The SBC shows you how you and the plan would share the cost for covered health care services. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, contact the claims administrator at 1-800-843-1329 or visit www.asp.arkansas.gov. 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 1-800-843-1329 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network providers: $1,000 Individual / $2,000 Family. Out-of-network providers: $2,000 Individual / $4,000 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. In-Network Standard Preventive care, In-Network PCP Office and Outpatient services, In-Network Urgent Care Services, ambulance services, emergency room surgery and related services, and multiple births when certain conditions apply.	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 or specific services.
What is the out-of-pocket limit for this plan?	***Medical Benefits*** In-Network providers: $4,000 Individual / $8,000 Family. Out-of-network providers: unlimited ***Pharmacy Benefits*** $2,850 Individual / $5,700 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.asp.arkansas.gov or call 1-800-843-1329 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). 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
		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	$30 copay/visit. Deductible does not apply.	40% coinsurance	When ordered by an in-network primary care physician, diagnostic tests, x-rays, and high tech radiology ordered and rendered at a hospital, outside lab, or radiology facility billed within three days of an office visit will be covered at no charge.
	Specialist visit	20% coinsurance	40% coinsurance	Chiropractic services are limited to 30 visits per member per calendar year.
	Preventive care/screening/ immunization	No charge	Not covered	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. 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)	*PCP*: No charge *Specialist*: 20% coinsurance	40% coinsurance	When ordered by an in-network primary care physician, diagnostic tests, x-rays, and high tech radiology ordered and rendered at a hospital, outside lab, or radiology facility billed within three days of an office visit will be covered at no charge.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Prior approval is required.

* For more information about limitations and exceptions, see the plan or policy document at www.asp.arkansas.gov.

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 drugs to treat your illness or condition: More information about **prescription drug coverage** is available at www.medimpact.com.	Generic drugs	Retail: $15 copay Mail Order: $45 copay	Not covered	All new prescriptions are limited to a 34-day supply. Subsequent refills of Maintenance drugs are available for up to a 90-day supply at certain contracted pharmacies and through mail order.
	Preferred brand drugs	Retail: $40 copay Mail Order: $120 copay	Not covered	
	Non-preferred brand drugs	Retail: $65 copay Mail Order: $195 copay	Not covered	
	Specialty drugs	Generic: $15 copay Preferred brand: $40 copay Non-preferred: $65 copay	Not covered	
If you have outpatient surgery:	Facility fee (e.g., ambulatory surgery center)	No charge	40% coinsurance	Prior approval for certain services is required.
	Physician/surgeon fees	No charge	40% coinsurance	——————none——————
If you need immediate medical attention:	Emergency room care	20% coinsurance	20% coinsurance	Surgery and related services administered in the ER are no charge.
	Emergency medical transportation	20% coinsurance Deductible does not apply.	20% coinsurance Deductible does not apply.	——————none——————
	Urgent care	$30 copay Deductible does not apply.	40% coinsurance	——————none——————
If you have a hospital stay:	Facility fee (e.g., hospital room)	20% coinsurance	$200 copay plus 40% coinsurance	The covered person is responsible for obtaining prior approval for all out-of-network provider inpatient admissions. Failure to obtain prior approval may result in a reduction in benefits.
	Physician/surgeon fees	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 mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	none
	Inpatient services	20% coinsurance	$200 copay plus 40% coinsurance	The covered person is responsible for obtaining prior approval for an out-of-network provider inpatient admissions. Failure to obtain prior approval may result in a reduction in benefits. Transplant services also require prior approval.
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Dependent pregnancy is not covered. However, any pre-natal, post-natal or maternity care that is required as Standard Preventive Care will be covered as shown under Preventive Care Benefits. 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).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	$200 copay plus 40% coinsurance	

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	Prior approval required.
	Rehabilitation services	20% coinsurance	40% coinsurance	Prior approval required for initial Physical, Occupational, and Speech Therapy visit. After 15 visits, medical record review required for subsequent visits.
	Habilitation services	Not covered	Not covered	Habilitation services are not covered.
	Skilled nursing care	20% coinsurance	40% coinsurance	Prior approval required
	Durable medical equipment	20% coinsurance	40% coinsurance	Prior approval required.
	Hospice services	20% coinsurance	40% coinsurance	Hospice care is limited to a maximum of $5,000 per lifetime.
If your child needs dental or eye care	Children's eye exam	20% coinsurance	40% coinsurance	Additional services may be available under a separate vision benefit plan.
	Children's glasses	Not covered	Not covered	Additional services may be available under a separate vision benefit plan.
	Children's dental check-up	Not covered	Not covered	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.)		
• Acupuncture • Bariatric surgery	• Dental care • Habilitation services • Infertility treatment	• Long-term care • Private-duty nursing • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic care • Cosmetic surgery (when eligible services are considered reconstructive).	• Hearing aids (limited to $1,400 per ear every three years). • Non-emergency care when traveling outside the U.S.	• Routine eye care • Routine foot care (when required for prevention of complications associated with diabetes mellitus).

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 Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 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: Arkansas State Police 1 State Police Plaza, Little Rock Arkansas 72209 or by telephone at 1-501-618-8720.

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 Essential Coverage? 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 1-800-843-1329.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-843-1329.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-843-1329.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-843-1329.

———————————*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.asp.arkansas.gov.

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** **$1,000**
- **Specialist** **20% coinsurance**
- **Hospital (facility)** **20% coinsurance**
- **Other** **20% coinsurance**

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	$1,000
Copayments	$10
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,370**

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

- **The plan's overall deductible** **$1,000**
- **Specialist** **20% coinsurance**
- **Hospital (facility)** **20% coinsurance**
- **Other** **20% coinsurance**

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	$1,000
Copayments	$900
Coinsurance	$40
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,960**

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

- **The plan's overall deductible** **$1,000**
- **Specialist** **20% coinsurance**
- **Hospital (facility)** **20% coinsurance**
- **Other** **20% coinsurance**

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	$1,000
Copayments	$10
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,410**

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