



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/PNPJUU0S>. 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 1-844-201-1514 to request a copy. This plan does not cover services from out-of-network providers, except in an emergency situation or as otherwise required by law. To find your full plan benefit information or in-network providers, please visit [myNebraskaBlue.com](http://myNebraskaBlue.com).

| Important Questions  | Answers   | Why this Matters:   |
|--|---|---|
| <b>What is the overall deductible?</b>                             | Individual/Family<br>In-Network: \$1,500/\$3,000<br>Out-of-Network: Not Covered   | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, they have to meet their own individual <u>deductible</u> until the overall family <u>deductible</u> amount has been met.   |
| <b>Are there services covered before you meet your deductible?</b> | Yes, <u>preventive care</u> , some <u>prescription drugs</u> , and <u>provider</u> office services.   | This <u>plan</u> covers some items and services even if you haven't yet met the annual <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> . |
| <b>Are there other deductibles for specific services?</b>          | No.   | You don't have to meet <u>deductibles</u> for specific services.  |
| <b>What is the out-of-pocket limit for this plan?</b>              | In-Network: \$7,500/\$15,000<br>Out-of-Network: Not Covered   | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.   |
| <b>What is not included in the out-of-pocket limit?</b>            | <u>Premium</u> , <u>balance billed</u> charges, penalties, denial for failure to obtain certification and services this <u>plan</u> doesn't cover.                  | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .  |
| <b>Will you pay less if you use a network provider?</b>            | Yes. See <a href="http://www.NebraskaBlue.com/find-a-doctor">www.NebraskaBlue.com/find-a-doctor</a> or call 1-844-201-1514 for a list of <u>network providers</u> . | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . Within the state of Nebraska, this <u>plan</u> has no <u>out-of-network</u> coverage. Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.   |
| <b>Do you need a referral to see a specialist?</b>                 | No.   | You can see the <u>specialist</u> you choose without a <u>referral</u> .  |

 All copayment and coinsurance costs shown in this chart are after your overall deductible has been met, if a deductible applies.

| Common Medical Event  | Services You May Need                            | What You Will Pay   |   | Limitations, Exceptions, & Other Important Information  |
|---|--|---|---|---|
|   |  | In-Network Provider<br>(You will pay the least)   | Out-of-Network Provider<br>(You will pay the most)  |   |
| <b>If you visit a health care provider's office or clinic</b> | Primary care visit to treat an injury or illness | \$0 <u>copay</u> /visit   | Not covered   | Some office services may be subject to <u>deductible</u> and/or <u>coinsurance</u> .  |
|   | <u>Specialist</u> visit                          | 30% <u>coinsurance</u>  | Not covered   | None  |
|   | <u>Preventive care/screening/immunization</u>    | No charge for federally mandated services.  | Not covered except as required by law. For immunizations for children up to age 7, the <u>deductible</u> is waived. | You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for. |
| <b>If you have a test</b>                                     | <u>Diagnostic test</u> (x-ray, blood work)       | 30% <u>coinsurance</u>  | Not covered   | None  |
|   | Imaging (CT/PET scans, MRIs)                     | 30% <u>coinsurance</u>  | Not covered   | <u>Prior certification</u> may be required. Failure to obtain <u>prior certification</u> when required will result in denial of the <u>claim</u> .                                      |
| <b>If you need drugs to treat your illness or condition</b>   |  | For all <u>prescription drugs</u> , 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 <u>specialty drugs</u> ) by paying 3 <u>copay</u> amounts. Certain <u>prescription drugs</u> may require <u>prior certification</u> . Failure to obtain <u>prior certification</u> will result in denial of the <u>claim</u> . Home delivery benefits are not available <u>out-of-network</u> . The following cost-shares apply only when obtaining drugs through a pharmacy. |   |   |
|   | Generic drugs                                    | Tier 1: \$3/prescription, <u>deductible</u> waived<br>Tier 2: \$10/prescription, <u>deductible</u> waived   | Tier 1: Not covered<br>Tier 2: Not covered  | None  |
|   | Preferred brand drugs                            | Tier 3: \$100/prescription, <u>deductible</u> waived  | Tier 3: Not covered   | None  |

\* For more information about limitations and exceptions, see the plan or policy document at <https://coc.NebraskaBlue.com/PNPJJU0S>

| Common Medical Event   | Services You May Need                          | What You Will Pay  |  | Limitations, Exceptions, & Other Important Information   |
|--|--|--|--|--|
|  |  | In-Network Provider<br>(You will pay the least)                                    | Out-of-Network Provider<br>(You will pay the most) |  |
| More information about <a href="http://www.nebraskablue.com">prescription drug coverage</a> is available at <a href="http://www.nebraskablue.com">www.nebraskablue.com</a> | Non-preferred brand drugs                      | Tier 4: 55% <u>coinsurance</u>   | Tier 4: Not covered                                | None   |
|  | <u>Specialty drugs</u>                         | Tier 5: 60% <u>coinsurance</u><br>Tier 6: 70% <u>coinsurance</u>                   | Tier 5: Not covered<br>Tier 6: Not covered         | Retail and home delivery: 30-day supply maximum. Designated pharmacy may apply.  |
| <b>If you have outpatient surgery</b>  | Facility fee (e.g., ambulatory surgery center) | 30% <u>coinsurance</u>   | Not covered  | None   |
|  | Physician/surgeon fees                         | 30% <u>coinsurance</u>   | Not covered  | None   |
| <b>If you need immediate medical attention</b>   | <u>Emergency room care</u>                     | 30% <u>coinsurance</u>   | Same cost shares as <u>in-network provider</u>     | None   |
|  | <u>Emergency medical transportation</u>        | 30% <u>coinsurance</u>   | Same cost shares as <u>in-network provider</u>     | Limitations may apply to air ambulance.  |
|  | <u>Urgent care</u>                             | \$50 <u>copay/visit</u>  | Not covered  | <u>Copay</u> applies to <u>urgent care</u> facilities. Some <u>urgent care</u> services may be subject to the <u>deductible</u> and <u>coinsurance</u> . |
| <b>If you have a hospital stay</b>   | Facility fee (e.g., hospital room)             | 30% <u>coinsurance</u>   | Not covered  | <u>Prior certification</u> required. Failure to obtain <u>prior certification</u> will result in denial of the <u>claim</u> .                            |
|  | Physician/surgeon fee                          | 30% <u>coinsurance</u>   | Not covered  | None   |
| <b>If you need mental health, behavioral health, or substance abuse services</b>   | Outpatient services                            | Office Visit:<br>No charge<br>Other Outpatient Services:<br>30% <u>coinsurance</u> | Not covered  | None   |
|  | Inpatient services                             | 30% <u>coinsurance</u>   | Not covered  | <u>Prior certification</u> required. Failure to obtain <u>prior certification</u> will result in denial of the <u>claim</u> .                            |

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| Common Medical Event  | Services You May Need                     | What You Will Pay  |  | Limitations, Exceptions, & Other Important Information   |
|---|---|--|--|--|
|   |   | In-Network Provider<br>(You will pay the least)  | Out-of-Network Provider<br>(You will pay the most) |  |
| <b>If you are pregnant</b>  | Office visits                             | 30% <u>coinsurance</u>   | Not covered  | <u>Copay</u> may apply for visit to determine pregnancy. <u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Depending on the type of services, <u>copay</u> , <u>deductible</u> and <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC.  |
|   | Childbirth/delivery professional services | 30% <u>coinsurance</u>   | Not covered  | See pregnancy office visits limit.   |
|   | Childbirth/delivery facility services     | 30% <u>coinsurance</u>   | Not covered  | See pregnancy office visits limit.   |
| <b>If you need help recovering or have other special health needs</b> | <u>Home health care</u>                   | 30% <u>coinsurance</u>   | Not covered  | <u>Home health aide</u> : 60 days per calendar year. <u>Skilled nursing in the home</u> : Limited to 8 hours per day. <u>Prior certification</u> required. <u>Respiratory care</u> :   |
|   | <u>Rehabilitation services</u>            | Outpatient therapy:<br>30% <u>coinsurance</u><br>Manipulations:<br>30% <u>coinsurance</u><br>Other services:<br>30% <u>coinsurance</u> | Not covered  | <u>Outpatient physical, occupational, speech, physiotherapy</u> : Combined 45 session limit per calendar year.<br><u>Manipulations and adjustments</u> : Combined 20 session limit per calendar year.<br><u>Outpatient pulmonary rehabilitation</u> : Combined 18 session limit per diagnosis for certain diagnoses and criteria. <u>Prior certification</u> required.<br><u>Inpatient physical rehabilitation</u> : <u>Prior certification</u> required. Failure to obtain <u>prior certification</u> will result in denial of the <u>claim</u> . |
|   | <u>Habilitation services</u>              | 30% <u>coinsurance</u>   | Not covered  | <u>Outpatient physical, occupational, speech, physiotherapy</u> : Combined 45 session limit per calendar year. Educational services are not covered.   |

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| Common Medical Event                          | Services You May Need            | What You Will Pay   |  | Limitations, Exceptions, & Other Important Information   |
|---|----------------------------------|---|--|--|
|   |                                  | In-Network Provider<br>(You will pay the least)   | Out-of-Network Provider<br>(You will pay the most)                           |  |
|   | <u>Skilled nursing care</u>      | 30% <u>coinsurance</u>  | Not covered  | <i>In the home:</i> See the <u>Home health care</u> section. <u>Skilled nursing care</u> : Limited to 60 days per calendar year. <u>Prior certification</u> required. Failure to obtain <u>prior certification</u> will result in denial of the <u>claim</u> .   |
|   | <u>Durable medical equipment</u> | 30% <u>coinsurance</u>  | Not covered  | Rental or purchase, whichever is least costly. <u>Prior certification</u> may be required. Failure to obtain <u>prior certification</u> when required will result in denial of the <u>claim</u> .  |
|   | <u>Hospice services</u>          | 30% <u>coinsurance</u>  | Not covered  | <u>Prior certification</u> required.   |
| <b>If your child needs dental or eye care</b> | Children's eye exam              | 30% <u>coinsurance</u>  | Not covered  | Visual acuity tests are covered under the <u>preventive services</u> benefit. Eye exam limited to 1 per calendar year. Pediatric vision services are limited to covered persons up to age 19. Certain vision services may require <u>prior certification</u> . Additional vision services may be available when <u>medically necessary</u> .   |
|   | Children's glasses               | Lenses:<br>50% <u>coinsurance</u><br>Frames:<br>50% <u>coinsurance</u><br>Contacts:<br>50% <u>coinsurance</u> | Lenses:<br>Not covered<br>Frames:<br>Not covered<br>Contacts:<br>Not covered | <u>Pediatric vision</u> : Limited to covered persons up to age 19. <u>Frames and eyeglass lenses</u> : Limited to one set per calendar year. <u>Contact lenses (in lieu of eyeglasses)</u> : Limited to one purchase per calendar year. Certain vision services may require <u>prior certification</u> . Additional vision services may be available when <u>medically necessary</u> . |
|   | Children's dental check-up       | <u>Preventive, Simple and Complex Restorative services</u> :<br>30% <u>coinsurance</u>                        | Not covered  | <u>Pediatric dental services</u> : Limited to covered persons up to age 19. Age and frequency limits apply to some pediatric dental services. Certain dental services may require <u>prior certification</u> .   |

\* For more information about limitations and exceptions, see the plan or policy document at <https://coc.NebraskaBlue.com/PNPJJU0S>

**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)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the US
- Private-duty nursing
- Routine eye care (adults)
- Routine foot care
- Weight loss programs

This plan does not cover services from out-of-network providers, except in an emergency situation or as otherwise required by law.

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

- Chiropractic care
- Hearing aids

**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: Nebraska Department of Insurance at 1-877-564-7323 or [www.doi.ne.gov](http://www.doi.ne.gov). 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 1-844-201-1514 or visit [www.NebraskaBlue.com](http://www.NebraskaBlue.com) or the Nebraska Department of Insurance at 1-877-564-7323 or [www.doi.ne.gov](http://www.doi.ne.gov).

**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, kwiiijigo 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 <https://coc.NebraskaBlue.com/PNPJJU0S>

## 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 **\$1,500**
- 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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

**In this example, Peg would pay:**

| <u>Cost Sharing</u>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$1,500        |
| <u>Copayments</u>                 | \$10           |
| <u>Coinsurance</u>                | \$3,200        |
| <u>What isn't covered</u>         |                |
| Limits or <u>exclusions</u>       | \$60           |
| <b>The total Peg would pay is</b> | <b>\$4,770</b> |

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible **\$1,500**
- 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

**In this example, Joe would pay:**

| <u>Cost Sharing</u>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$600          |
| <u>Copayments</u>                 | \$800          |
| <u>Coinsurance</u>                | \$0            |
| <u>What isn't covered</u>         |                |
| Limits or <u>exclusions</u>       | \$70           |
| <b>The total Joe would pay is</b> | <b>\$1,470</b> |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The plan's overall deductible **\$1,500**
- 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

**In this example, Mia would pay:**

| <u>Cost Sharing</u>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$1,500        |
| <u>Copayments</u>                 | \$0            |
| <u>Coinsurance</u>                | \$400          |
| <u>What isn't covered</u>         |                |
| Limits or <u>exclusions</u>       | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,900</b> |

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