% coinsurance	40% coinsurance	——————none——————
If your child needs dental or eye care	Children's eye exam	Preventive care: No cost sharing. Outpatient services Medical Illness or Injury: 20% coinsurance	Preventive care: No cost sharing. Medical Illness or Injury: 40% coinsurance	Children's preventive care 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. 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
- Weight loss programs

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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Cosmetic surgery (limited to services that are considered reconstructive).
- Hearing aids (limited to $1,400 per ear every three years per device).
- Infertility treatment (in-vitro and related services are limited to three per lifetime).
- Non-emergency care when traveling outside the U.S. (limited services are available when considered medically necessary, a medical emergency or an injury).
- Private-duty nursing (when combined and billed through a home health agency).
- Routine eye care (limited to children under the age of six).
- Routine foot care (limited to members diagnosed with diabetes).

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: Hendrix College 1600 Washington Ave, Conway, Arkansas 72032 or 501-329-6811 or contact 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 1-800-370-5852.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-370-5852.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-370-5852.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-370-5852.

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	**$500**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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	$500
Copayments	$0
Coinsurance	$2,100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,660**

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

The plan's overall deductible	**$500**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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	$500
Copayments	$400
Coinsurance	$200
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,120**

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

The plan's overall deductible	**$500**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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	$500
Copayments	$0
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$900**

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