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, contact Omaha Track at 402-339-0332. 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.dol.gov/ebsa/healthreform or www.cciio.cms.gov .

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$2,500 individual $5,000 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?	Refer to the Summary of Benefits and Coverage (SBC)of the Integrated Group Health Plan	You will have to meet the deductible before the plan pays for any services.
Are there other deductibles for specific services?	Refer to the SBC of the Integrated Group Health Plan	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$2,500 individual $5,000 family	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	**Premiums**, **balance billing** charges, health care this **plan** doesn't cover and penalties	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?	Refer to the SBC of the Integrated Group Health Plan	Refer to the SBC of the Integrated Group Health Plan
Do you need a referral to see a specialist?	No	Refer to the SBC of the Integrated Group Health Plan

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
		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	Refer to the SBC of the Integrated Group Health Plan		Only qualified medical expenses up to the available account balance in the HRA
	Specialist visit	Refer to the SBC of the Integrated Group Health Plan		
	Preventive care/screening/ immunization	Refer to the SBC of the Integrated Group Health Plan		
If you have a test	Diagnostic test (x-ray, blood work)	Refer to the SBC of the Integrated Group Health Plan		Only qualified medical expenses up to the available account balance in the HRA
	Imaging (CT/PET scans, MRIs)	Refer to the SBC of the Integrated Group Health Plan		
If you need drugs to treat your illness or condition	Generic drugs	Refer to the SBC of the Integrated Group Health Plan		Only qualified medical expenses up to the available account balance in the HRA
	Preferred brand drugs	Refer to the SBC of the Integrated Group Health Plan		
	Non-preferred brand drugs	Refer to the SBC of the Integrated Group Health Plan		
	Specialty drugs	Refer to the SBC of the Integrated Group Health Plan		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Refer to the SBC of the Integrated Group Health Plan		Only qualified medical expenses up to the available account balance in the HRA
	Physician/surgeon fees	Refer to the SBC of the Integrated Group Health Plan		
If you need immediate medical attention	Emergency room care	Refer to the SBC of the Integrated Group Health Plan		Only qualified medical expenses up to the available account balance in the HRA
	Emergency medical transportation	Refer to the SBC of the Integrated Group Health Plan		
	Urgent care	Refer to the SBC of the Integrated Group Health Plan		
If you have a hospital stay	Facility fee (e.g., hospital room)	Refer to the SBC of the Integrated Group Health Plan		Only qualified medical expenses up to the available account balance in the HRA

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	Refer to the SBC of the Integrated Group Health Plan		
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Refer to the SBC of the Integrated Group Health Plan		Only qualified medical expenses up to the available account balance in the HRA
	Inpatient services	Refer to the SBC of the Integrated Group Health Plan		
If you are pregnant	Office visits	Refer to the SBC of the Integrated Group Health Plan		Only qualified medical expenses up to the available account balance in the HRA
	Childbirth/delivery professional services	Refer to the SBC of the Integrated Group Health Plan		
	Childbirth/delivery facility services	Refer to the SBC of the Integrated Group Health Plan		
If you need help recovering or have other special health needs	Home health care	Refer to the SBC of the Integrated Group Health Plan		Only qualified medical expenses up to the available account balance in the HRA
	Rehabilitation services	Refer to the SBC of the Integrated Group Health Plan		
	Habilitation services	Refer to the SBC of the Integrated Group Health Plan		
	Skilled nursing care	Refer to the SBC of the Integrated Group Health Plan		
	Durable medical equipment	Refer to the SBC of the Integrated Group Health Plan		
	Hospice services	Refer to the SBC of the Integrated Group Health Plan		
If your child needs dental or eye care	Children's eye exam	Refer to the SBC of the Integrated Group Health Plan		Only qualified medical expenses up to the available account balance in the HRA
	Children's glasses	Refer to the SBC of the Integrated Group Health Plan		
	Children's dental check-up	Refer to the SBC of the Integrated Group Health Plan		

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.)
• Please check the terms of the Summary Plan Description of the Integrated Group Health Plan

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)
• Please check the terms of the Summary Plan Description of the Integrated Group Health Plan

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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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 on how 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: [insert applicable contact information from instructions].

Does this plan provide Minimum Essential Coverage? **No**

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? **No**

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 402-339-0332.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 402-339-0332.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码402-339-0332.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 402-339-0332.

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

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	**$2,500**
Specialist copayment	**N/A**
Hospital (facility) coinsurance	**N/A**
Other coinsurance	**N/A**

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	$2,500
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,560**

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

The plan's overall deductible	**$2,500**
Specialist copayment	**N/A**
Hospital (facility) coinsurance	**N/A**
Other coinsurance	**N/A**

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	$2,500
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,500**

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

The plan's overall deductible	**$2,500**
Specialist copayment	**N/A**
Hospital (facility) coinsurance	**N/A**
Other coinsurance	**N/A**

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:

Cost Sharing	
Deductibles	$2,500
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,500**

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