Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
BlueCross and BlueShield of Nebraska: City of Omaha Police Bargaining Active, COBRA &

Coverage Period: 1/1/2019 - 12/31/2019 Coverage for: Individual/Family | Plan Type: QHDHP

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 1-888-592-8961 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Individual/Employee +1/Family In-Network: $2,700/$5,400/$5,400 Out-of-Network: $5,400/$10,800/$10,800	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.	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?	Individual/Employee +1/Family In-Network: $2,700/$5,400/$5,400 Out-of-Network: $10,800/$21,600/$21,600	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 certification 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 1-844-664-9371 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.

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	0% coinsurance	30% coinsurance	None
	Specialist visit	0% coinsurance	30% coinsurance	None
	Preventive care/screening/ immunization	No charge for federally mandated services.	Routine mammograms, colonoscopies, immunizations: 30% coinsurance, except deductible is waived on pediatric immunizations up to age 7. Employee only: No charge for first $175 then deductible and 30% coinsurance.	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.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	0% coinsurance	30% coinsurance	Prior certification may be required. Failure to obtain prior certification when required will result in denial of the claim.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.nebraskablue.com		For all prescription drugs, out-of-pocket costs shown are per 30-day supply retail, 90-day supply mail order. Certain prescription drugs may require prior certification. Failure to obtain prior certification will result in denial of the claim. Mail order benefits are not available out-of-network.		
	Generic drugs	0% coinsurance	0% coinsurance plus 50% penalty	None
	Preferred brand drugs	0% coinsurance	0% coinsurance plus 50% penalty	None
	Non-preferred brand drugs	0% coinsurance	0% coinsurance plus 50% penalty	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)	Out-of-Network Provider (You will pay the most)	
	Specialty drugs	Same as any other retail drug	Not covered	30-day supply maximum. Designated pharmacy may apply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	30% coinsurance	None
	Physician/surgeon fees	0% coinsurance	30% coinsurance	None
If you need immediate medical attention	Emergency room care	0% coinsurance	Same cost shares as in-network provider	None
	Emergency medical transportation	0% coinsurance	Same cost shares as in-network provider	Limitations may apply to air ambulance.
	Urgent care	0% coinsurance	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	30% coinsurance	Prior certification required. Failure to obtain prior certification will result in denial of the claim.
	Physician/surgeon fee	0% coinsurance	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	0% coinsurance	30% coinsurance	None
	Inpatient services	0% coinsurance	30% coinsurance	Prior certification required. Failure to obtain prior certification will result in denial of the claim.
If you are pregnant	Office visits	0% coinsurance	30% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, deductible and coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC.
	Childbirth/delivery professional services	0% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	0% coinsurance	30% 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)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	0% coinsurance	30% coinsurance	*Home health aide:* 60 days per calendar year. *Skilled nursing in the home:* Limited to 8 hours per day. Prior certification required.
	Rehabilitation services	0% coinsurance	30% coinsurance	*Outpatient physical, occupational, speech, physiotherapy and chiropractic manipulations and adjustments*: Combined 75 session limit per calendar year. *Outpatient cardiac rehabilitation*: 18 session limit per calendar year. *Outpatient pulmonary rehabilitation*: 36 session limit per per calendar year. Prior certification required. *Inpatient physical rehabilitation*: Prior certification required. Failure to obtain prior certification will result in denial of the claim.
	Habilitation services	0% coinsurance	30% coinsurance	See the *Rehabilitation services* and *If you have a hospital stay* sections. Educational services are not covered.
	Skilled nursing care	0% coinsurance	30% coinsurance	*In the home:* See the Home health care section. *Skilled nursing care:* Limited to 60 days per calendar year. Prior certification required. Failure to obtain prior certification will result in denial of the claim.
	Durable medical equipment	0% coinsurance	30% coinsurance	Rental or purchase, whichever is least costly. Prior certification may be required. Failure to obtain prior certification when required will result in denial of the claim.
	Hospice services	0% coinsurance	30% coinsurance	Prior certification required. Hospice services are limited to 180 days while covered under the plan.

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 your child needs dental or eye care	Children's eye exam	No charge	30% coinsurance	Routine eye exam including refraction limited to one per calendar year. Additional vision services may be available when medically necessary.
	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	Not covered	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.)

- Acupuncture
- Cosmetic surgery
- Dental care (adults)
- Dental care (children)
- Glasses
- Hearing aids
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine foot care
- Weight loss programs

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

- Bariatric surgery
- Chiropractic care
- Non-emergency care when traveling outside the US
- Routine eye care (adults)

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 1-888-592-8960 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.
If you don't have Minimum Essential Coverage for a month under this plan or under other coverage, 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./No.
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 1-888-592-8961.

如果需要中文的帮助，请拨打这个号码 1-888-592-8961.

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-592-8961.

Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-592-8961.

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

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	$2,700
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	$2,700
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$2,760

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

The plan' s overall deductible	$2,700
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	$2,700
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$200
The total Joe would pay is	$2,900

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

The plan's overall deductible	$2,700
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,900

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