Arkansas
BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

Benefit Summary

ARKANSAS TECH UNIVERSITY

BC 3000-70_E - (1)

WELCOME

Arkansas Blue Cross and Blue Shield is pleased to be your health insurance provider. For more than 75 years, Arkansas Blue Cross has been a name Arkansans have trusted. This Benefit Summary gives you an overview of your health coverage. *This summary is not your policy.* You will receive a Benefit Certificate that describes your complete health insurance coverage in greater detail.

SAVE MONEY WITH YOUR HEALTH INSURANCE

Most of us are interested in saving money, and when you use the services of in-network providers, you will pay less money out of pocket. Please take a moment to review this important information about your coverage.

Provider: You will see the term health care provider throughout this document. Providers are doctors, hospitals and others who offer medical services, such as labs or radiology clinics.

In-network providers: In-network health care providers are part of a group of participants who have agreed to give you a discount.

- In-network providers bill according to our agreement
- In-network providers participate in discounts for your medical services
- We pass the savings on to you, resulting in lower out-of-pocket expenses.

Please check to see that your health care provider is in your network.

Out-of-network providers: Out-of-network health care providers may not offer discounted services to our members.

- Out-of-network providers follow their own billing rules for services
- Your out-of-pocket expenses will be greater when you use an out-of-network provider
- Your health insurance policy is set up with a higher coinsurance.

Always check the network status of a provider that your doctor may refer you to for additional care. If you're referred to an out-of-network provider by an in-network provider, you still may have to pay higher costs.

Medical emergency: In a medical emergency, go directly to the nearest hospital. Medical services are covered at your plan's in-network deductible and health coinsurance amounts. Please note, if a visit to the hospital emergency room isn't a medical emergency, then in-network coverage may not be allowed. This can result in higher out-of-pocket costs. See your Benefit Certificate for a complete description of medical emergencies.

At Arkansas Blue Cross, your continued good health is our main concern.

HOW TO FIND AN IN-NETWORK PROVIDER

Always use your member number (on your ID card) to ensure the proper network when searching online.

For a list of in-network providers, visit us online at: arkansasbluecross.com/find a doctor
Your Provider Network is: True Blue or call Customer Service at:
501-378-2010 or **1-800-238-8379**

Important Note: *For your protection, we want you to know that some doctors and hospitals may require up-front payment of your anticipated portion of the deductible and coinsurance fees. For some health policies, out-of-state providers may not be included at in-network rates. Check your Evidence of Coverage for your plan details.*

Descriptions	Your Portion
Individual Deductible: A dollar amount that you pay for healthcare services before the health plan begins to pay. Every policy has an individual or family deductible. If you are the only person on your policy, then you will pay for healthcare costs covered by your plan until you meet your individual deductible. Family deductibles work differently.	**$3,000** In-network **$9,000** Out-of-network
Family Deductible: If you or anyone in your family meets the individual deductible, then your health plan will begin to pay a portion of medical expenses for that person for that calendar year (also called coinsurance). However, when the family deductible is met by any combination of family members, coinsurance will pay on all family members. *Continues on page four.*	**$6,000** In-network **$18,000** Out-of-network

Coinsurance: A percentage of all remaining eligible medical expenses that is your responsibility to pay after your deductible has been satisfied.

Copayment: The amount you're required to pay to a preferred provider for covered medical expenses.

Annual Limit on Cost Sharing: The claims amount that you must pay in a calendar year before you're no longer expected to pay copayments, deductible or coinsurance for the remainder of the year. The annual limitation on cost sharing is outlined in the Schedule of Benefits.

Annual Limit on Cost Sharing

	Individual	Family
In-Network	**$6,000**	**$12,000**
Out-of-Network*	**$18,000**	**$36,000**

**Annual limit on out-of-network costs does not include copayments.*

Service Type**	Your Cost In-network coinsurance	Your Cost Out-of-network coinsurance
Professional Services		
Primary care physician visit — **Copayment amount** $40	**0%**	**50%**
Specialty physician visit (Coinsurance may apply to additional services) — **Copayment amount** $80	**30%**	**50%**
Adult preventive services	**0%**	**20%**
Children's preventive services	**0%**	**20%**
Professional fees for inpatient surgical and medical services	**30%**	**50%**
Professional fees for outpatient surgical and medical services	**30%**	**50%**
Hospital and Other Medical Facility Services		
Inpatient services	**30%**	**50%**
Outpatient services (Includes surgery, diagnostics, lab and X-ray)	**30%**	**50%**
Emergency room visit	**30%**	**30%**
Maternity and obstetrics	**30%**	**50%**
Therapeutic Services		
Inpatient (limited to 60 days)	**30%**	**50%**
Outpatient (limited to 30 visits total) — **Copayment amount** $40 ▪ Physical, occupational and speech therapy ▪ Chiropractic — **Copayment amount** $80	**0%** **30%**	**50%** **50%**
Other Services		
Durable medical equipment***	**30%**	**50%**
Diabetic supplies	**30%**	**50%**
Mental health	**30%**	**50%**
Ambulance services — Ground	**30%**	**30%**
— Air	**30%**	**30%**

***Additional fees may apply. Please check your Benefit Certificate. *** Prior approval required for durable medical equipment that exceeds $5,000.*

Important Disclaimer from Arkansas Blue Cross and Blue Shield

This document is intended only to highlight your benefits and should not be relied on to fully determine coverage. **Some of the above services are subject to visit, day and/or dollar limits.** Please refer to your Benefit Certificate for a full explanation of your benefits, the limitations of these benefits and the services that are not covered. If this document conflicts in any way with the policy issued to your employer, the policy shall prevail.

Your Drug Coverage

Your prescription drug benefit is an important part of your health coverage. There are often lower-cost options available; ask your doctor for alternatives.

All **preventive** prescription drugs are covered in full.

Generic drugs will cost less and have lower copayments. Selecting generic drugs is a way to save money on your overall healthcare expenses.

Preferred brand-name drugs will cost less and will have lower copayments than **non-preferred brand-name** drugs.

Non-Preferred brand-name drugs are more expensive drugs. **Specialty** drugs typically require defined handling and home storage demands, crucial patient education and careful monitoring.

Your coverage features a mail order option that may offer savings on drugs that have been prescribed on an ongoing basis. Check your [Benefit Certificate/ Certificate of Coverage/Schedule of Benefits] for details.

Copayments by Category

**One copayment per 100-day supply*

Preventive	Generic	Preferred Brand	Non-preferred Brand	Specialty
Covered in full	**$20.00**	**$50.00**	**$70.00**	**$250.00**
Mail order*	**$40.00**	**$100.00**	**$140.00**	**$500.00**

Family Deductible Details

Bob and Sue Thompson have one child, Margo. Their family deductible is $3,000 and the individual deductible is $1,500. Sue paid $1,200 in covered healthcare expenses. Bob paid $1,100 in covered healthcare expenses. Margo paid $700 in covered healthcare expenses. None of the Thompson's met the individual deductible. However, their family's total expense $3,000 (meeting the family deductible) and the health plan will begin paying coinsurance for all family members.

Other Member Services

Blueprint Portal – your personal online self-service center – allows you access to a wealth of information from the home page of our website at arkansasbluecross.com. Access or register for *Blueprint Portal* through the sign in box on the home page.

Questions?

We hope you'll call us with any questions or concerns.
Our office hours are Monday through Friday from 8 a.m. to 4:30 p.m. (CST).

Customer Service Number: **501-378-2010** or **1-800-238-8379**

More information can be found on our website at: arkansasbluecross.com

Local Sales and Service Center: Arkansas Blue Cross and Blue Shield
416 S University Ave
Suite 110
Little Rock, AR 72205

E PLAN # BC 3000-70_E - (1) MPI #3229 11/15

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, call 1-800-238-8379 or visit us at www.arkansasbluecross.com/employers/administrative/benefit-certificates. 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.arkansasbluecross.com/sbc-glossary or call 1-800-238-8379 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For in-network providers $3,000 individual / $6,000 family ; for out-of-network providers $9,000 individual / $18,000 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. Preventive care, prescription drugs, and primary care services 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?	For in-network provider - $6,000 individual / $12,000 family. For out-of-network providers - $18,000 individual/ $36,000 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?	Out-of-network Deductible,premiums, balance-billing charges, 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 https://secure.arkansasbluecross.com/providerdirectory/trueblueppo.aspx or call 1-800-238-8379 for a list of In-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 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
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a healthcare provider's office or clinic	Primary care visit to treat an injury or illness	$40 copay/visit; deductible does not apply	50% coinsurance	---none---
	Specialist visit	$80 copay/visit	50% coinsurance	---none---
	Preventive care/screening/ immunization	No Charge	30% coinsurance	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)	30% coinsurance	50% coinsurance	---none---
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	---none---
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.arkansasbluecross.com/members/pharmacy-resources.	Generic drugs	Retail $20 copay/prescription Mail $40 copay/prescription; deductible does not apply	Not Covered	Covers up to a 30-day supply (retail subscription)Mail order is covered
	Preferred brand drugs	Retail $50 copay/prescription Mail $100 copay/prescription; deductible does not apply	Not Covered	Covers up to a 30-day supply (retail subscription)Mail order is covered
	Non-preferred brand drugs	Retail $70 copay/prescription Mail $140 copay/prescription; deductible does not apply	Not Covered	Covers up to a 30-day supply (retail subscription)Mail order is covered
	Specialty drugs	Retail $250 copay/ prescription; deductible does not apply	Not Covered	Prior authorization, step therapy or quantity limitations may apply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	---none---
	Physician/surgeon fees	30% coinsurance	50% coinsurance	---none---
If you need immediate medical attention	Emergency room care	30% coinsurance	30% coinsurance	---none---
	Emergency medical transportation	30% coinsurance	30% coinsurance	---none---
	Urgent care	$80 copay/visit	50% coinsurance	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	---none---
	Physician/surgeon fees	30% coinsurance	50% coinsurance	---none---

*For more information about limitations and exceptions, see the **plan** or policy document at www.arkansasbluecross.com/employers/administrative/benefit-certificates.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-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	30% coinsurance	50% coinsurance	3 visits free before coinsurance applies, thereafter, coinsurance will apply for all other outpatient services and procedures; PCP copay applies to office visits
	Inpatient services	30% coinsurance	50% coinsurance	---none---
If you are pregnant	Office visits	30% coinsurance	50% coinsurance	Coverage for routine ultrasounds limited to 1; Maternity care may include tests and services described elsewhere in the SBC
	Childbirth/delivery professional services	30% coinsurance	50% coinsurance	---none---
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	---none---
If you need help recovering or have other special health needs	Home health care	30% coinsurance	50% coinsurance	Coverage is limited to 40 visits/calendar year
	Rehabilitation services	30% coinsurance	50% coinsurance	Outpatient services limited to 30 visits/ person/calendar year
	Habilitation services	Not Covered	Not Covered	None
	Skilled nursing care	30% coinsurance	50% coinsurance	Limited to 30 days/calendar year
	Durable medical equipment	30% coinsurance	50% coinsurance	---none---
	Hospice services	30% coinsurance	50% coinsurance	---none---
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

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
- Cosmetic Surgery
- Dental Care
- Eye exam
- Glasses
- Habilitation services
- Hearing aids
- Long term care
- Private-duty nursing
- 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.)

- Bariatric Surgery
- Chiropractic care (Outpatient rehabilitation services limited to 30 visits/person/calendar year)
- Infertility treatment
- Non-emergency care when traveling outside of U.S. (Subject to discretion of the company)

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: Arkansas Insurance Department at 1-800-852-5494, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or **www.dol.gov/ebsa/healthreform** or contact the **plan** at 1-800-238-8379. 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 **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 the **plan** at 1-800-238-8379. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or **www.dol.gov/ebsa/healthreform**. Additionally, a consumer assistance program can help you file your **appeal**. The contact information is:

Arkansas Insurance Department
1 Commerce Way, Suite 102, Little Rock, AR 72202
Telephone 1-800-852-5494, Email address: insurance.consumers@arkansas.gov

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 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 1-844-662-2276.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-662-2276.
Chinese (中文): 如果需要中文的帮助 , 请拨打这个号码 1-844-662-2276.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-662-2276.

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

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	$3,000
Specialist copayment	$80
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	$100
Coinsurance	$2,800
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$5,970**

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

The plan's overall deductible	$3,000
Specialist copayment	$80
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,600
Copayments	$1,800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$3,460**

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

The plan's overall deductible	$3,000
Specialist copayment	$80
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,400
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,600**

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