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 1-800-800-4298 or visit us at https://secure.healthadvantage-hmo.com/members/eoclist.aspx. 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.healthadvantage-hmo.com/glossary or call 1-800-800-4298 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network provider $4,100 individual / $8,200 family; for out-of-network provider $12,300 individual / $24,600 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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care is 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 network provider –$6,100 Individual / $12,200 For out-of-network provider - $18,300 individual/ $36,600 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, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Out-of-network coinsurance, 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. https://www.healthadvantage-hmo.com/members/network-selection or call 1-800-800-4298 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 the specialist you choose without a referral.

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HIOS #: 13262AR0230009-00
10/14/2026

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 healthcare provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit; deductible does not apply	50% coinsurance	**See below Other Covered Services chart for details
	Specialist visit	$80 copay /visit; deductible does not apply	50% coinsurance	Services and procedures other than consult and eval are paid at 40% coinsurance in-network; Coinsurance applies after deductible
	Preventive care/screening/ immunization	No Charge	Not Covered	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)	40% coinsurance	50% coinsurance	Coinsurance applies after deductible.
	Imaging (CT/PET scans, MRIs)	40% coinsurance	50% coinsurance	Coinsurance applies after deductible.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.healthadvantage-hmo.com/ha-formulary-2027	Generic drugs	Retail $25 copay/prescription Mail $75 copay/prescription; deductible does not apply	Not Covered	Covers up to 30-day supply (retail prescriptions); 31-90 day supply (mail order prescription)
	Preferred brand drugs	Retail $85 copay/prescription Mail $255 copay/ prescription; deductible does not apply	Not Covered	Covers up to 30-day supply (retail prescriptions); 31-90 day supply (mail order prescription)
	Non-preferred brand drugs	Retail $1,500 copay/ prescription Mail $4,500 copay/ prescription; deductible does not apply	Not Covered	Covers up to 30-day supply (retail prescriptions); 31-90 day supply (mail order prescription)
	Specialty drugs	Retail $6,100 copay/ prescription; deductible does not apply	Not Covered	Prior authorization, step therapy or quantity limitations may apply; Non-preferred specialty drugs may apply a higher copay in-network; Coverage requires prior authorization.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% coinsurance	50% coinsurance	Coinsurance applies after deductible.
	Physician/surgeon fees	40% coinsurance	50% coinsurance	Coinsurance applies after deductible.

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 immediate medical attention	Emergency room care	$975 copay/visit	$975 copay/visit	Copay applies after deductible
	Emergency medical transportation	40% coinsurance	40% coinsurance	Coinsurance applies after deductible
	Urgent care	$80 copay/visit; deductible does not apply	50% coinsurance	Coinsurance applies after deductible
If you have a hospital stay	Facility fee (e.g., hospital room)	$975 copay/day	50% coinsurance	Copay and coinsurance apply after deductible
	Physician/surgeon fees	40% coinsurance	50% coinsurance	Coinsurance applies after deductible
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/visit; deductible does not apply	50% coinsurance	$25 copay for consultation, evaluation, and psychotherapy services in-network; 40% coinsurance for other outpatient services; **See below Other Covered Services chart
	Inpatient services	$975 copay/day	50% coinsurance	Copay and coinsurance apply after deductible.
If you are pregnant	Office visits	40% coinsurance	50% coinsurance	Coverage for routine ultrasounds limited to 1; Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC; Coinsurance applies after deductible
	Childbirth/delivery professional services	40% coinsurance	50% coinsurance	Coinsurance applies after deductible
	Childbirth/delivery facility services	40% coinsurance	50% coinsurance	Coverage for out-of-network newborn services is limited to $2,000 per Member for all services first 90 days after birth; Coinsurance applies after deductible

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	40% coinsurance	50% coinsurance	Coverage is limited to 50 visits/Member/calendar year. Coinsurance applies after deductible.
	Rehabilitation services	$25 copay/visit; deductible does not apply	Not Covered	Outpatient services limited to 30 visits/Member/calendar year and paid at $25 copay; Inpatient services limited to 60 days/Member/calendar year and paid at 40% coinsurance in-network after deductible. **See below Other Covered Services
	Habilitation services	$25 copay/visit; deductible does not apply	Not Covered	Developmental services limited to 180 units/Member/calendar year and paid at 40% coinsurance in-network after deductible; Outpatient services limited to 30 visits/Member/calendar year and paid at $25 copay in-network. **See below Other Covered Services
	Skilled nursing care	$975 copay/day	50% coinsurance	Limited to 60 days/Member/calendar year; Copay and Coinsurance apply after deductible.
	Durable medical equipment	50% coinsurance	50% coinsurance	Coinsurance applies after deductible
	Hospice services	40% coinsurance	50% coinsurance	Hospice care must be certified by a physician as having a life expectancy of six months or less. Coinsurance applies after deductible.
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	Limited to one exam per child per calendar year
	Children's glasses	40% coinsurance	50% coinsurance	Limited to one pair of glasses with lenses or contacts per child per calendar year. Coinsurance applies after deductible.
	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.)

- Abortions are not covered. Pregnancy terminations under the direction of a physician are covered but only when performed in an in-network or outpatient hospital setting.
- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care
- Infertility Treatment
- Long term care
- Non-emergency care when traveling outside of U.S. (Subject to discretion of the company)
- Private-duty nursing
- Routine eye care (Adult)

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

- Chiropractic care (Limited to 30 visits/Member/ calendar year)
- Hearing aids ($1,400/hearing aid/replacement)
- Routine foot care is covered for podiatric conditions

**Covers 3 free visits before copay and applies to first 3 claims submitted in the calendar year for consult and evaluation services in-network if services are from one of the following categories: Primary Care Physician visits, Outpatient Rehabilitation, Outpatient Habilitation, or Outpatient Mental Health Services.

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 http://www.dol.gov/ebsa/healthreform or contact the **plan** at 1-800-800-4298. 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 Arkansas Insurance Department, Consumer Services Division. Additionally, a consumer assistance program can help you file your **appeal**. The contact information is:

Arkansas Insurance Department, Consumer Services Division
1 Commerce Way, Suite 102, Little Rock, Arkansas 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? Not Applicable.
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.
Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 1-844-662-2276 uff.
Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-844-662-2276.
Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-844-662-2276.
Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 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	$4,100
Specialist copayment	$80
Hospital (facility) copayment	$975
Other coinsurance	40%

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	$2,300
Copayments	$0
Coinsurance	$3,400
What isn't covered	
Limits or exclusions	$40
The total Peg would pay is	**$6,140**

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

The plan's overall deductible	$4,100
Specialist copayment	$80
Hospital (facility) copayment	$975
Other coinsurance	40%

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	$4,100
Copayments	$500
Coinsurance	$900
What isn't covered	
Limits or exclusions	$60
Total Example Cost	**$5,560**

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

The plan's overall deductible	$4,100
Specialist copayment	$80
Hospital (facility) coinsurance	$975
Other coinsurance	40%

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	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
Total Example Cost	**$1,900**

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

NOTICE OF LANGUAGE ASSISTANCE, AUXILIARY AIDS/SERVICES AND NON-DISCRIMINATION NOTICE

We provide free language assistance, appropriate auxiliary aids and services, and reasonable modifications to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, written information in various formats (large print, audio, accessible electronic formats, other formats), and language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, call or contact Customer Service at 1-800-238-8379 (TTY:771) or Civil Rights Coordinator.

ATTENTION: Free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in assessable formats are available free of charge. Call 1-800-238-8379 (TTY: 711) or speak to your provider.

Spanish: ATENCIÓN: Disponemos de servicios gratuitos de asistencia lingüística. También hay disponibles de forma gratuita ayudas y servicios auxiliares adecuados para proporcionar información en formatos accesibles. Llame al
1-800-238-8379 (TTY: 711) o hable con su proveedor.

Chinese Simplified: 注意：提供免费语言服务。此外，免费提供适合残障人士使用的辅助和支持服务。请致电 1-800-238-8379 (TTY: 711)或联系您的服务提供商。

Chinese Traditional: 注意：我們提供免費的語言協助服務，以及免費的適當輔助工具和其他服務，讓您能夠獲得無障礙格式的資訊。請撥打 1-800-238-8379 (TTY: 711)或諮詢您的服務提供者。

Tagalog: PAUNAWA: Available para sa iyo ang mga libreng serbisyo sa tulong sa wika. Available rin nang walang bayad ang mga naaangkop na auxiliary na tulong at serbisyo para magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-238-8379 (TTY: 711) o makipag-usap sa iyong provider.

French: ATTENTION: Des services d'assistance linguistique sont gratuitement mis à votre disposition. Des aides et services auxiliaires appropriés visant à vous informer dans des formats accessibles sont également mis à votre disposition gratuitement. Appelez le 1 800 238 8379 (TTY: 711) ou discutez avec votre prestataire.

Vietnamese: CHÚ Ý: Các dịch vụ hỗ trợ ngôn ngữ sẽ được cung cấp miễn phí cho quý vị. Các dịch vụ và hỗ trợ giao tiếp phù hợp nhằm cung cấp thông tin ở các định dạng dễ tiếp cận cũng được cung cấp hoàn toàn miễn phí. Hãy gọi 1-800-238-8379 (TTY: 711) hoặc trao đổi với nhà cung cấp của quý vị.

German: HINWEIS: Ihnen stehen kostenlose Sprachmittlungsdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zum barrierefreien Zugang zu Informationen stehen ebenfalls kostenfrei zur Verfügung. Rufen Sie 1-800-238- 8379 (TTY: 711) an oder sprechen Sie mit Ihrem Leistungserbringer.

Korean: 주의: 무료 언어 지원 서비스를 이용하실 수 있습니다. 접근 가능한 형식으로 정보를 제공하기 위한 적절한 보조 도구와 서비스도 무료로 제공됩니다. 1-800-238-8379 (TTY: 711)번으로 전화하거나 담당 서비스 제공자에게 문의하십시오.

Russian: ВНИМАНИЕ! Вам доступны бесплатные услуги языковой поддержки. Приемлемые вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-238-8379 (TTY: 711) или обратитесь к своему поставщику услуг.

Arabic: ملحوظة: خدمات المساعدة اللغوية متاحة لك مجانًا، كما أن وسائل وخدمات المساعدة الإضافية المناسبة لتوفير المعلومات بصيغ يسهل عليك الوصول إليها متاحة مجانًا أيضًا. يرجى الاتصال على الرقم: 1-800-238-8379 (TTY: 711) أو التحدث إلى مقدم الرعاية

Hindi: ध्यान दें: आपके लिए निशुल्क भाषा सहायता सेवाएं उपलब्ध हैं। आसान फ़ॉर्मैट में सूचना उपलब्ध कराने के लिए उचित सहायक साधन और सेवाएं भी निशुल्क उपलब्ध हैं। 1-800-238-8379 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

Italian: ATTENZIONE: Ha a disposizione servizi di assistenza linguistica gratuiti. Potrà usufruire gratuitamente anche di sussidi e servizi ausiliari appropriati per ottenere le informazioni in formati accessibili. Chiami il numero 1-800-238-8379 (TTY: 711) o chieda al suo operatore sanitario.

Portuguese: ATENÇÃO: Serviços gratuitos de assistência linguística estão disponíveis para você. Ajudas e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-800-238-8379 (TTY: 711) ou fale com seu provedor.

French Creole: ATANSYON: Genyen sèvis asistans lang gratis disponib pou ou. Epitou, genyen lòt èd ak sèvis apwopriye disponib gratis pou ede moun jwenn enfòmasyon nan yon fòma ki aksesib. Rele 1-800-238-8379 (TTY: 711) oswa pale ak founisè w la.

Polish: UWAGA: może Pan/Pani skorzystać z bezpłatnych usług pomocy językowej. Odpowiednie dodatkowe pomoce i usługi w zakresie zapewniania dostępu do informacji w przystępnym formacie również są dostępne bezpłatnie. Prosimy dzwonić pod numer 1-800-238-8379 (TTY: 711) lub porozmawiać z lekarzem.

Japanese: 注意：無料の言語サポートサービスをご利用いただけます。アクセシブルなフォーマットで情報を提供するための適切な援助やサービスも無料でご利用いただけます。1-800-238-8379（TTY：711）にお電話いただくか、医療提供者にご相談ください

NON-DISCRIMINATION NOTICE

Our Company complies with applicable federal and state civil rights laws and does not discriminate, exclude, or treat people differently on the basis of race, color, national origin, age, disability, or sex.

If you believe that we have failed to provide these language assistance or auxiliary aids and services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex.

Civil Rights Coordinator
601 Gaines Street, Little Rock, AR 72201
Phone: 1-844-662-2276 (TTY: 711)
You can file a grievance in person, by mail, or by email. If you need help filing a grievance our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201
Phone: 1-800-368-1019; TDD: 1-800-537-7697

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.