Summary of Benefits

Lancaster County – D and Y
$600 Deductible Plan

Effective Date: January 1, 2015

	In-network Provider	Out-of-network Provider
Deductible (the amount the Covered Person pays each Calendar Year for Covered Services before benefits are payable		
• Individual	$600	$1,200
• Family (Embedded)[1]	$1,200	$2,400
Coinsurance (the percentage amount the Covered Person must pay for most Covered Services after the Deductible has been met)		
• Covered Person pays	20%	40%
Out-of-pocket Limit[2] (does not include premium, penalty and amounts not covered by the plan)[3]		
• Individual	$1,800	$3,200
• Family	$3,600	$6,400
Physician Office		
• Primary Care Physician (including quick care clinics) Office Services	$20 Copay per visit	Deductible and Coinsurance
• Specialist Physician Office Services	$20 Copay per visit	Deductible and Coinsurance
Preventive Services		
• Affordable Care Act (ACA) required Preventive Services (may be subject to limits that include, but are not limited to age, gender, and frequency)	Plan Pays 100%	Deductible and Coinsurance
• ACA required covered Preventive Services (outside of limits)	Plan Pays 100%	Deductible and Coinsurance
• Other covered Preventive Services not required by ACA	Plan Pays 100%	Deductible and Coinsurance
Immunizations		
• Pediatric (up to age 7)	Plan Pays 100%	Coinsurance
• Age 7 and older	Plan Pays 100%	Deductible and Coinsurance
Urgent Care Facility (a single Copay applies to each urgent care visit)	$40 Copay per visit	Deductible and Coinsurance
Emergency Room Services (Services received in a hospital emergency room setting) Copay waived if admitted to the hospital within 24 hours for the same diagnosis	$150 Copay per visit, then subject to In-network Deductible and Coinsurance	
Inpatient and Outpatient Hospital Facility Services	Deductible and Coinsurance	Deductible and Coinsurance

Chart continues on reverse side

Prescription Drugs	In-network Provider	Out-of-network Provider
Pharmacy Out of Pocket Maximum $3,000 Individual $6000 Family (Mandatory Generic)		
Retail – per 30-day supply • Generic (including non-formulary contraceptives) • Formulary brand name • Non-formulary brand name	$5 min $25 max 25% coinsurance $25 min $50 max 25% coinsurance $50 min $75 max 50% coinsurance	$5 min $25 max 25% coinsurance + 25% penalty $25 min $50 max 25% coinsurance + 25% penalty $50 min $75 max 50% coinsurance + 25% penalty
Mail order – per 90-day supply • Generic (including non-formulary contraceptives) • Formulary brand name • Non-formulary brand name	2 times retail 2 times retail 2 times retail	No benefits No benefits No benefits
Specialty drugs (specialty drugs must be purchased through a designated specialty pharmacy after two fills)	$75 min $100 max 25% coinsurance	$75 min $100 max 25% coinsurance

NOTES

[1]Embedded – if you have single coverage, you only need to satisfy the individual Deductible and Out-of-pocket Limit amounts. If you have family coverage, no one family member contributes more than the individual amount. Family members may combine their covered expenses to satisfy the required family Deductible and Out-of-pocket Limit amounts.

[2]Out of Pocket limit includes the medical deductible, medical co-insurance and medical co-pays.

[3]Once the annual Out-of-pocket Limit is reached, most covered Services are payable by the plan at 100% for the rest of the Calendar Year.

This document is a brief overview of the Copay, Deductible and Coinsurance amounts under the plan. It is a general overview only. It does not provide all the details of the coverage provided by the plan, including benefits, exclusions and limitations. In the event there are discrepancies between this document and the Summary Plan Description (SPD), the terms and conditions of the SPD will govern. For more complete information, refer to your SPD.

Blue Cross and Blue Shield of Nebraska (BCBSNE) provides claim administration services only and assumes no financial risk or responsibility for claims as provided in the Administrative Services Agreement between BCBSNE and the plan.