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 the claims administrator at 1-800-370-5852 or visit www.blueadvantagearkansas.com. 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 https://www.healthcare.gov/sbc-glossary or call 1-800-370-5852 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network providers $3,000 individual / $6,000 family Out-of-Network providers $6,000 individual / $12,000 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, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. In-Network Preventive care.	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?	In-Network providers $4,000 individual / $8,000 family Out-of-network providers Unlimited	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 Unit out-of-pocket limit must be met, before the plan will pay Covered Charges at 100% for that Family Unit for the remainder of the Calendar Year.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover, out-of-network pharmacy copays, and prior approval penalties.	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.blueadvantagearkansas.com or call 1-800-370-5852 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).
Do you need a referral to see a specialist?	No.	You can see the specialist 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
		In-Network Provider (You will pay the least) Deductible applies unless indicated otherwise.	Out-of-Network Provider (You will pay the most) Deductible applies unless indicated otherwise.	
If you visit a health care provider's office or clinic:	Primary care visit to treat an injury or illness	**MDLIVE:** 20% coinsurance PCP: 20% coinsurance	50% coinsurance	Chiropractic care is limited to 30 visits In-Network per calendar year; Out-of-Network chiropractic care is not covered.
	Specialist visit	**MDLIVE:** 20% coinsurance Specialist: 20% coinsurance	50% coinsurance	
	Preventive care/screening/ immunization	No charge	50% coinsurance Colonoscopies: 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)	20% coinsurance	50% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	——————none——————
If you need drugs to treat your illness or condition: More information about **prescription drug coverage** is available at https://liviniti.com.	Generic drugs	20% coinsurance	$25 copay, then 20% coinsurance	Copays incurred at an Out-of-Network (Non-preferred) pharmacy will not contribute to deductible or out-of-pocket limit.
	Preferred brand drugs	20% coinsurance	$25 copay, then 20% coinsurance	
	Non-preferred brand drugs	20% coinsurance	$25 copay, then 20% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least) Deductible applies unless indicated otherwise.	Out-of-Network Provider (You will pay the most) Deductible applies unless indicated otherwise.	
	Specialty drugs	20% coinsurance	$25 copay, then 20% coinsurance	
If you have outpatient surgery:	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	——————none——————
	Physician/surgeon fees	20% coinsurance	50% coinsurance	——————none——————
If you need immediate medical attention:	Emergency room care	**True- emergency:** 20% coinsurance **Non-emergency:** 20% coinsurance	**True- emergency:** 20% coinsurance **Non-emergency:** 50% coinsurance	——————none——————
	Emergency medical transportation	20% coinsurance	20% coinsurance	Ground, water, and air ambulance limited to $2,500 per trip.
	Urgent care	**True emergency:** 20% coinsurance **Non-emergency:** 20% coinsurance	**True emergency:** 20% coinsurance **Non-emergency:** 50% coinsurance	——————none——————
If you have a hospital stay:	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	The covered person is responsible for obtaining Prior Approval for all out-of-network providers. Penalty for failure to obtain Prior Approval for an Out-of-Network admission is a 50% reduction in payable benefits.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	——————none——————

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least) Deductible applies unless indicated otherwise.	Out-of-Network Provider (You will pay the most) Deductible applies unless indicated otherwise.	
If you need mental health, behavioral health, or substance abuse services:	Outpatient services	20% coinsurance	50% coinsurance	————————none————————
	Inpatient services	20% coinsurance	50% coinsurance	The covered person is responsible for obtaining Prior Approval for all out-of-network providers. Penalty for failure to obtain Prior Approval for an Out-of-Network admission is a 50% reduction in payable benefits.
If you are pregnant:	Office visits	20% coinsurance	50% coinsurance	Routine obstetrical ultrasounds limited to one per pregnancy.
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	————————none————————
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	————————none————————
If you need help recovering or have other special health needs:	Home health care	20% coinsurance	50% coinsurance	Home health care services limited to 100 days per calendar year.
	Rehabilitation services	20% coinsurance	50% coinsurance	Cardiac rehabilitation limited to 36 outpatient visits per calendar year. Occupational, Physical, Speech, Pulmonary Rehabilitation, and Cognitive Therapies are combined and limited to 60 visits.
	Habilitation services	Not covered	Not covered	No coverage for Habilitation services.
	Skilled nursing care	20% coinsurance	50% coinsurance	Skilled Nursing limited to 60 days per calendar year.
	Durable medical equipment	20% coinsurance	50% coinsurance	————————none————————
	Hospice services	20% coinsurance	50% coinsurance	————————none————————

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least) Deductible applies unless indicated otherwise.	Out-of-Network Provider (You will pay the most) Deductible applies unless indicated otherwise.	
If your child needs dental or eye care:	Children's eye exam	**Medical eye exam:** 20% coinsurance **Routine eye exam:** No charge, under the age of six	**Medical eye exam:** 50% coinsurance **Routine eye exam:** Under the age of six, 50% coinsurance	Routine eye exam is not covered once the age of six is reached. 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	No coverage for dental check-ups under Medical Benefit Plan. 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
- Cosmetic surgery
- Dental care
- Habilitation services
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care
- Routine foot care

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

- Bariatric surgery (limited to $4,000 per calendar year)
- Chiropractic care (limited to 30 visits per calendar year)
- Infertility (limited to treatment and diagnostic testing)
- Private-duty nursing (when combined with home health care)

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 Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol.gov/ebsa/healthreform. 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: Nabholz Construction Company 612 Garland, Conway, Arkansas, 72032 or by telephone at 1-501-505-5948. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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 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 1-800-370-5852.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-370-5852.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-370-5852.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-370-5852.

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.blueadvantagearkansas.com.

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** **$3,000**
- **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	$3,000
Copayments	$0
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,060**

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

- **The plan's overall deductible** **$3,000**
- **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	$3,000
Copayments	$0
Coinsurance	$500
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$3,520**

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

- **The plan's overall deductible** **$3,000**
- **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	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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