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<br>In-Network: $4,000/$8,000<br>Out-of-Network: $6,000/$12,000 | 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. | 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: $4,000/$8,000<br>Out-of-Network: $10,000/$20,000 | 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 | 0% coinsurance | 40% coinsurance | Preauthorization may be required. |
| | Specialist visit | 0% coinsurance | 40% coinsurance | Preauthorization may be required. |
| | Preventive care/screening/ immunization | No charge for federally mandated services. | No charge. | 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) | 0% coinsurance | 40% coinsurance | Preauthorization may be required. |
| | Imaging (CT/PET scans, MRIs) | 0% coinsurance | 40% coinsurance | Preauthorization may be required. |
| If you need drugs to treat your illness or condition<br><br>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. If allowed by your prescription, up to a 90-day supply may be obtained at one time (except for specialty drugs). Home delivery benefits are not available out-of-network. The following cost-shares apply only when obtaining drugs through a pharmacy. | | |
| | Generic drugs | 0% coinsurance | 40% coinsurance | Preauthorization may be required. |
| | Preferred brand drugs | 0% coinsurance | 40% coinsurance | Preauthorization may be required. |
| | Non-preferred brand drugs | 0% coinsurance | 40% coinsurance | Preauthorization may be required. |

* For more information about limitations and exceptions, see the plan or policy document at [www.insert.com].

| 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 | 0% coinsurance | Not covered | Retail and home delivery: 30-day supply maximum. Designated pharmacy may apply. Preauthorization may be required. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 0% coinsurance | 40% coinsurance | Preauthorization may be required. |
| | Physician/surgeon fees | 0% coinsurance | 40% coinsurance | Preauthorization may be required. |
| 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 | 40% coinsurance | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 0% coinsurance | 40% coinsurance | Preauthorization may be required. |
| | Physician/surgeon fee | 0% coinsurance | 40% coinsurance | Preauthorization may be required. |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | 0% coinsurance | Office Visit: Same cost shares as In-network provider<br>Other Outpatient Services: Same cost shares as In-network provider | Preauthorization may be required. |
| | Inpatient services | 0% coinsurance | 40% coinsurance | Preauthorization may be required. |
| If you are pregnant | Office visits | 0% coinsurance | 40% 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. Preauthorization may be required. |
| | Childbirth/delivery professional services | 0% 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 at [www.insert.com].

| 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) | |
| | Childbirth/delivery facility services | 0% coinsurance | 40% coinsurance | See pregnancy office visits limit. Preauthorization may be required. |
| If you need help recovering or have other special health needs | Home health care | 0% coinsurance | 40% coinsurance | *Home health care:* 100 visits per calendar year.: Limited to 4 hours per visit, up to 3 visits per day. Preauthorization may be required. |
| | Rehabilitation services | Outpatient therapy: 0% coinsurance Manipulations: 0% coinsurance Other services: 0% coinsurance | Outpatient therapy: 40% coinsurance Manipulations: 40% coinsurance Other services: 40% coinsurance | No limit for *Outpatient physical, occupational, speech, physiotherapy* or Outpatient Cardiac or Pulmonary rehabilitation. No limit for *Manipulations and adjustments*. *Inpatient physical rehabilitation* and *Skilled Nursing Facility*: Combined limit of 100 days per Calendar Year. Preauthorization may be required. |
| | Habilitation services | Outpatient therapy: 0% coinsurance Other services: 0% 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 | 0% coinsurance | 40% coinsurance | *In the home:* See the Home health care section. *Skilled nursing care:* Limited to 100 days per calendar year. Preauthorization may be required. |
| | Durable medical equipment | 0% coinsurance | 40% coinsurance | Rental or purchase, whichever is least costly. Preauthorization may be required. |
| | Hospice services | 0% coinsurance | 40% coinsurance | Preauthorization may be required. |
| If your child needs dental or eye care | Children's eye exam | No charge | No charge | Visual acuity tests are covered under the preventive services benefit. Additional vision services may be available when medically necessary. Preauthorization may be required. |

* For more information about limitations and exceptions, see the plan or policy document at [www.insert.com].

| 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:<br>Not covered<br>Frames:<br>Not covered<br>Contacts:<br>Not covered | Lenses:<br>Not covered<br>Frames:<br>Not covered<br>Contacts:<br>Not covered | No coverage for glasses. |
| | Children's dental check-up | Preventive, Simple and Complex Restorative services:<br>Not covered<br>Orthodontic Services:<br>Not covered | Preventive, Simple and Complex Restorative services:<br>Not covered<br>Orthodontic Services:<br>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)
- Non-emergency care when traveling outside the US
- Long-term care
- 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
- Infertility treatment
- Private-duty nursing
- Routine eye care (adults)
- Routine foot care

* For more information about limitations and exceptions, see the plan or policy document at [www.insert.com].

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? 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 1-844-201-0763.

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 at [www.insert.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 | $4,000 |
| 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 | $12,700 |

In this example, Peg would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $4,000 |
| Copayments | $0 |
| Coinsurance | $0 |
| *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 | $4,000 |
| 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 | $5,600 |

In this example, Joe would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $4,000 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $70 |
| The total Joe would pay is | $4,070 |

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

| | |
|---|---|
| The plan's overall deductible | $4,000 |
| 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 | $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 the EXAMPLE covered services.