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, call toll-free 1 (800) 822-5899. 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 https://www.healthcare.gov/sbc-glossary or call 1-800-822-5899 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$200 individual/$600 family	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 plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	No	You will have to meet the deductible before the plan pays for any services.
Are there other deductibles for specific services?	No	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?	$10,000/ individual	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges in excess of benefit maximums and health care 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?	Not Applicable	This plan does not use a provider network. You can receive covered services from any provider.
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 **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information*
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	Fee schedule used.
	Specialist visit	20% coinsurance	Fee schedule used Acupuncture, infertility treatments and weight loss programs are not covered
	Preventive care/screening/ immunization	Not Covered	These services are excluded.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	Fee schedule used.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Fee schedule used.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available by calling 1-800-822-5899.	Generic drugs	20% coinsurance	Up to a 34-day supply Certain prescriptions are not covered. Over-the-counter medications are not covered.
	Brand drugs with no generic alternative	20% coinsurance	
	Brand drugs with a generic alternative	20% coinsurance plus the difference in cost between the generic and the brand name drug	
	Specialty drugs	Same as above based on drug type	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Maximum benefit of $640 per surgical session. Fee schedule used.
	Physician/surgeon fees	20% coinsurance	
If you need immediate medical attention	Emergency room care	If illness - 20% coinsurance after $100 copay/visit and calendar year deductible. If accidental injury - 20% coinsurance after $25 copay/visit and calendar year deductible.	Maximum benefit of $640 per visit. Fee schedule used.
	Emergency medical transportation	20% coinsurance	Coverage maximum per transfer –$40.
	Urgent care	$20% coinsurance	Fee schedule used.
If you have a hospital stay	Facility fee (e.g., hospital room)	Intensive/Cardiac care, Progressive care or Other care - 20% coinsurance after a $25 copay/day.	Maximum benefit of $720/day for Intensive/Cardiac care, $660/day for Progressive care and $640/day for Other care. $25,000 maximum per confinement. Bariatric surgery excluded.

*For more information about limitations and exceptions, see the plan or policy document at www.nebainc.com/mybenefits or by calling 1-800 822-5899.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information*
	Physician/surgeon fees	20% coinsurance	Bariatric surgery excluded. Fee schedule used.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not Covered	Coverage is excluded.
	Inpatient services	Not Covered	Coverage is excluded.
If you are pregnant	Office visits	20% coinsurance	Fee schedule used.
	Childbirth/delivery professional services		
	Childbirth/delivery facility services	20% coinsurance after a $25 copay/day	Maximum benefit of $ $640/day. $25,000 maximum per confinement.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	30 days calendar year maximum benefit. Fee schedule used.
	Rehabilitation services	20% coinsurance	Physical, speech or occupational therapy treatment must be ordered by a physician and provided by a licensed therapist. Chiropractic coverage is limited to $20 maximum per visit and $400 per calendar year. Fee schedule used.
	Habilitation services	Not Covered	These services are excluded.
	Skilled nursing care	20% coinsurance	Fee schedule used.
	Durable medical equipment	20% coinsurance	Rental cannot exceed purchase price. Fee schedule used.
	Hospice services	20% coinsurance	Fee schedule used.
If your child needs dental or eye care	Children's eye exam	Not Covered	These services are excluded.
	Children's glasses	Not Covered	These services are excluded.
	Children's dental check-up	Not Covered	These services are excluded.

*For more information about limitations and exceptions, see the plan or policy document at www.nebainc.com/mybenefits or by calling 1-800 822-5899.

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
- Certain prescription drugs are not covered
- Cosmetic surgery
- Dental care (Adult and child)
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Mental health and behavioral health treatment
- Non-emergency care when traveling outside the US
- Over-the-counter medications
- Preventive care
- Routine eye care (Adult and child)
- Routine foot care
- Substance abuse treatment
- 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
- Private-duty nursing

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: Department of Labor's Employee Benefits Security Administration at (866) 444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 the Plan at 1-800-822-5899 or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) https://www.dol.gov/ebsa/healthreform.

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:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-800-822-5899.]

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

*For more information about limitations and exceptions, see the plan or policy document at www.nebainc.com/mybenefits or by calling 1-800 822-5899.

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** **$200**
- **Specialist coinsurance** **20%**
- **Hospital (facility) copay+ coinsurance** **$25+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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$200
Copayments	$50
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$6,200
The total Peg would pay is	**$7,550**

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

- **The plan's overall deductible** **$200**
- **Specialist coinsurance** **20%**
- **Hospital (facility) copay+ coinsurance** **$25+20%**
- **Other (Rx) 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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$200
Copayments	$0
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$2,600
The total Joe would pay is	**$3,800**

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

- **The plan's overall deductible** **$200**
- **Specialist coinsurance** **20%**
- **Hospital (facility) copay+ coinsurance** **$25+20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic tests (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$200
Copayments	$100
Coinsurance	$500
What isn't covered	
Limits or exclusions	$800
The total Mia would pay is	**$1,600**

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