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/4O6ID6W6. 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 or call 1-888-592-8961 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Individual/Family In-Network: $4,000/$8,000 Out-of-Network: $9,000/$18,000	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.
Are there services covered before you meet your deductible?	Yes, preventive care and provider office services.	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 https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes, $100 individual / $200 family for certain prescription drugs. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	In-Network: $6,500/$13,000 Out-of-Network: $11,900/$23,800	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.
What is not included in the out-of-pocket limit?	Premium, balance billed charges, penalties, denial for failure to obtain certification and services this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.nebraskablue.com/find-a-doctor or call 1-888-592-8961 for a list of network providers.	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.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/visit	50% coinsurance	Some office services may be subject to deductible and/or coinsurance.
	Specialist visit	$75 copay/visit	50% coinsurance	Some office services may be subject to deductible and/or coinsurance.
	Preventive care/screening/ immunization	No charge for federally mandated services.	50% coinsurance. For immunizations for children up to age 7, the deductible is waived.	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.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	Prior certification may be required. Failure to obtain prior certification when required will result in denial of the claim.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.nebraskablue.com		For all prescription drugs, 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 specialty drugs) by paying 3 copay amounts. Certain prescription drugs may require prior certification. Failure to obtain prior certification will result in denial of the claim. Mail order benefits are not available out-of-network.		
	Generic drugs	$10/prescription	$10/prescription plus 25% penalty	None
	Preferred brand drugs	$40/prescription	$40/prescription plus 25% penalty	None
	Non-preferred brand drugs	$75/prescription	$75/prescription plus 25% penalty	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Specialty drugs	$100/prescription	Not covered	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	50% coinsurance	None
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	$250 copay/visit, then 20% coinsurance, deductible waived	Same cost shares as in-network provider	Copay waived if admitted.
	Emergency medical transportation	$100 copay per transport	Same cost shares as in-network provider	Limitations may apply to air ambulance.
	Urgent care	$45 copay/visit	50% coinsurance	Copay applies to urgent care facilities. Some urgent care services may be subject to the deductible and coinsurance.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Prior certification required. Failure to obtain prior certification will result in denial of the claim.
	Physician/surgeon fee	20% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	50% coinsurance	None
	Inpatient services	20% coinsurance	50% coinsurance	Prior certification required. Failure to obtain prior certification will result in denial of the claim.
If you are pregnant	Office visits	20% coinsurance	50% coinsurance	Copay may apply for visit to determine pregnancy. Cost sharing does not apply to certain preventive services. Depending on the type of services, copay, deductible and coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	See pregnancy office visits limit.
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	See pregnancy office visits limit.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	*Home health aide:* 60 days per calendar year. *Skilled nursing in the home:* Limited to 8 hours per day. Prior certification required. *Respiratory care:* 60 days per calendar year.
	Rehabilitation services	Outpatient therapy: 20% coinsurance Manipulations: 20% coinsurance Other services: 20% coinsurance	Outpatient therapy: 50% coinsurance Manipulations: 50% coinsurance Other services: 50% coinsurance	*Outpatient physical, occupational, speech, physiotherapy*: Combined 60 session limit per calendar year. *Manipulations and adjustments*: Combined 30 session limit per calendar year. *Outpatient cardiac rehabilitation*: Combined 18 session limit per diagnosis. *Outpatient pulmonary rehabilitation*: Combined 18 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.
	Habilitation services	20% coinsurance	50% coinsurance	See the *Rehabilitation services* and *If you have a hospital stay* sections. Educational services are not covered.
	Skilled nursing care	20% coinsurance	50% coinsurance	*In the home:* See the Home health care section. *Skilled nursing care:* Limited to 60 days per calendar year. Prior certification required. Failure to obtain prior certification will result in denial of the claim.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Durable medical equipment	20% coinsurance	50% coinsurance	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.
	Hospice services	20% coinsurance	50% coinsurance	Prior certification required.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Visual acuity tests are covered under the preventive services 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 prior certification. Additional vision services may be available when medically necessary.
	Children's glasses	Lenses: Not covered Frames: Not covered Contacts: Not covered	Lenses: Not covered Frames: Not covered Contacts: Not covered	No coverage for glasses.
	Children's dental check-up	Not covered	Not covered	No coverage for dental check-up.

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
- Private-duty nursing
- 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
- Routine eye care (adults)

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 1-888-592-8960 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; 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.
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.

如果需要中文的帮助，请拨打这个号码 1-888-592-8961.

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 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.

BlueCross BlueShield Nebraska

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	$4,000
Specialist copay	$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)*

Total Example Cost	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles *	$4,200
Copayments	$200
Coinsurance	$1,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$5,960

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

The plan's overall deductible	$4,000
Specialist copay	$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)*

Total Example Cost	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles *	$300
Copayments	$2,400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$200
The total Joe would pay is	$2,900

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

The plan's overall deductible	$4,000
Specialist copay	$75
Hospital (facility) coinsurance	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)*

Total Example Cost	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$600
Copayments	$300
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,000

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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

Federally Required Notices

Discriminationis 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 becauseof 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 servicesor 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 68180-0001, Toll Free (800) 991-5840, Fax 402-392-4130, civilrights@nebraskablue.com. You can filea grievance in person or by mail, fax. or email. If you need help filing a grievance, our Manager, Corporate Complianceis available to helpyou.

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 phoneat:

U.S. Department of Health and Human Services
200 1nd ependence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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 تطبيقك أو تأمينك. ابحث عن التواريخ الرئيسية في هذا الإشعار. قد يلزمك اتخاذ إجراء قبل المواعيد النهائية المحددة للحفاظ على التأمين الصحي أو للحصول على مساعدة بشأن التكاليف. إذا كنت أنت أو أحد من تساعدهم لديكم أسئلة، فلك الحق في الحصول على مساعدة ومعلومات بلغتك وبدون تكلفة. للتحدث مع أحد المترجمين الفوريين، اتصل برقم 1-800-991-5840

Chinese Traditional

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German

Achtung: Diese M it teilu ng kann wichtige lnformationen uber lhren Antrag oder die Versicherungsde ckung beinhalten. Beachten Sie wichtige Fristen in dieser Mitt eilung. Sie mu ssen unt er Umstiinden Ma nahmen innerhalb bestimmter Frist en ergreifen, um lhren Krankenversicherungsschutz zu erhalt en oder eine Kosten erstatt ung zu erhalt en. Wenn Sie oder jemand, dem Sie h elfe n, Fragen hat, konnen Sie kost enlos Hilfe und lnformationen in lhrer Sprache erhalt en. Um mit einem Dolmet scher zu sp rechen, rufen Sie bi tt e 1 -80 0 -99 1 -58 40 an.

Spanish (M exico}

ATENCION: Este aviso puede contener informacion importante sobre su solicitu d o cobert ura. Ponga at encion a las fechas clave en este aviso. Puede ser que usted necesite realizar algunas acciones para determinadas fechas y asi mantene r su cobertura de salud o para obtener ayuda con los costos. Si usted o algui en a qui en usted ayuda tiene alguna pregunta, tiene el derecho de recibir info rmacion y ayuda en su propio idioma sin costo. Para hablar con un interprete, llame al 1 -800-991-5840 .

Farsi

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French (Europe)

ATI ENTION: Cet avis peut contenir des informations import antes concernant votre demande ou votre garantie. Pretez attention aux dates d es indiquees. Il vous faudra peut-etre prendre des mesure s avant une certaine date pour pouvoir conserver vot re assurance - sant e ou beneficier d'aides au paiement. Si vous ou une personne que vous aidez avez des questio ns, vous pouvez obte nir gratuitement de !'assist ance et des information s dans votre langue. Pour parler a u n i nte r pr e te , appelez le 1-800-991-5840.

Japanese

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Oromo

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Russian

BHIIIM AHIIIE! 8 AaHHOM yBeAOMll eHHHMO)f(eT COAep)f(aTb Cll Ba)f(Hall HH<j>OpMa4 1-111 O eawei-i 3al1BKe H/1"1 CTpaxoe Ke . 8 HeM TaK)f(e yKa3aHbl K/lIOYeBble AaTbl. BaM MO)f(eT noTpe6oeaTbCll Bbln O/IHHTb HeKOTOpble AeHCTBHll K onpeAe/le HHOMYcpoKy AJlll coxpaHeHHll eawei-iMeAHL\HHCKOH CTpaXOBKH H/1"1 nO/l'y'leHHll noMOW,H B on11aTepaCXOAOB. EC11Hy sac H/1"1y Ye/lO BeKa, KOTOpOMY Bbl noMoraer e, B03HHKHYT eonpOCbl , Bbl HMee r e np aeo nO/l 'y'IHTb nOMOW,b H HH<j>OpMal\ HIO Ha CBOeM ll3b1Ke 6ecn 11aTHO. lJTT 6 bl noroeopHTb C n epe BOAYHKOM, n03BOHHTe n o HOMepy 1-800-991-5840 .

Vietnamese

CHU Y: Thong bao nay c6 th chll'a tho g in quan tr9ng ve don dang ky ho c b o hi m cua qu¥ v j. Tim nhO,ng ngay chinh trong thong bao nay. Quy vj c6 the can hanh d9ng trU'6'c m9t so thai hc:in de duy tri bao hiem sl!'c kh6e cua minh ho c dU'Q'C giup do c6 tinh phi. Neu quy Vi ho c ngU'ai quy Vi da ng giu p do , c6 th ac mac , quy Vi c6 quyen lay thong tin Va dU'Q'C trQ' giup bang ngon ngO, cua minh mien phi. E) n6i chuy n v&i m¢t thong dich vien, g9i so 1-800-991-5840.