

The Summary of Benefits 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 services. NOTE: Information about the cost of this plan (the premium) will be provided separately. This is only a summary. For information about your coverage or to get a copy of complete terms of coverage, visit [www.NebraskaBlue.com](http://www.NebraskaBlue.com). For general definitions of common terms, such as allowed amount, balance billing, copay, deductible, provider, underlined terms see the Glossary. You can view the Glossary at [io.cms.gov](http://io.cms.gov) or call 1-844-201-0763 to request a copy.

All copayment and coinsurance costs shown in this table are for a year when your overall deductible has been met, if a deductible applies. Certain Common Medical Events, including prescription drugs, may require preauthorization. Failure to obtain preauthorization will result in denial of a claim.

| Common Medical Event                                   | Services You May Receive                      | What You Will Pay                      |                     |   | Limitations, Exceptions, & Other Important Information |
|--|---|--|---------------------|---|--|
|  |   | Enhanced Tier (You will pay the least) | In-Network Provider | 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 injury or illness |  |                     |   |  |
|  |   |  |                     |   |  |

| Common Event                             | Services You May Need              | What You Will Pay                      |                     |   | Limitations, Exclusions & Other Important Information  |
|--|------------------------------------|--|---------------------|---|--|
|  |                                    | Enhanced Tier (You will pay the least) | In-Network Provider | Out-of-Network Provider (You will pay the most) |  |
|  | Physician/surgeon fees             | 15% coinsurance                        | 30% coinsurance     | 45% coinsurance                                 | Preauthorization may be required.  |
| and immediate attention                  | Emergency room care                | 15% coinsurance                        | 30% coinsurance     | Same cost shares as In-network provider         | None   |
|  | Emergency medical transportation   | 15% coinsurance                        | 30% coinsurance     | Same cost shares as In-network provider         | Limitations may apply to air ambulance.  |
|  | Urgent care                        | 15% coinsurance                        | 30% coinsurance     | Same cost shares as In-network provider         | None   |
| in a hospital                            | Facility fee (e.g., hospital room) | 15% coinsurance                        | 30% coinsurance     | 45% coinsurance                                 | Preauthorization may be required.  |
|  | Physician/surgeon fees             | 15% coinsurance                        | 30% coinsurance     | 45% coinsurance                                 | Preauthorization may be required.  |
| and mental behavioral substance services | Outpatient services                | 15% coinsurance                        | 30% coinsurance     | 45% coinsurance                                 | Preauthorization may be required.  |
|  | Inpatient services                 | 15% coinsurance                        | 30% coinsurance     | 45% coinsurance                                 | Preauthorization may be required.  |
| pregnant                                 | Office visits                      | 15% coinsurance                        | 30% coinsurance     | 45% coinsurance                                 | Cost sharing does not apply to certain preventive services. Depending on the type of services, |



| Common Medical Event | Services You May Not Receive | What You Will Pay   |   |   | Limitations, Exclusions & Other Important Information |
|----------------------|------------------------------|---|---|---|---|
|                      |                              | Enhanced Tier (You will pay the least)  | In-Network Provider   | Out-of-Network Provider (You will pay the most)   |   |
|                      | Children's glasses           | Lenses: Not covered<br>Frames: Not covered<br>Contacts: Not covered                                   | Lenses: Not covered<br>Frames: Not covered<br>Contacts: Not covered                                   | Lenses: Not covered<br>Frames: Not covered<br>Contacts: Not covered                                   | No coverage for glasses.                              |
|                      | Children's dental check-up   | Preventive, Simple and Complex Restorative services: Not covered<br>Orthodontic Services: Not covered | Preventive, Simple and Complex Restorative services: Not covered<br>Orthodontic Services: Not covered | Preventive, Simple and Complex Restorative services: Not covered<br>Orthodontic Services: Not covered | No coverage for dental check-up.                      |

**Excluded Services & Not 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)
- Long-term care
- Private-duty nursing
- Routine eye care (adults)
- Routine eye care (children)
- Routine foot care
- Weight loss programs

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

- Chiropractic care
- Hearing aids (To age 19)
- Infertility treatment
- Non-emergency care while traveling outside the US

**Your Rights to Continue Coverage** There are agencies that can help if you want to continue your coverage after it ends. For group health coverage subject to ERISA, the Department of Labor's Employee Benefits Security Administration at 1-866-484-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) for non-federal governmental group health coverage. For more information about your rights, contact information for those agencies, or 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 or claim for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, explanation of benefits you will receive for that claim. Your plan documents also provide complete information to submit an appeal, or a grievance for any reason. For more information about this notice, or assistance, contact: Blue Cross and Blue Shield of Nebraska at 1-844-201-0763 or visit [NebraskaBlue.com](http://NebraskaBlue.com), the Nebraska Department of Insurance at 1-877-564-7323 or [doi.ne.gov](http://doi.ne.gov) for group health coverage subject to ERISA, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) for your employer's human resources or employee benefits department.

**Does this plan provide Minimum Essential Coverage?**

**Yes.** Minimum Essential Coverage generally includes health insurance available through the marketplace, 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 a 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 premium tax credit help you pay for a plan through the Marketplace.

**Language Access Services:**

Para obtener información en español, llame al 1-844-201-0763 o visite [NebraskaBlue.com](http://NebraskaBlue.com). Para obtener información en español, llame al 1-844-201-0763 o visite [NebraskaBlue.com](http://NebraskaBlue.com).

----- To see examples of how this plan might cover costs for a sample medical situation, see the next page. -----



