

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 age or to get a copy of the complete terms of coverage, see [NebraskaBlue.com](#). For general definitions of common terms, such as allowed amount, balance billing, grace, copayment, deductible, provider, other underlined terms see the Glossary. You can view the Glossary at [iio.cms.gov](#) or call 1-844-201-0763 to request a copy.

Important Questions	Answers	Why this Matters:
<p>What is the overall <u>deductible</u>?</p>	<p>Individual/Family Enhanced In-Network: \$3,200/\$6,400 In-Network: \$3,200/\$6,400 Out-of-Network: \$6,400/\$12,800</p>	<p>Generally, you must pay all of the costs <u>services</u> up to the <u>deductible</u> amount before this plan begins to pay. If you have <u>other family</u> members on the policy, they have to meet their own individual <u>deductible</u> until the <u>family deductible</u> amount has been met.</p>
<p>Are there services covered before you meet your <u>deductible</u>?</p>		



All copayment and coinsurance costs shown in this table are based on the assumption that your overall deductible has been met, if a deductible applies. Certain Common Medical Events, including prescription drug services, require preauthorization. Failure to obtain preauthorization will result in denial of a claim.

Common Medical Event	Services You May Need	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 an injury or illness	0% coinsurance	20% coinsurance	30% coinsurance	Preauthorization may be required.
	Specialist visit	0% coinsurance	20% coinsurance	30% coinsurance	Preauthorization may be required.
	Preventive care/screening immunization	No charge for federally mandated services.	No charge for federally mandated services.	30% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what you will pay for. Preauthorization may be required.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	20% coinsurance	30% coinsurance	Preauthorization may be required.
	Imaging (CT/PET scan, MRIs)	0% coinsurance	20% coinsurance	30% coinsurance	Preauthorization may be required.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.myempirxhealth.com	Generic drugs	Deductible, 20% Coinsurance		You must pay 100% of the prescription drug price and submit a claim form for reimbursement of any covered expense	
	Preferred brand drugs				
	Non-preferred brand drugs				
	Specialty drugs	Contact the EmpiRx Health Specialty pharmacy at www.myempirxhealth.com 833-419-3436 for specialty drug information	Not Covered	Specialty drugs must be obtained through the EmpiRx Health Specialty Pharmacy	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	20% coinsurance	30% coinsurance	Preauthorization may be required.

Common Medical 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)	
	Childbirth/delivery facility services	0% <u>coinsurance</u>	20% <u>coinsurance</u>	30% <u>coinsurance</u>	See pregnancy office visits <u>limit</u> . <u>Preauthorization</u> may be required.

If you need help recovering or have



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 Frames: Not covered Contacts: Not covered	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	Preventive, Simple and Complex Restorative services: Not covered Orthodontic Services: Not covered	Preventive, Simple and Complex Restorative services: Not covered Orthodontic Services: Not covered	Preventive, Simple and Complex Restorative services: Not covered Orthodontic Services: Not covered	No coverage for dental check-up.

Excluded Services & Not Covered Services: [TJ 06/24/2024 09:43:10] TD 0569 (Type: 915) .041 .773 .836 rg 309.52 T2.68 1.5

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 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 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 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, the Nebraska Department of Insurance at 1-877-564-7323 or doi.ne.gov for group health coverage subject to ERISA, the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform for your employer's human resources or employee benefits department.

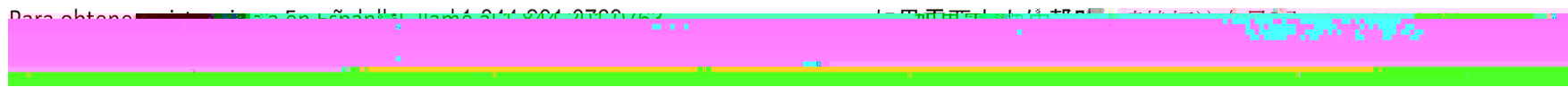
Does this plan provide Minimum Essential Coverage?

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:



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

About these Coverage Examples:

The <u>plan's overall deductible</u>	\$3,200
<u>Specialist coinsurance</u>	0%
Hospital (facility) <u>coinsurance</u>	0%
Other <u>coinsurance</u>	0%

This EXAMPLE event includes services like:

- Specialist office visits (maternal care)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services