Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual/Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.nebraskablue.com or by calling 1-888-592-8961.

Important Questions	Answers	Why this Matters:
What is the overall **deductible**?	In-network: **$600** individual / **$1,200** family Out-of-network: **$1,200** individual / **$2,400** family Does not apply to most preventive care or prescription drugs. Copayments and coinsurance don't count toward the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 3 for how much you pay for covered services after you meet the **deductible**.
Are there other **deductibles** for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 3 for other costs for services this plan covers.
Is there an **out-of-pocket limit** on my expenses?	Yes. Medical: In-network: **$2,600** individual / **$5,200** family Out-of-network: **$4,400** individual / **$8,800** family Prescription Drugs: **$3,000** individual/**$6,000** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.

Questions: Call 1-888-592-8961 or visit us at www.nebraskablue.com If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at http://www.cms.gov/CCIIO/Resources/Files/Downloads/uniform-glossary-final.pdf or call 1-888-592-8961 to request a copy.

This document contains only a partial description of the benefits, limitations, exclusions and other provisions of this health care plan. It is not a policy. It is a general overview only. It does not provide all the details of this coverage, including benefits, exclusions and policy limitations. In the event there are discrepancies between this document and the policy, the terms and conditions of the policy will govern.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146 Released on April 23, 2013 (corrected).

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Important Questions	Answers	Why this Matters:
What is not included in the **out-of-pocket limit**?	None of the following are included: penalties, premiums, balance-billed charges, and services this plan doesn't cover.	Even though you pay these expenses, they do not count toward the **out-of-pocket limit.**
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 3 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a **network** of **providers**?	Yes. For a list of in-network **providers**, see www.nebraskablue.com or call 1-888-592-8961	If you use an in-network doctor or other health care **provider,** this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred,** or participating for **providers** in their **network.** See the chart starting on page 3 for how this plan pays different kinds of **providers.**
Do I need a referral to see a **specialist**?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 9. See your policy or plan document for information about **excluded services**.

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- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible.**
- The amount the plan pays for covered services is based on the **allowed amount.** If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit	40% coinsurance	Some office services are subject to the deductible and coinsurance.
	Specialist visit	$20 copay/visit	40% coinsurance	Allergy injections and serum: $20 copay/visit. Benefits will vary based on the network provider type.
	Other practitioner office visit	Convenient care clinic: $20 copay/visit Chiropractic office visit: $20 copay/visit Manipulations: $20 copay/visit	Convenient care clinic: 40% coinsurance Chiropractic office visit: 40% coinsurance Manipulations: 40% coinsurance	Some office services are subject to the deductible and coinsurance. Limitations on chiropractic services may apply. See Rehabilitation Services. Acupuncture is not covered.
	Preventive care/screening/immunization	No charge for federally mandated preventive services.	40% coinsurance For immunizations for children up to age 7, the deductible is waived.	Age, gender and frequency limits may apply to some preventive services. Services other than those which are federally mandated may be subject to other cost share amounts.

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Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	Benefits will vary based on the place of service and provider type.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Prior certification may apply.
If you need drugs to treat your illness or condition				For all prescription drugs, out-of-pocket costs shown are per 30-day supply retail and 90-day supply mail order. If allowed by your prescription, up to a 90-day supply may be obtained at one time (except for specialty drugs) by paying 3 copay amounts. Certain prescription drugs may require prior authorization. Mail order benefits are not available out of network.
	Generic drugs	Retail and Mail Order: 25% coinsurance	Retail: 25% coinsurance plus 25% penalty	Retail: (per 30- day supply)$5 minimum / $25 maximum per prescription: Mail Order: (per 90-day supply) $10 minimum / $50 maximum per prescription.
	Formulary brand drugs	Retail and Mail Order: 25% coinsurance	Retail: 25% coinsurance plus 25% penalty	Retail: (per 30- day supply)$25 minimum / $50 maximum per prescription: Mail Order: (per 90-day supply) $50 minimum / $100 maximum per prescription.

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Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
More information about **prescription drug coverage** is available at www.nebraskablue.com.	Non-formulary brand drugs	Retail and Mail Order: 50% coinsurance	Retail: 50% coinsurance plus 25% penalty	Retail: (per 30- day supply)$50 minimum / $75 maximum per prescription: Mail Order: (per 90-day supply) $100 minimum / $150 maximum per prescription.
	Specialty drugs	Retail and Mail Order: 25% coinsurance	Not Covered	$75 minimum / $100 maximum per prescription Retail and mail order: 30-day supply maximum. Designated pharmacy may apply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	---------- none ----------
	Physician/surgeon fees	20% coinsurance	40% coinsurance	---------- none ----------
If you need immediate medical attention	Emergency room services	$150 copay/visit, then deductible and 20% coinsurance	Same as in-network level of benefits	Copay waived if admitted.
	Emergency medical transportation	20% coinsurance	Same as in-network level of benefits	Limitations may apply to air ambulance.
	Urgent care	$40 copay/visit	40% coinsurance	Copay applies to urgent care facilities. Some urgent care services are subject to deductible and coinsurance.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Prior certification required.
	Physician/surgeon fee	20% coinsurance	40% coinsurance	---------- none ----------

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Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/behavioral health outpatient services	$20 copay/office visit Other outpatient services: 20% coinsurance	40% coinsurance	Some office services are subject to the deductible and coinsurance.
	Mental/behavioral health inpatient services	20% coinsurance	40% coinsurance	Prior certification required.
	Substance use disorder outpatient services	$20 copay/office visit Other outpatient services: 20% coinsurance	40% coinsurance	Some office services are subject to the deductible and coinsurance.
	Substance use disorder inpatient services	20% coinsurance	40% coinsurance	Prior certification required.
If you are pregnant	Prenatal and postnatal care	20% coinsurance	40% coinsurance	---------- none ----------
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	---------- none ----------
	Home health care	20% coinsurance	40% coinsurance	*Home health aide and Skilled nursing in the home:* Limited to 60 days per calendar year. (Prior certification required for skilled nursing in the home) *Respiratory care:* Limited to 60 days per calendar year.

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Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Rehabilitation services	20% coinsurance	40% coinsurance	*Outpatient physical, occupational, speech, physiotherapy and chiropractic or osteopathic manipulations and adjustments:* INN $20 Copay/OON Deductible/Coinsurance. Combined 75 session limit per calendar year. *Outpatient cardiac rehabilitation:* Combined 18 session limit per diagnosis for certain cardiac diagnoses. *Outpatient pulmonary rehabilitation:* Combined 18 session limit per calendar year. Prior certification required. *Inpatient physical rehabilitation:* Must follow within 90 days of discharge from acute hospitalization. Prior certification required.
	Habilitation services	20% coinsurance	40% coinsurance	See the *Rehabilitation services* and *If you have a hospital stay* sections. Educational services are not covered. Additional limitations and exclusions may apply.
	Skilled nursing care	20% coinsurance	40% coinsurance	*In the home:* See the *Home health care* section. *Skilled nursing facility stay:* Limited to 60 days per calendar year. Prior certification required.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
	Durable medical equipment	20% coinsurance	40% coinsurance	Rental or purchase, whichever is least costly. Rental shall not exceed the cost of purchasing. Prior certification is required for subsequent purchases of durable medical equipment.
	Hospice service	20% coinsurance	40% coinsurance	Prior certification required.
If your child needs dental or eye care	Eye exam	$20 copay/visit	40% coinsurance	Visual acuity tests are covered under the preventive services benefit. Eye exam limited to 1 per 24 months.
	Glasses	Lenses: Not covered Frames: Not covered Contacts: Not covered	Lenses: Not covered Frames: Not covered Contacts: Not covered	No coverage for glasses.
	Dental check-up	Preventive, Simple and Complex Restorative services: Not covered	Preventive, Simple and Complex Restorative services: Not covered	No coverage for dental check-up.

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (adults)
- Dental care (children)
- Glasses
- Hearing aids
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Non-emergency care when traveling outside the US
- Routine eye care (adults)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.
For more information on your rights to continue coverage, contact your employer's human resources or employee benefits department. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

- Blue Cross and Blue Shield of Nebraska at 1-888-592-8961 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.
- Your employer's human resources or employee benefits department.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actual value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Para obtener asistencia en Español, llame al 1-888-592-8961.

Kung kailangan ninyo ang tulong 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, kwiijigo 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:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby

(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan Pays:** $4,940
- **Patient Pays:** $2,600

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventative	$40
Total	**$7,540**

Patient Pays:

Deductibles	$1,200
Copays	$0
Coinsurance	$1,200
Limits or exclusions	$200
Total	**$2,600**

Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan Pays:** $3,800
- **Patient Pays:** $1,600

Sample Care Costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory Tests	$100
Vaccines, other preventative	$100
Total	**$5,400**

Patient Pays:

Deductibles	$600
Copays	$100
Coinsurance	$900
Limits or exclusions	$0
Total	**$1,600**

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

No. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

Yes. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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