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, www.NebraskaBlue.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 at www.cciio.cms.gov or call 1-844-201-0763 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Individual/Family In-Network: $1,500/$3,000 Out-of-Network: $3,000/$6,000	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, they have to meet their own individual deductible until the overall family deductible amount has been met.
Are there services covered before you meet your deductible?	Yes, preventive care, prescription drugs, and provider office services.	This plan covers some items and services even if you haven't yet met the annual 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: $3,000/$6,000 Out-of-Network: $6,000/$12,000	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?	Premium, balance billed charges, penalties, denial for failure to obtain preauthorization and services 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. See www.NebraskaBlue.com/find-a-doctor or call 1-844-201-0763 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 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 bill). 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.

All copayment and coinsurance costs shown in this chart are after your overall deductible has been met, if a deductible applies. Certain Common Medical Events, including prescription drugs, may require preauthorization. Failure to obtain preauthorization will result in denial of the claim.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-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	$15 copay/visit	40% coinsurance	Some office services may be subject to deductible and/or coinsurance. Preauthorization may be required.
	Specialist visit	$40 copay/visit	40% coinsurance	Some office services may be subject to deductible and/or coinsurance. Preauthorization may be required.
	Preventive care/screening/ immunization	No charge for federally mandated services.	40% coinsurance. For immunizations for children up to age 7, the deductible is waived.	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Preauthorization may be required.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	40% coinsurance	Preauthorization may be required.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Preauthorization may be required.
If you need drugs to treat your illness or condition	For all prescription drugs, out-of-pocket costs shown are per 30-day supply. If allowed by your prescription, up to a 90-day supply may be obtained at one time (except for specialty drugs) via mail order by paying 2.5 copay amounts. Certain prescription drugs may require prior certification. Failure to obtain prior certification will result in denial of the claim. Home delivery benefits are not available out-of-network. The following cost-shares apply only when obtaining drugs through a pharmacy.			
More information about prescription drug coverage is available at www.optumrx.com	Generic drugs	$10/prescription	50% coinsurance	For more information about prescription drugs, please see the plan document here.
	Preferred brand drugs	$30/prescription	50% coinsurance	
	Non-preferred brand drugs	$50/prescription	50% coinsurance	
	Specialty drugs	Same as any retail drug	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Preauthorization may be required.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Preauthorization may be required.

* For more information about limitations and exceptions, see the plan or policy document here.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-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	$200 copay/visit, then 20% coinsurance, deductible waived	Same cost shares as In-network provider	Copay waived if admitted. Preauthorization may be required.
	Emergency medical transportation	20% coinsurance	Same cost shares as In-network provider	Limitations may apply to air ambulance.
	Urgent care	$60 copay/visit	40% coinsurance	Copay applies to urgent care facilities. Some urgent care services may be subject to the deductible and coinsurance.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization may be required.
	Physician/surgeon fee	20% coinsurance	40% coinsurance	Preauthorization may be required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: No charge Other Outpatient Services: 20% coinsurance	40% coinsurance	Preauthorization may be required.
	Inpatient services	20% coinsurance	40% coinsurance	Preauthorization may be required.
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Copay may apply for visit to determine pregnancy. Cost sharing does not apply to certain preventive services. Depending on the type of services, copay, deductible and coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC. Preauthorization may be required.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	See pregnancy office visits limit. Preauthorization may be required.
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	See pregnancy office visits limit. Preauthorization may be required.

* For more information about limitations and exceptions, see the plan or policy document here.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-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	40% coinsurance	*Home health aide:* 60 days per calendar year. *Skilled nursing in the home:* Limited to 8 hours per day. *Respiratory care:* 60 days per calendar year. Preauthorization may be required.
	Rehabilitation services	Outpatient therapy: $20 copay/visit Manipulations: $20 copay/visit Other services: 20% coinsurance	Outpatient therapy: $20 copay/visit Manipulations: $20 copay/visit Other services: 40% coinsurance	*Outpatient physical, occupational, speech, physiotherapy*: Combined 60 session limit per calendar year. *Manipulations and adjustments*: Combined 30 session limit per calendar year. *Outpatient cardiac rehabilitation*: Combined 18 session limit per diagnosis. *Outpatient pulmonary rehabilitation*: Combined 18 session limit per diagnosis for certain diagnoses and criteria. Preauthorization may be required.
	Habilitation services	Outpatient therapy: $20 copay/visit Other services: 20% coinsurance	Outpatient therapy: 40% coinsurance Other services: 40% coinsurance	See the *Rehabilitation services* and *If you have a hospital stay* sections. Educational services are not covered. Preauthorization may be required.
	Skilled nursing care	20% coinsurance	40% coinsurance	*In the home:* See the Home health care section. *Skilled nursing care:* Limited to 60 days per calendar year. Preauthorization may be required.
	Durable medical equipment	20% coinsurance	40% coinsurance	Rental or purchase, whichever is least costly. Preauthorization may be required.
	Hospice services	20% coinsurance	40% coinsurance	Preauthorization may be required.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Visual acuity tests are covered under the preventive services benefit. No coverage for eye exams.

* For more information about limitations and exceptions, see the plan or policy document here.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Children's glasses	Lenses: Not covered Frames: Not covered Contacts: Not covered	Lenses: Not covered Frames: Not covered Contacts: Not covered	No coverage for glasses.
	Children's dental check-up	Preventive, Simple and Complex Restorative services: Not covered Orthodontic Services: Not covered	Preventive, Simple and Complex Restorative services: Not covered Orthodontic Services: Not covered	No coverage for dental check-up.

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.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (adults)
- Dental care (children)
- Glasses (children)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the US
- Prescription drugs
- Private-duty nursing
- Routine eye care (adults)
- Routine eye care (children)
- Weight loss programs

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

- Acupuncture
- Chiropractic care
- Hearing aids
- Routine foot care

* For more information about limitations and exceptions, see the plan or policy document here.

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: For group health coverage subject to ERISA, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; for non-federal governmental group health plans, the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov; or your employer's human resources department. 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: Blue Cross and Blue Shield of Nebraska at 1-844-201-0763 or visit www.NebraskaBlue.com, the Nebraska Department of Insurance at 1-877-564-7323 or www.doi.ne.gov, for group health coverage subject to ERISA, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, your employer's human resources or employee benefits department.

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? 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:

Para obtener asistencia en Español, llame al 1-844-201-0763.

如果需要中文的帮助，请拨打这个号码1-844-201-0763.

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-201-0763.

Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-201-0763.

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

* For more information about limitations and exceptions, see the plan or policy document here.

BlueCross BlueShield Nebraska

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	$1,500
Specialist copay	$40
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	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$80
Coinsurance	$1,400
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	$3,050

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

The plan's overall deductible	$1,500
Specialist copay	$40
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	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$4,100
The total Joe would pay is	$4,700

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

The plan's overall deductible	$1,500
Specialist copay	$40
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	$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,400
Copayments	$400
Coinsurance	$100
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	$1,910

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