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.ccio.cms.gov or call 1-888-592-8961 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why this Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>Individual/Family In-Network: $450/$900 Out-of-Network: $650/$1,300</td>
<td>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.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes, preventive care and prescription drugs.</td>
<td>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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>In-Network: $2,050/$4,100 Out-of-Network: $2,650/$5,300</td>
<td>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.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Deductible, premium, balance billed charges, penalties, denial for failure to obtain certification and services this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="http://www.nebraskablue.com/find-a-doctor">www.nebraskablue.com/find-a-doctor</a> or call 1-888-592-8961 for a list of network providers.</td>
<td>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.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>
### Common Medical Event

#### Services You May Need

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>In-Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>30% coinsurance</td>
<td>45% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>30% coinsurance</td>
<td>45% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge for federally mandated services.</td>
<td>No charge. For immunizations for children up to age 7.</td>
<td>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.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>30% coinsurance</td>
<td>45% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>30% coinsurance</td>
<td>45% coinsurance</td>
<td>Prior certification may be required. Failure to obtain prior certification when required will result in denial of the claim.</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>Not covered</td>
<td>Not covered</td>
<td>No coverage for prescription drugs.</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>Not covered</td>
<td>Not covered</td>
<td>No coverage for prescription drugs.</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>Not covered</td>
<td>Not covered</td>
<td>No coverage for prescription drugs.</td>
</tr>
<tr>
<td>More information about prescription drug coverage is available at <a href="http://www.nebraska-blue.com">www.nebraska-blue.com</a></td>
<td>Specialty drugs</td>
<td>Not covered</td>
<td>Not covered</td>
<td>No coverage for prescription drugs.</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>30% coinsurance</td>
<td>45% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>30% coinsurance</td>
<td>45% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
<td></td>
</tr>
<tr>
<td>----------------------</td>
<td>----------------------------------------</td>
<td>--------------------------------------------------------</td>
<td>--------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay)</td>
<td></td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>30% coinsurance</td>
<td>Same cost shares as in-network provider</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>30% coinsurance</td>
<td>Same cost shares as in-network provider</td>
<td>Limitations may apply to air ambulance.</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>30% coinsurance</td>
<td>45% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>30% coinsurance</td>
<td>45% coinsurance</td>
<td>Prior certification required. Failure to obtain prior certification will result in denial of the claim.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>30% coinsurance</td>
<td>45% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>30% coinsurance</td>
<td>45% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>30% coinsurance</td>
<td>45% coinsurance</td>
<td>Prior certification required. Failure to obtain prior certification will result in denial of the claim.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>30% coinsurance</td>
<td>45% coinsurance</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>30% coinsurance</td>
<td>45% coinsurance</td>
<td>See pregnancy office visits limit.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>30% coinsurance</td>
<td>45% coinsurance</td>
<td>See pregnancy office visits limit.</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>30% coinsurance</td>
<td>45% coinsurance</td>
<td>Skilled nursing in the home: Prior certification required.</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay)</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>---------------------------------------------</td>
<td>----------------------------------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>Outpatient therapy, including manipulations: 30% coinsurance Other services: 30% coinsurance</td>
<td>Outpatient therapy, including manipulations: 45% coinsurance Other services: 45% coinsurance</td>
<td>Outpatient physical, occupational, speech, physiotherapy and chiropractic manipulations and adjustments: Combined 60 session limit per calendar year. Outpatient cardiac rehabilitation: Combined 18 session limit per diagnosis. Outpatient pulmonary rehabilitation: Combined 36 session limit per diagnosis for certain diagnoses and criteria. Prior certification required. Inpatient physical rehabilitation: Prior certification required. Failure to obtain prior certification will result in denial of the claim.</td>
<td></td>
</tr>
<tr>
<td>Habilitation services</td>
<td>30% coinsurance</td>
<td>45% coinsurance</td>
<td>See the Rehabilitation services and If you have a hospital stay sections. Educational services are not covered.</td>
<td></td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>30% coinsurance</td>
<td>45% coinsurance</td>
<td>In the home: See the Home health care section. Skilled nursing care: Limited to 30 days per calendar year. Prior certification required. Failure to obtain prior certification will result in denial of the claim.</td>
<td></td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>30% coinsurance</td>
<td>45% coinsurance</td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>Hospice services</td>
<td>30% coinsurance</td>
<td>45% coinsurance</td>
<td>Prior certification required.</td>
<td></td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's eye exam</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Visual acuity tests are covered under the preventive services benefit. No coverage for eye exams.</td>
</tr>
</tbody>
</table>
### Common Medical Event | Services You May Need | What You Will Pay | Limitations, Exceptions, & Other Important Information
--- | --- | --- | ---
**Children's glasses** | **In-Network Provider (You will pay the least)** | Lenses: Not covered Frames: Not covered Contacts: Not covered | Lenses: Not covered Frames: Not covered Contacts: Not covered
| **Out-of-Network Provider (You will pay** | | | No coverage for glasses.

### 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
- Bariatric surgery
- Cosmetic surgery
- Dental care (adults)
- Dental care (children)
- Glasses (children)
- Hearing aids
- Infertility treatment
- Long-term care
- Prescription drugs
- Private-duty nursing
- Routine eye care (adults)
- Routine eye care (children)
- 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.)**

- Chiropractic care
- Non-emergency care when traveling outside the US
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.
Kung kailangan ninyo ang tulungan sa Tagalog tumawag sa 1-888-592-8961.
如果需要中文的帮助，请拨打这个号码 1-888-592-8961.
Dinek’ehgo shika at’ohwol ninisingo, kwijjigo 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: $450
- Specialist coinsurance: 30%
- Hospital (facility) coinsurance: 30%
- Other coinsurance: 30%

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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$600</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,600</td>
</tr>
<tr>
<td>What isn't covered</td>
<td>$80</td>
</tr>
</tbody>
</table>

The total Peg would pay is **$2,280**

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

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

- The plan’s overall deductible: $450
- Specialist coinsurance: 30%
- Hospital (facility) coinsurance: 30%
- Other coinsurance: 30%

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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$450</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$200</td>
</tr>
<tr>
<td>What isn't covered</td>
<td>$6,200</td>
</tr>
</tbody>
</table>

The total Joe would pay is **$6,850**

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

- The plan’s overall deductible: $450
- Specialist coinsurance: 30%
- Hospital (facility) coinsurance: 30%
- Other coinsurance: 30%

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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$450</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$400</td>
</tr>
<tr>
<td>What isn't covered</td>
<td>$80</td>
</tr>
</tbody>
</table>

The total Mia would pay is **$850**

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

Discrimination is Against the Law

Blue Cross and Blue Shield of Nebraska (BCBSNE) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. BCBSNE does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

BCBSNE:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Customer Service at (800) 991-5840.

If you believe that BCBSNE has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Manager, Corporate Compliance, P.O. Box 3248, Omaha, NE 68103-0001, Toll Free (800) 991-5840, Fax 402-392-4130, civilrights@nebraskahealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Manager, Corporate Compliance is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 530H, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)


ATTENTION: This notice may have important information about your application or coverage. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or get help with costs. If you or someone you’re helping has questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-800-991-5840.

*This notice is translated as federally required.

Arabic

تنبيه: قد يتضمن هذا الإشعار معلومات مهمة عن كيفية تقديم طلب yêuمن أو استفسار في هذه القضية. قد يلزمك تنفيذ إجراء قبل المواعيد المتباعدة المحددة للحقيقة على التغطية الصحيحة أو الحصول على مساعدة بشأن التكلفة. إذا كنت تتطلب أو أحد من مساعدات لديك، فكل الحق في الحصول على مساعدة والخدمات بتغطية تكلفة. للتحدث مع أحد المترجمين الفوريين، اتصل برقم 1-800-991-5840.

Chinese Traditional

注意：本通知可能含有與您的申請或保單有關的重要資訊。在本通知中尋找重要的日期，您可能需要在某個截止日期前採取行動，以保持您的健康保險或獲得費用方面的幫助。如果您或您正幫助的人有疑問，您有權利以您的語言免費獲得提供的幫助與資訊。致電口譯員，請撥打1-800-991-5840。

German


Spanish (Mexico)

ATENCION: Este aviso puede contener información importante sobre su solicitud o cobertura. Ponga atención a las fechas clave en este aviso. Puede ser que usted necesite realizar algunas acciones para determinadas fechas y así mantener su cobertura de salud o para obtener ayuda con los costos. Si usted o alguien a quien usted ayuda tiene alguna pregunta, tiene el derecho de recibir información y ayuda en su propio idioma sin costo. Para hablar con un intérprete, llame al 1-800-991-5840.

50-101 (02-02-17)