The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan 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, www.NebraskaBlue.com. 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 1-844-201-0763 to request a copy.

Important Questions	Answers	Why this Matters:
Are there services covered before you meet your deductible?	Yes, preventive care and prescription drugs.	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

	Preventive Services Under Age 2 Services include periodic exams, visits, radiology, x-rays, pathology and laboratory	No charge for federally mar			
	Age 2 and Above - Servi include physical exams, smears, hearing examinations, radiology, laboratory testing, cardia stress tests	Plan Pays 100% up to $25 applicable Deductible and			
If you have a test	Diagnostic test (x-ray, blood work)	15% coinsurance	30% coinsurance	45% coinsurance	Preauthorization may be required.
	MRIs)	15% coinsurance	30% coinsurance	[redacted]	authorization may be required.
If you need drugs to treat your illness or condition					

* For more information about limitations and exceptions, see the plan or policy document at [www.insert.com].

Common Medical Event	

* For more information about limitations and exceptions, see the plan or policy document at [www.insert.com].

* For more information about limitations and exceptions, see the plan or policy document at [www.insert.com].

Common Medical Event	Services You May Ne	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Select In-Netwo Provider (You v 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:

* For more information about limitations and exceptions, see the plan or policy document at [www.insert.com].

* For more information about limitations and exceptions, see the plan or policy document at [www.insert.com].

The plan's overall deductible	$1,350
Specialist coinsurance	15%
Hospital (facility) coinsurance	15%
Other coinsurance	15%

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 visits (anesthesia)

Total Example Cost	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,350
Copayments	$0
Coinsurance	$1,600
What isn't covered	
Limits or exclusions	$70
The total Peg would pay	

The plan's overall deductible	$1,350
Specialist coinsurance	15%
Hospital (facility) coinsurance	15%
Other coinsurance	15%

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	$5,600

In this example, Joe would pay:

The plan's overall deductible	$1,350
Specialist coinsurance	15%
Hospital (facility) coinsurance	15%
Other coinsurance	15%

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	$2,800

In this example, Mia would pay:

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