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, contact your local Benefits Counselor or log onto the Tyson Benefits website. For general definitions of common terms, such as plan allowance, balance billing, coinsurance, copay, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary on the Tyson Benefits website or call your local Benefits Counselor to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers $1,600 TEAM Member only coverage / $3,200 family coverage; for out-of-network providers $1,600 TEAM Member only coverage / $3,200 family coverage.	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, the total amount of deductible expenses paid by all family members can meet the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive 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 copay 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?	Yes. All prescription drug claims count toward, and are combined with medical plan benefits, for purposes of meeting the overall deductible.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For network providers $6,550 individual / $13,100 family. There is no out-of-pocket limit for out-of-network providers.	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-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count towards the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. Visit the website or call the number on the back of your insurance ID card 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 (a 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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All copay 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	20% coinsurance	50% coinsurance	None
	Specialist visit	20% coinsurance	50% coinsurance	None
	Preventive care/screening/ immunization	No charge for covered services	50% 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)	20% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	Preauthorization is required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	None
	Physician/surgeon fees	20% coinsurance	50% coinsurance	Coverage includes a second opinion

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 on the Tyson Benefits website.	Generic drugs	•20% coinsurance/$10 minimum, $20 maximum (up to 30 day supply) at Tier 1 pharmacies •30% coinsurance/$20 minimum, $40 maximum (up to 30-day supply) at Tier 2 pharmacies •20% coinsurance/$20 minimum, $40 maximum (up to a 90-day supply)	After $50 deductible, 50% of network pharmacy price, plus any difference between the network pharmacy price and the non-network pharmacy price.	Copay does not apply until deductible is met. Select generic maintenance medications have $0 copay when purchased through the CVS Mail-Order Program or at a Tier 1 Retail Pharmacy. Refill limits apply for 30-day supplies of maintenance medications filled at pharmacies other than Tier 1 Retail Pharmacies,
	Preferred brand drugs	•20% coinsurance/$30 minimum, $60 maximum (up to 30 day supply) at Tier 1 pharmacies •30% coinsurance/$60 minimum, $120 maximum (up to 30-day supply) at Tier 2 pharmacies •20% coinsurance/$60 minimum, $150 maximum (up to a 90-day supply)	After $50 deductible, 50% of network pharmacy price, plus any difference between the network pharmacy price and the non-network pharmacy price.	Copay does not apply until deductible is met. If a brand-name drug is filled when a generic equivalent is available (for any reason), you pay the difference in cost of the brand-name drug plus the higher brand copay.
	Non-preferred brand drugs	•20% coinsurance/$135 minimum, $240 maximum (up to 30 day supply) at Tier 1 pharmacies •30% coinsurance/$200 minimum, $360 maximum (up to 30-day supply) at Tier 2 pharmacies •20% coinsurance/$270 minimum, $485 maximum (up to a 90-day supply)	After $50 deductible, 50% of network pharmacy price, plus any difference between the network pharmacy price and the non-network pharmacy price.	Copay does not apply until deductible is met. If a brand-name drug is filled when a generic equivalent is available (for any reason), you pay the difference in cost of the brand-name drug plus the higher brand copay.
	Specialty drugs	$75 copay	Not covered	Copay does not apply until deductible is met. Coverage is limited to a 30-day supply purchased through CVS Caremark Specialty pharmacy

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	First 2 visits: $100 copay; 3+ visits: $200 copay, then deductible and 20% coinsurance	First 2 visits: $100 copay; 3+ visits: $200 copay, then deductible and 50% coinsurance	Out-of-network emergency services may be paid at in-network rates if the condition is an emergency, but can be balance billed. Final determination will be made by the Claims Administrator.
	Emergency medical transportation	20% coinsurance	50% coinsurance	Coverage is limited to transportation to the nearest facility and excludes ambulance services when the patient could be safely transported by other means.
	Urgent care	20% coinsurance	50% coinsurance	Coinsurance applies when services are not billed as an office visit.
	Telemedicine visit	20% coinsurance	Not covered	Includes access to psychologists
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Preauthorization is required.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	Coverage includes a second opinion
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	50% coinsurance	None
	Inpatient services	20% coinsurance	50% coinsurance	Including residential treatment for substance abuse treatment. Preauthorization is required.
If you are pregnant	Office visits	20% coinsurance	50% coinsurance	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). Charges for a dependent newborn child will be separate from the mother's charges, and will apply toward the family deductible and out-of-pocket limit.
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	50% 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	50% coinsurance	Coverage is limited to when provided by a licensed home health care agency, and the patient is under the care of a physician. Limited to 60 visits/calendar year.
	Rehabilitation services	20% coinsurance	50% coinsurance	Speech therapy 30 visits/calendar year. Occupational therapy, physical therapy and chiropractic therapy limited to a combined 30 visits/calendar year. Inpatient rehabilitation services limited to 60 days/calendar year.
	Habilitation services	Not covered	Not covered	None
	Skilled Nursing Care & Long-Term/Acute Care (LTAC)	20% coinsurance	50% coinsurance	Coverage is limited to 60 days/calendar year.
	Durable medical equipment	20% coinsurance	50% coinsurance	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	Hospice services	20% coinsurance	50% coinsurance	Six (6) month limited benefit for participants with an estimated life expectancy of six (6) months or less, as attested by the physician treating the illness
If your child needs dental or eye care	Children's eye exam	$25 copay	Charges in excess of $50	Coverage limited to one exam every 12 months.
	Children's glasses	$25 copay plus charges in excess of $75 for frames	Charges in excess of: • $50 for single vision lenses; • $75 for bifocal lenses; • $100 for trifocal lenses; and • $60 for frames	Coverage limited to one pair of glasses every 24 months.
	Children's dental check-up	No charge	Any amount charged in excess of the Plan Allowance.	Limited to twice/calendar year

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
- Cosmetic Surgery
- Hearing aids
- Infertility treatment
- Long-term and Custodial care
- Routine eye care (Adult)
- Routine foot care
- Weight loss services and programs

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

- Chiropractic care – combined with occupational therapy and physical therapy, coverage is limited to 30 visits per calendar year
- Dental care (Adult)
- Non-emergency care when traveling outside the U.S. – except if for the sole purpose of obtaining medical care
- Private-duty nursing – coverage is limited to when approved through Home Health Care Plan.

Your Rights to Continue Coverage: If you lose coverage under the plan, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health care coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premiums you pay while covered under the plan. Other options to continue coverage are 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: BlueAdvantage Administrators of Arkansas at 800-452-6199.

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the 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 479-290-4000.]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 479-290-4000.]
[Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** 479-290-4000.]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 479-290-4000.]

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

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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, copays 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. Dependent newborn charges are separate.)

The plan's overall deductible	$3200
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$3,200
Copays	$0
Coinsurance	$1,920
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$5,120**

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1600
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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
Copays	$0
Coinsurance	$1,160
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,760**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The plan's overall deductible	$1600
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$1,600
Copays	$0
Coinsurance	$60
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,660**

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