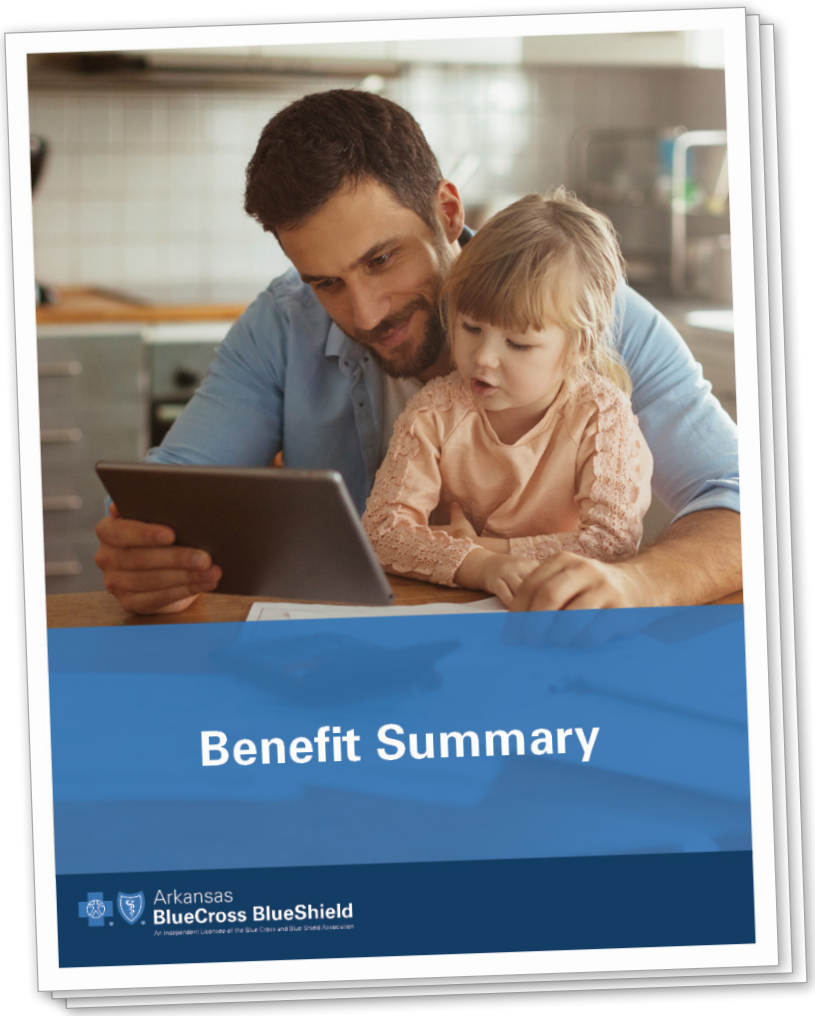
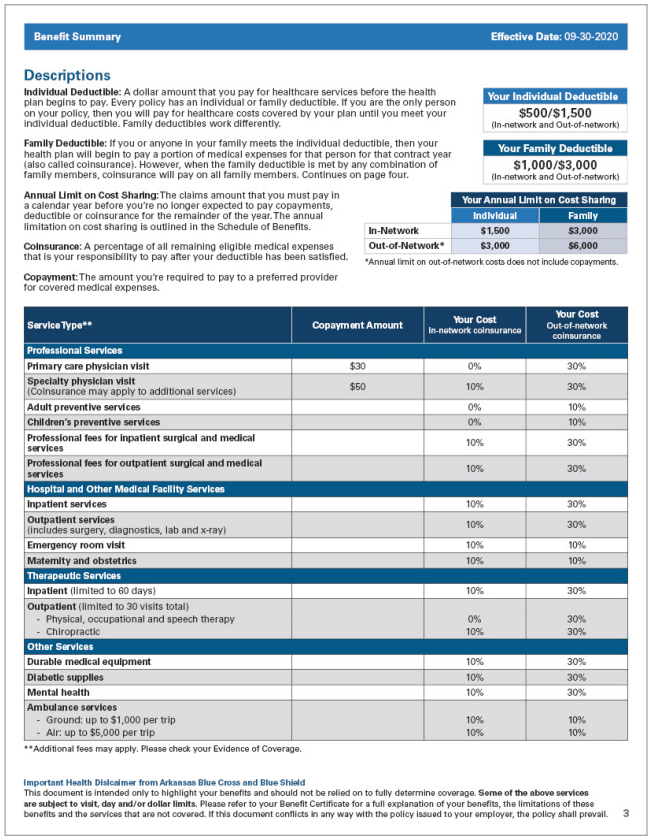
Summary of Benefits and Coverage (SBC)

blueprint

When looking for health plans, you will have access to a Summary of Benefits and Coverage (SBC) outlining exactly what a plan will pay for different medical services. Sometimes called a “schedule of benefits,” this will provide you with a summary to use for comparison on cost and coverage. This is beneficial when choosing what plan will work best for you. You can access your plan’s SBC in Blueprint Portal.





Benefit Summary — **Effective Date:** 09-30-2020

Descriptions

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.

Your Individual Deductible
$500/$1,500
(In-network and 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 contract 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.

Your Family Deductible
$1,000/$3,000
(In-network and Out-of-network)

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.

Your Annual Limit on Cost Sharing

	Individual	Family
In-Network	$1,500	$3,000
Out-of-Network*	$3,000	$6,000

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

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.

Service Type**	Copayment Amount	Your Cost In-network coinsurance	Your Cost Out-of-network coinsurance
Professional Services			
Primary care physician visit	$30	0%	30%
Specialty physician visit (Coinsurance may apply to additional services)	$50	10%	30%
Adult preventive services		0%	10%
Children’s preventive services		0%	10%
Professional fees for inpatient surgical and medical services		10%	30%
Professional fees for outpatient surgical and medical services		10%	30%
Hospital and Other Medical Facility Services			
Inpatient services		10%	30%
Outpatient services (Includes surgery, diagnostics, lab and x-ray)		10%	30%
Emergency room visit		10%	10%
Maternity and obstetrics		10%	10%
Therapeutic Services			
Inpatient (limited to 60 days)		10%	30%
Outpatient (limited to 30 visits total) - Physical, occupational and speech therapy - Chiropractic		0% 10%	30% 30%
Other Services			
Durable medical equipment		10%	30%
Diabetic supplies		10%	30%
Mental health		10%	30%
Ambulance services - Ground: up to $1,000 per trip - Air: up to $5,000 per trip		10% 10%	10% 10%

**Additional fees may apply. Please check your Evidence of Coverage.

Important Health 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. 3

Arkansas
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