2025 AFFORDABLE CARE ACT (ACA) PLANS

FOR YOU & YOUR FAMILY

Health Advantage

An Independent Licensee of the Blue Cross and Blue Shield Association

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WHY CONSIDER AN ACA PLAN?

1 **YOU CAN'T BE TURNED DOWN.**

You'll be able to enroll in a health insurance plan even if you have a pre-existing condition.

2 **YOU MIGHT SAVE MONEY.**

We can tell you if you qualify for financial assistance that will help lower your monthly premiums. The majority of members who buy plans on the Health Insurance Marketplace receive financial assistance.

3 **ENROLLING IS EASY.**

Each year, there is an Open Enrollment Period (OEP). This is your chance to join or switch to the health plan you really want.

- The OEP for 2025 is November 1, 2024 to January 15, 2025. Enroll by December 15, 2024 for coverage to start January 1.
- It's possible to enroll outside of OEP. Significant events such as marriage, childbirth or losing employer coverage might make you eligible.*

4 **ESSENTIAL HEALTH BENEFITS ARE COVERED.**

Our plans cover all essential health benefit categories required by the healthcare law. To learn more, see page 6.

FIND OUT IF YOU QUALIFY FOR LOW-COST HEALTH INSURANCE

FREE RATE QUOTE!

CALL 800-392-2583

8 A.M. to 5 P.M., Monday – Friday

Give us a call to get Arkansas' most trusted and accepted coverage at the lowest price possible.

- Access to more doctors, hospitals and top specialists*
- Coverage that's chosen by more doctors for their own families*
- A plan that opens doors in all 50 states*
- Locations throughout Arkansas to serve you
- The peace of mind that comes with a Health Advantage card in your pocket

* Health Advantage Plans exist in every state and every county in the United States and are connected by the BlueCard provider network. Out-of-area benefits for ARHOME plans, Silver Value and Bronze Value are restricted to urgent or emergent services and/or services that receive prior approval. Health Market Science (HMS) Provider MasterFile, Q12013 and BCBSA Provider Data Repository (PDR); 92.1% of all actively practicing doctors and specialists are contracted with a Blue Plan.

*Typically, these special circumstances require enrollment into a health plan within 60 days of the life event. A Health Advantage agent can make sense of the enrollment process and help walk you through it.

KEY BENEFITS

	Gold Standardized	Silver AH	Silver Standardized
On/Off Exchange	Both	Both	Both
Includes BlueCard	No	No	No
Individual Deductible	$1,500	$5,600	$5,000
Family Deductible	$3,000	$11,200	$10,000
Individual Out-of-Pocket Max	$7,800	$6,000	$8,000
Family Out-of-Pocket Max	$15,600	$12,000	$16,000
Coinsurance	25%	30%	40%
PCP & OP Rehab/Hab Office Visits	$30 Copay	$30 Copay after Ded	$40 Copay
Specialist Office Visit (Consult/Evaluation)	$60 Copay	$45 Copay after Ded	$80 Copay
Mental Health/Substance Abuse OP Office Visit	$30 Copay	$30 Copay after Ded	$40 Copay
Medical Equipment & Supplies	Ded/Coins	$250 Copay after Ded	Ded/Coins
Maternity and Family Planning	Ded/Coins	Ded/Coins	Ded/Coins
Urgent Care	$45 Copay	$45 Copay after Ded	$60 Copay
Emergency Room	Ded/Coins	$800 Copay after Ded	Ded/Coins
Inpatient Hospital, MH/SA	Ded/Coins	$800 Copay per day after Ded	Ded/Coins
Outpatient Hospital & Surgical Services	Ded/Coins	$45 Copay after Ded	Ded/Coins
High-Tech Imaging	Ded/Coins	$500 Copay after Ded	Ded/Coins
Lab/X-RAY	Ded/Coins	$30 Copay after Ded	Ded/Coins
Rx Tier 1 Preventive	$0	$0	$0
Rx Tier 2 Generic	$15/$30 Copay*	$100/$200 Copay*	$20/$40 Copay*
Rx Tier 3 Preferred Brand	$30/$60 Copay*	$1,000/$2,000 Copay*	$40/$80 Copay*
Rx Tier 4 Non-Preferred Brand	$60/$120 Copay*	$2,000/$4,000 Copay*	$80/$160 Copay after Ded*
Rx Tier 5 Specialty	$250 Copay	$6,000 Copay	$350 Copay after Ded
Rx Tier 6 Specialty	$250 Copay	$6,000 Copay	$350 Copay after Ded

Health Advantage is a Qualified Health Plan issuer in the Health Insurance Marketplace.

* For maintenance drugs in tiers 2-4, if you utilize our mail order program, you will receive a three-month supply of drugs for the cost of a two-month supply.

WHY AREN'T THERE MONTHLY PREMIUMS ON THIS GRID?

Our qualified health plans are age-, tobacco- and area-rated, meaning the monthly premium is based on your age, residence and tobacco usage. Also, depending on your annual income, you may qualify for financial assistance, which would lower your monthly premium. Through government financial assistance, many Arkansans will be able to get a health plan for a very low cost and maybe even free. (Note: Information in grid represents in-network benefits.)

	Silver Premier Suitcase	Bronze Suitcase	Bronze Exp Standardized
On/Off Exchange	Both	Both	Both
Includes BlueCard	Yes	Yes	No
Individual Deductible	$4,050	$9,200	$7,500
Family Deductible	$8,100	$18,400	$15,000
Individual Out-of-Pocket Max	$7,750	$9,200	$9,200
Family Out-of-Pocket Max	$15,500	$18,400	$18,400
Coinsurance	40%	0%	50%
PCP & OP Rehab/Hab Office Visits	3 @ $0, then $35 Copay	3 @ $0, then $45 Copay	$50 Copay
Specialist Office Visit (Consult/Evaluation)	$95 Copay	$100 Copay	$100 Copay
Mental Health/Substance Abuse OP Office Visit	3 @ $0, then $35 Copay	3 @ $0, then $45 Copay	$50 Copay
Medical Equipment & Supplies	Ded/50% Coins	Ded/Coins	Ded/Coins
Maternity and Family Planning	Ded/Coins	Ded/Coins	Ded/Coins
Urgent Care	$95 Copay	Ded/Coins	$75 Copay
Emergency Room	$575 Copay after Ded	Ded/Coins	Ded/Coins
Inpatient Hospital, MH/SA	$575 Copay Per Day after Ded	Ded/Coins	Ded/Coins
Outpatient Hospital & Surgical Services	Ded/Coins	Ded/Coins	Ded/Coins
High-Tech Imaging	Ded/Coins	Ded/Coins	Ded/Coins
Lab/X-RAY	Ded/Coins	Ded/Coins	Ded/Coins
Rx Tier 1 Preventive	$0	$0	$0
Rx Tier 2 Generic	$25/$50 Copay*	$30/$60 Copay*	$25/$50 Copay*
Rx Tier 3 Preferred Brand	$85/$170 Copay*	$210/$420 Copay*	$50/$100 Copay after Ded*
Rx Tier 4 Non-Preferred Brand	$1,600/$3,200 Copay*	$1,600/$3,200 Copay*	$100/$200 Copay after Ded*
Rx Tier 5 Specialty	$5,000 Copay	$5,000 Copay	$500 Copay after Ded
Rx Tier 6 Specialty	$5,000 Copay	$5,000 Copay	$500 Copay after Ded

Off-Exchange Plans: Plans only available if purchased directly from Health Advantage.

*For maintenance drugs in tiers 2-4, if you utilize our mail order program, you will receive a three-month supply of drugs for the cost of a two-month supply.

ADDITIONAL BENEFITS

Digital Tools

In our Blueprint Portal mobile app and website, you'll have 24/7 access to your digital ID card, claims and other helpful benefit information – as well as convenient tools to find doctors, estimate treatment and prescription costs, easily contact customer service and much more.

BlueCard Nationwide Coverage

Some plans include BlueCard, allowing members to save money and receive the best healthcare across the U.S. and in many places around the world.

Virtual Healthcare Resources

When you can't get to the doctor, scheduling a virtual appointment 24/7 with a doctor, therapist or pediatrician is easy.

Wellness Rewards and Discounts

Members receive healthy living rewards and enjoy discounts on a range of health and wellness products including eyeglasses, gym memberships, personal training, hotels, athletic gear, hearing aids and more.

Mental and Behavioral Health Programs

We encourage you to prioritize your whole health using our mental and behavioral resources and greater access to providers, programs and solutions.

Flexible Payment Options

Eligible members can pay for out-of-pocket medical and pharmacy expenses over time. No interest, fees or costs to sign up.

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Visit healthadvantage-hmo.com to learn more!

MAKING SENSE OF SECURITY

Coinsurance

Coinsurance is your share of the costs, usually after you've met your deductible. For example, if your plan pays 80% for a service, you would pay 20% in coinsurance. With your Health Advantage plan, when you reach your out-of-pocket max, you no longer have to pay coinsurance for covered services.

Copays

Copays are what you pay at the doctor or pharmacy. They do not count against your deductible. An example would be paying $25 at a doctor's visit or $15 for a prescription. With your Health Advantage plan, when your out-of-pocket max is met, you no longer have to pay copayments for covered services.

Essential Health Benefits*

Our plans cover the essential health benefit categories required by the healthcare law. The essential health benefit categories are: ambulatory patient services, emergency services, hospitalization, pregnancy, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and pediatric services.

Out-of-Pocket Maximum

The out-of-pocket max is the most you'll spend for covered medical services in a year. After you reach this amount, you will no longer have to pay coinsurance or deductibles. (This does not include your monthly premium.)

Primary Care Provider (PCP)

A doctor who directly provides or coordinates a range of healthcare services for a patient (also known as a family doctor, general practitioner, internal medicine doctor or pediatrician).

Qualifying Life Event

A change in your life that makes you eligible to make changes to your current plan or enroll in a health plan outside of the Open Enrollment Period. Examples include moving to a new state, losing employer coverage, marriage, divorce or birth of a child.

*Our plans do not include pediatric dental services. Pediatric dental coverage is available in the Health Insurance Marketplace and can be purchased as a stand-alone product.

Annual Limit On Cost Sharing

The maximum amount a member is required to spend in a year before the insurance company begins paying 100% of that member's covered health care expenses for the remainder of the year. The monthly premium does not count toward the annual limit on cost sharing.

- Individual Annual Limit on Cost Sharing = If there is one person on the policy, you have an individual annual limit on cost sharing.
- Family Annual Limit on Cost Sharing = If there are two or more persons on the policy, you have a family annual limit on cost sharing. There are two ways a family can meet its annual limit on cost sharing:
  1. All family members together meet the family annual limit on cost sharing. Then, Health Advantage begins paying 100% of covered services for all family members.
  2. One person in the family meets the individual annual limit on cost sharing. Then, Health Advantage begins paying 100% of that person's covered health expenses. The rest of the family, in any combination, must then meet the remainder of the family annual limit on cost sharing before Health Advantage begins paying 100% of covered services for the rest of the family.

Deductible

The amount a member must spend on medical expenses before the insurance plan begins to pay. Medical services covered by a copayment are paid by the plan even before the deductible is met. The monthly premium does not count toward the deductible.

- Individual Deductible = If there is one person on the policy, you have an individual deductible.
- Family Deductible = If there are two or more persons on the policy, you have a family deductible. There are two ways a family can meet its deductible (see example at bottom of page):
  1. All family members together meet the family deductible. Then, Health Advantage begins paying for covered services at the applicable coinsurance for all family members.
  2. One person in the family meets the individual deductible. Then, Health Advantage begins paying for covered services at the applicable coinsurance for that person. The rest of the family, in any combination, must then meet the remainder of the family deductible before Health Advantage begins paying for covered services at the applicable coinsurance for the rest of the family.

How Does a Family Deductible Work?

EXAMPLE:

A family of three (Mr. Smith, Mrs. Smith and Johnny Smith) has a plan with a $500 individual deductible and $1,000 family deductible. Mr. Smith meets the $500 individual deductible. Health Advantage begins paying for covered services at the applicable coinsurance for Mr. Smith only.

SCENARIO 1

Mrs. Smith or Johnny Smith meets the $500 individual deductible. Health Advantage begins paying for covered services at the applicable coinsurance for all family members.

SCENARIO 2

Mrs. Smith and Johnny Smith together reach the remaining $500 of the $1,000 deductible, and Health Advantage begins paying for covered services at the applicable coinsurance for all family members.

When one family member reaches his or her individual deductible, Health Advantage begins paying for covered services at the applicable coinsurance for that person. When the remaining family members reach the remaining portion of the family deductible (either individually or collectively), Health Advantage begins paying for covered services at the applicable coinsurance for all family members.

Many Arkansans may be eligible to receive a tax credit that could lower their monthly health insurance premium. Some may receive a tax credit so they will have a very low or even $0 monthly premium. Many Arkansans may be able to get free health insurance through a program called ARHOME. Many Arkansans may qualify for a Health Advantage health plan with no monthly premium. With ARHOME, you can see any Health Advantage doctor you choose, your preventive care will be covered at no cost to you and you'll receive access to the kind of high-quality healthcare for which Health Advantage has built a reputation. We can help you find out if you qualify for a free health plan from Health Advantage.

The Affordable Care Act (ACA) includes a number of special provisions for American Indians and Alaskan Natives, such as: 1) They can get services from the Indian Health Services, tribal health programs or urban Indian health programs; 2) They may receive services at no cost sharing; and 3) They may have special monthly enrollment periods.

For out-of-network coverage cost sharing increases and the balance billing (the difference between the provider's bill and the Health Advantage allowed amount) must be paid by the subscriber. Health Advantage qualified health plans have limitations and terms under which the health benefit plan may be continued or discontinued. The plans are age-rated, area-rated, and tobacco-rated, meaning premiums are based on the age, residence, and tobacco usage of the member.

Benefits and Services Not Included: Injuries or diseases caused by war; dentistry (except for some oral surgery); eye refractions, eyeglasses for adults unless needed because of accidental injury; cosmetic surgeries, unless needed because of accidental injury; services or supplies not meeting primary coverage criteria; medical or hospital services collectible under Workers Compensation or any law providing benefits for dependents of military personnel; services rendered in government hospitals; inpatient services, if they could have been performed safely and adequately on an outpatient basis; services and supplies which are experimental or investigational in nature; benefits provided under Medicare or other government programs (except Medicaid); services of social workers, unless included as part of the daily room and board allowance; radial keratotomies or epikeratophakia or any services performed to correct nearsightedness; hospital and physician services for rest cures; services by an immediate relative (spouse, parents, children, brother, sister or legal guardian); dietary supplements when used in connection with weight reduction programs. Benefits and services are not included for any treatment (surgical or nonsurgical) for weight loss. Renewal may be refused by class.

Limitations of Hospital Benefits: Health Advantage requires pre-admission approval for all non-emergent hospital admissions. For prior approval please call the toll-free number on the back of your ID card. Services rendered in a hospital outside of the United States of America will be paid at the sole discretion of the Plan.

Subrogation: If benefit payments are made for which a third party may be liable, Health Advantage is entitled to recover out of payments made by that third party to the full extent of benefits paid.

Coordination Against Group and Major Medical Coverage: Benefits for services or supplies available to you under any other group or blanket disability insurance, Union Welfare Plan, employer or employee benefit organization, self-insurance or any other non-regulated group disability benefits plan, major medical policy or no-fault automobile liability insurance will be coordinated so that the total amount of benefits payable from all these plans combined does not exceed 100% of actual medical expenses.

IMPORTANT NOTE: Your premium will be accepted after coverage has been approved. This product brochure provides a brief description of the important features of the Health Advantage qualified health benefit plans evidence of coverage. This brochure is not the evidence of coverage, and only the actual provisions will control. The evidence of coverage itself sets forth in detail the rights and obligations of both you and your health benefit plan. It is, therefore, important that you read the evidence of coverage carefully. Changes to this evidence of coverage only may be made during the annual open enrollment period or as a result of a special enrollment period.

Health Advantage
An Independent Licensee of the Blue Cross and Blue Shield Association

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 to include discrimination on the basis of sexual orientation and gender identity; sex stereotypes; sex characteristics (including intersex traits); and pregnancy or related conditions.

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

ATENCIÓN: si habla español, 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.

CHÚ Ý: Nếu bạn nói Tiếng Việt, 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.