
 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, <https://coc.nebraskablue.com/406IID6W6>. 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:
<p>What is the overall deductible?</p>	<p>The employer self-funds a portion of the deductible under the major medical plan insured by Blue Cross Blue Shield of Nebraska, so your actual in-network deductible becomes \$500 per individual for a calendar year, and \$1,000 for a family per calendar year.</p>	<p>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, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.</p>
<p>Are there services covered before you meet your deductible?</p>	<p>Yes. See the primary SBC of the insured group health plan.</p>	<p>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/.</p>
<p>Are there other deductibles for specific services?</p>	<p>Yes. See the primary SBC of the insured group health plan.</p>	<p>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.</p>
<p>What is the out-of-pocket limit for this plan?</p>	<p>The employer self-funds a portion of the out of pocket maximum under the major medical plan insured by Blue Cross Blue Shield of Nebraska so your actual out of pocket maximum for in-network claims becomes \$3,700 per individual for a calendar year, and \$7,400 for a family per calendar year.</p>	<p>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.</p>
<p>What is not included in the out-of-pocket limit?</p>	<p>Premiums, balance-billing charges, penalties, denial for failure to obtain certification and services this plan doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p>

<p>Will you pay less if you use a network provider?</p>	<p>Yes. See www.nebraskablue.com/find-a-doctor or call 1-888-592-8961 for a list of network providers.</p>	<p>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). 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.</p>
<p>Do you need a referral to see a specialist?</p>	<p>No.</p>	<p>You can see the specialist you choose without a referral.</p>

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 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
		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	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.
	Specialist visit	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.
	Preventive care/screening/immunization	No charge for federally mandated services.	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.
If you have a test	Diagnostic test (x-ray, blood work)	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.
	Imaging (CT/PET scans, MRIs)	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.nebraskablue.com	Generic drugs	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.
	Preferred brand drugs	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	
	Non-preferred brand drugs	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	
	Specialty drugs	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	None
	Physician/surgeon fees	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	None
If you need immediate medical attention	Emergency room care	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.
	Emergency medical transportation	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	
	Urgent care	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	

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 have a hospital stay	Facility fee (e.g., hospital room)	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.
	Physician/surgeon fees	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.
	Inpatient services	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	
If you are pregnant	Office visits	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.
	Childbirth/delivery professional services	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	
	Childbirth/delivery facility services	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	
If you need help recovering or have other special health needs	Home health care	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.
	Rehabilitation services	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.
	Habilitation services	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.
	Skilled nursing care	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.
	Durable medical equipment	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.
	Hospice services	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	See the primary SBC of the insured group health plan.
	Children's glasses	Not covered	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](#).)

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|---|--|--|
| <ul style="list-style-type: none">• Acupuncture• Bariatric surgery• Cosmetic surgery• Dental care (adults) | <ul style="list-style-type: none">• Dental care (children)• Glasses (children)• Hearing aids• Infertility treatment | <ul style="list-style-type: none">• Long-term care• Private-duty nursing• Routine foot care• Weight loss programs |
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

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|---|--|---|
| <ul style="list-style-type: none">• Chiropractic care | <ul style="list-style-type: none">• Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none">• Routine eye care (adults) |
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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: Blue Cross Blue Shield of Nebraska at 1-888-592-8960 or visit www.nebraskablue.com; 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, 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, 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 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 [319-752-3200].]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [319-752-3200].]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 [319-752-3200].]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' [319-752-3200].]

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

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](#) \$500
- [Specialist copayment](#) \$75
- [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:

Cost Sharing	
Deductibles	\$500
Copayments	\$200
Coinsurance	\$2,140
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$2,900

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

- The [plan's](#) overall [deductible](#) \$500
- [Specialist copayment](#) \$75
- [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:

Cost Sharing	
Deductibles*	\$300
Copayments	\$2,400
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](#) \$500
- [Specialist copayment](#) \$75
- [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:

Cost Sharing	
Deductibles*	\$500
Copayments	\$300
Coinsurance	\$120
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$920

The amounts shown in the maternity [claim](#) example above are based on amounts using a single per person [deductible](#). Some [plans](#) may actually apply a two-person or family [deductible](#) to maternity services for the mother and newborn baby.

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.