




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](http://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](http://www.cciio.cms.gov) or call 1-888-592-8961 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$400 individual / \$800 employee + 1 / \$800 family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, they have to meet their own individual <u>deductible</u> until the overall family <u>deductible</u> amount has been met.
Are there services covered before you meet your <u>deductible</u> ?	Yes, <u>preventive care</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the annual <u>deductible</u> amount.
Are there other <u>deductibles</u> for specific services?	Yes, \$100 per person for certain <u>prescription drugs</u> . There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	Medical: \$1,000 individual / \$2,000 employee + 1 / \$2,000 family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premium</u> , <u>balance billed</u> charges, penalties, denial for failure to obtain certification, prescription drugs and services this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See <a href="http://www.nebraskablue.com/find-a-doctor">www.nebraskablue.com/find-a-doctor</a> or call 1-844-664-9371 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (a balance bill). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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 <u>provider's office</u> or clinic	Primary care visit to treat an injury or illness	20% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<u>Specialist visit</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No charge	Routine mammograms/ colonoscopies: 30% <u>coinsurance</u> No charge for first \$200 then deductible and 30% <u>coinsurance</u> , except deductible is waived on pediatric immunizations for children up to age 7.	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Prior certification</u> may be required. Failure to obtain <u>prior certification</u> when required will result in denial of the <u>claim</u> .
If you need drugs to treat your illness or condition		For all <u>prescription drugs</u> , out-of-pocket costs shown are per 30-day supply retail, 90-day supply mail order. Certain <u>prescription drugs</u> may require <u>prior certification</u> . Failure to obtain <u>prior certification</u> will result in denial of the <u>claim</u> . Mail order benefits are not available <u>out-of-network</u> .		
	Generic drugs	Retail: \$5/prescription Mail Order: \$10/prescription	Retail: Deductible and 50% penalty	None
	Preferred brand drugs	Retail and Mail Order: 20% <u>coinsurance</u> . Once <u>deductible</u> and out-of-pocket reached - Retail: \$5/prescription, Mail Order: \$10/prescription, remainder of year	Retail: Deductible and 50% penalty	In-network: Retail: \$20 minimum / \$40 maximum per prescription Mail Order: \$40 minimum / \$80 maximum per prescription
More information about <u>prescription drug coverage</u> is available at <a href="http://www.nebraskablue.com">www.nebraskablue.com</a>				

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)	
	Non-preferred brand drugs	Same as Preferred	Retail: Deductible and 50% penalty	In-network: Retail: \$30 minimum / \$60 maximum per prescription Mail Order: \$60 minimum / \$120 maximum per prescription
	<u>Specialty drugs</u>	Generic: \$3.33/prescription Preferred: 20% coinsurance Non-preferred: 20% coinsurance	Not covered	30-day supply maximum. Designated pharmacy may apply. Preferred minimum \$13.33 / maximum \$26.67; Non-Preferred minimum \$20 / maximum \$40, per prescription
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u>	Same cost shares as <u>in-network provider</u>	None
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	Same cost shares as <u>in-network provider</u>	Limitations may apply to air ambulance.
	<u>Urgent care</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Prior certification</u> required. Failure to obtain <u>prior certification</u> will result in denial of the <u>claim</u> .
	Physician/surgeon fee	20% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Inpatient services	20% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Prior certification</u> required. Failure to obtain <u>prior certification</u> will result in denial of the <u>claim</u> .
If you are pregnant	Office visits	20% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Depending on the type of services, <u>deductible</u> and <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	30% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	30% <u>coinsurance</u>	

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	<u>Home health care</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Home health aide</u> : 60 days per calendar year. <u>Skilled nursing in the home</u> : Limited to 8 hours per day. <u>Prior certification</u> required.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Outpatient physical, occupational, speech, physiotherapy and chiropractic manipulations and adjustments</u> : Combined 60 session limit per calendar year. <u>Outpatient cardiac rehabilitation</u> : 18 session limit per calendar year. <u>Outpatient pulmonary rehabilitation</u> : 36 session limit per calendar year. <u>Prior certification</u> required. <u>Inpatient physical rehabilitation</u> : <u>Prior certification</u> required. Failure to obtain <u>prior certification</u> will result in denial of the <u>claim</u> .
	<u>Habilitation services</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	See the <u>Rehabilitation services</u> and <u>If you have a hospital stay</u> sections. Educational services are not covered.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>In the home</u> : See the <u>Home health care</u> section. <u>Skilled nursing care</u> : Limited to 60 days per calendar year. <u>Prior certification</u> required. Failure to obtain <u>prior certification</u> will result in denial of the <u>claim</u> .
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	Rental or purchase, whichever is least costly. <u>Prior certification</u> may be required. Failure to obtain <u>prior certification</u> when required will result in denial of the <u>claim</u> .
	<u>Hospice services</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	<u>Prior certification</u> required. <u>Hospice services</u> 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	Not covered	Eye exam including refraction.  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](http://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](http://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](http://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](http://www.nebraskablue.com), the Nebraska Department of Insurance at 1-877-564-7323 or [www.doi.ne.gov](http://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](http://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.

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, kwijigo holne' 1-888-592-8961.

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

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 \$400
- 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
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u> *	\$600
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$600
<u>What isn't covered</u>	
<u>Limits or exclusions</u>	\$60
The total Peg would pay is	\$1,260

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

- The plan's overall deductible \$400
- 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
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u> *	\$400
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$900
<u>What isn't covered</u>	
<u>Limits or exclusions</u>	\$200
The total Joe would pay is	\$1,700

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

- The plan's overall deductible \$400
- 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
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$400
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$300
<u>What isn't covered</u>	
<u>Limits or exclusions</u>	\$0
The total Mia would pay is	\$700

\*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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