

 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/BCB0J984>. 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 1-844-201-0763 to request a copy.

Important Questions	Answers	Why This Matters:
<p><b>What is the overall <a href="#">deductible</a>?</b></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 <b>\$500</b> per individual for a calendar year, and <b>\$1,000</b> for a family per calendar year.</p>	<p>Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a>, each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a>.</p>
<p><b>Are there services covered before you meet your <a href="#">deductible</a>?</b></p>	<p>Yes. See the primary SBC of the insured group health plan.</p>	<p>This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a>. See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</p>
<p><b>Are there other <a href="#">deductibles</a> for specific services?</b></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 <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.</p>
<p><b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b></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 in-network out of pocket maximum becomes <b>\$3,700</b> per individual for a calendar year, and <b>\$7,400</b> for a family per calendar year.</p>	<p>The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a>, they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.</p>
<p><b>What is not included in the <a href="#">out-of-pocket limit</a>?</b></p>	<p><a href="#">Premiums</a>, <a href="#">balance billed charges</a>, penalties, denial for failure to obtain certification, and health</p>	<p>Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a>.</p>

	care this <a href="#">plan</a> doesn't cover.	
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://www.nebraskablue.com/find-a-doctor">www.nebraskablue.com/find-a-doctor</a> or call 1-844-201-0763 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146  
Released on April 6, 2016



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies. This is a summary of your enhanced benefits after your primary plan processes the claim. Your [copayment](#) and [coinsurance](#) remains the same as the primary plan unless otherwise noted.

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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	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.
	<a href="#">Specialist</a> 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.
	<a href="#">Preventive care/screening/immunization</a>	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.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (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.	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="#">nebraskablue.com</a> .	Tier 1	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.
	Tier 2	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	
	Tier 3	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	
	<a href="#">Specialty drugs</a>	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	
<b>If you have outpatient surgery</b>	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.	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.	See the primary SBC of the insured group health plan.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	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.
	<a href="#">Emergency medical transportation</a>	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	
	<a href="#">Urgent care</a>	See the primary SBC of the insured group health plan.	See the primary SBC of the insured group health plan.	
<b>If you have a hospital stay</b>	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.	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)	
		insured group health plan.	insured group health plan.	group health plan.
<b>If you need mental health, behavioral health, or substance abuse services</b>	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.	
<b>If you are pregnant</b>	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.	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	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.
	<a href="#">Rehabilitation services</a>	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.
	<a href="#">Habilitation services</a>	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.
	<a href="#">Skilled nursing care</a>	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.
	<a href="#">Durable medical equipment</a>	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.
	<a href="#">Hospice services</a>	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.
<b>If your child needs dental or eye care</b>	Children's eye exam	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.
	Children's glasses	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.
	Children's dental check-up	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.

### 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](#).)**

- See the primary insured group health plan

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

- See the primary insured group health plan

**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 and Blue Shield of Nebraska at 1-844-201-0763 or visit [www.nebraskablue.com](http://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](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 1-844-201-0763 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?** **No.** This plan combined with your primary insurance plan does provide Minimum Essential Coverage. 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?** **No.** This plan combined with your primary insurance plan does provide Minimum Value Standards. 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
- PCP [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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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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
<b>The total Peg would pay is</b>	<b>\$2,900</b>

**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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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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
<b>The total Joe would pay is</b>	<b>\$2,900</b>

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

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

<b>Total Example Cost</b>	<b>\$1,900</b>
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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
<b>The total Mia would pay is</b>	<b>\$920</b>

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.