A Guide to Your Health Benefits

Educators Health Alliance (EHA)

$1150 Deductible

(Effective Date: 09/01/2018)

BlueCross BlueShield Nebraska

98-653 1/2018

Payment for Services	In-network Provider	Out-of-network Provider
Covered Services are reimbursed based on the Allowable Charge. Blue Cross and Blue Shield of Nebraska In-network Providers have agreed to accept the benefit payment as payment in full, not including Deductible, Coinsurance and/or Copayment amounts and any charges for non-covered services, which are the Covered Person's responsibility. That means In-network providers, under the terms of their contract with Blue Cross and Blue Shield, can't bill for amounts over the Contracted Amount. Out-of-network Providers can bill for amounts over the Out-of-network Allowance.		
In-network Provider: The provider network is shown on your I.D. card. For help in locating In-network Providers, visit www.nebraskablue.com.		
Deductible (the amount the Covered Person pays each Calendar Year for Covered Services before the Coinsurance is payable) • Individual • Family (Embedded*)	 $1,150 $2,300	 $2,300 $4,600
Coinsurance (the percentage amount the Covered Person must pay for most Covered Services after the Deductible has been met) • Covered Person Pays	 20%	 40%
Out-of-pocket Limit (does not include premium, penalty and amounts not covered by the plan) • Individual • Family (Embedded*)	 $4,900 $9,800	 $9,800 $19,600
Once the annual Out-of-pocket Limit is reached, most Covered Services are payable by the plan at 100% for the rest of the Calendar Year.		
In-network and Out-of-network Deductible and Out-of-pocket Limits are separate and cross accumulate. All other limits (days, visits, sessions, dollar amounts, etc.) do cross accumulate between In-network and Out-of-network, unless noted differently.		
Day, session or visit limits for certain services shown on this summary are not applicable to Mental Illness and/or Substance Dependence and Abuse.		
*Embedded – If you have single coverage, you only need to satisfy the individual Deductible and Out-of-pocket Limit amounts. If you have family coverage, no one family member contributes more than the individual amount. Family members may combine their covered expenses to satisfy the required family Deductible and Out-of-pocket amounts.		

Copayment(s) (copay(s)) apply to:

- Physician Office
- Telehealth Services
- Urgent Care Facility
- Emergency Care
- Prescription Drugs

The Copay amount varies by the type of Covered Service. Refer to the appropriate category for benefit information.

Out-of-pocket Limit includes:

- Deductible
- Coinsurance
- Medical Copays
- Prescription Drug Copays

Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Physician Office		
• Primary Care Physician Office Visit	$30 Copay	Deductible and Coinsurance
• Specialist Physician Office Visit	$50 Copay	Deductible and Coinsurance
• Other Covered Services and supplies provided in the Physician's Office (with or without an office visit billed)	Deductible and Coinsurance	Deductible and Coinsurance
• Allergy Injections and Serum (only one copay applies per day per provider)	Deductible and Coinsurance	Deductible and Coinsurance
• Other Injections	Deductible and Coinsurance	Deductible and Coinsurance
Primary Care Physician is a physician who has a majority of his or her practice in internal or general medicine, obstetrics/gynecology, general pediatrics or family practice. A **physician assistant** is covered in the same manner as a Primary Care Physician. ***Specialist Physician*** is a physician who is not a Primary Care Physician. ***Office Visit Benefits*** for Primary Care and Specialist Physician Office Visit include office visits (including the initial visit to diagnose pregnancy) and consultations. ***Other Covered Services not part of the Physician Office Benefit (Refer to the appropriate category for benefit information) include:*** Allergy Injections & Serum; Other Injections; Advanced Diagnostic Imaging (CT, MRI, MRA, MRS, PET & SPECT scans and other Nuclear Medicine); Pregnancy Services; Preventive Services; Radiation Therapy & Chemotherapy; Surgery & Anesthesia; Therapy & Manipulations; Durable Medical Equipment; Sleep Studies; Biofeedback; Psychological Evaluations, Assessments, and Testing.		
Telehealth Services (by a designated provider)	$10 Copay	Not Covered
Convenient Care/Retail Clinics (Quick Care)	Same as a Primary Care Physician	Same as a Primary Care Physician
Urgent Care Facility Services (a single copay applies to each urgent care visit)	$50 Copay then Deductible and Coinsurance	Deductible and Coinsurance
Emergency Care Services (services received in a Hospital emergency room setting) • Facility • Professional Services (Copayment is waived if admitted to the hospital within 24 hours for the same diagnosis)	$75 Copay then Deductible and Coinsurance Deductible and Coinsurance	In-network level of benefits In-network level of benefits
Outpatient Hospital or Facility Services Services such as surgery, laboratory and radiology, cardiac and pulmonary rehabilitation, observation stays, and other services provided on an outpatient basis	Deductible and Coinsurance	Deductible and Coinsurance
Inpatient Hospital or Facility Services Charges for room and board, diagnostic testing, rehabilitation and other ancillary services provided on an inpatient basis	Deductible and Coinsurance	Deductible and Coinsurance

Preventive Services	In-network Provider	Out-of-network Provider
Preventive Services • Affordable Care Act (ACA) required preventive services (may be subject to limits that include, but are not limited to, age, gender, and frequency)	Plan Pays 100%	Deductible and Coinsurance
• ACA required covered preventive services (outside of limits)	Deductible and Coinsurance	Deductible and Coinsurance
• Other covered preventive services not required by ACA	Plan Pays 100%	Deductible and Coinsurance
Immunizations • Pediatric (up to age 7) • Age 7 and older • Related to an illness	Plan Pays 100% Plan Pays 100% Same as any other illness	Coinsurance Deductible and Coinsurance Same as any other illness

Mental Illness and/or Substance Dependence and Abuse Covered Services	In-network Provider	Out-of-network Provider
Inpatient Services	Deductible and Coinsurance	Deductible and Coinsurance
Outpatient Services • Office Services • Telehealth Services (by a designated provider) • All Other Outpatient Items & Services	Deductible and Coinsurance $10 Copay Deductible and Coinsurance	Deductible and Coinsurance Not Covered Deductible and Coinsurance
Emergency Care Services (services received in a Hospital emergency room setting) • Facility • Professional Services	Deductible and Coinsurance Deductible and Coinsurance	In-network level of benefits In-network level of benefits

Other Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Acupuncture	Not Covered	Not Covered
Advanced Diagnostic Imaging (CT, MRI, MRA, MRS, PET & SPECT scans and other Nuclear Medicine)	Deductible and Coinsurance	Deductible and Coinsurance
Ambulance (to the nearest facility for appropriate care) • Ground Ambulance • Air Ambulance	Deductible and Coinsurance Deductible and Coinsurance	In-network level of benefits Deductible and Coinsurance (In-network level of benefits if due to an emergency)
Biofeedback	Deductible and Coinsurance	Deductible and Coinsurance
Bone Anchored Hearing Aids (BAHA) and Cochlear implants	Deductible and Coinsurance	Deductible and Coinsurance
Dermatological Services	Same as any other illness	Same as any other illness
Diabetic Services Services include education, self-management training, podiatric appliances and equipment.	Deductible and Coinsurance	Deductible and Coinsurance
Durable Medical Equipment and Supplies (including Prosthetics) (rental or purchase, whichever is least costly; rental shall not exceed the cost of purchasing)	Deductible and Coinsurance	Deductible and Coinsurance
Eye Glasses or Contact Lenses Only covered if required because of a change in prescription as a result of intraocular surgery or ocular injury (must be within 12 months of surgery or injury)	Deductible and Coinsurance	Deductible and Coinsurance

Other Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Hearing Aids	Not Covered	Not Covered
Home Health Aide and Skilled Nursing Home Health Aide (limited to 60 days per Calendar Year) Skilled Nursing Care (limited to 8 hours per day)	Deductible and Coinsurance	Deductible and Coinsurance
Home Infusion Therapy	Deductible and Coinsurance	Deductible and Coinsurance
Hospice Services	Deductible and Coinsurance	Deductible and Coinsurance
Independent Laboratory • Diagnostic • Preventive	Deductible and Coinsurance Same as Preventive Services In-network level of benefits	In-network level of benefits Same as Preventive Services In-network level of benefits
Infertility • Services to diagnose • Treatment to promote fertility	Same as any other illness Not Covered	Same as any other illness Not Covered
Nicotine Addiction • Medical services and therapy • Nicotine addiction classes & alternative therapy, such as acupuncture	Same as Substance Dependence and Abuse Not Covered	Same as Substance Dependence and Abuse Not Covered
Obesity • Non-surgical treatment • Surgical Treatment	Not Covered Not Covered	Not Covered Not Covered
Oral Surgery and Dentistry Services such as impacted wisdom teeth, incision and drainage abscesses, excision of tumors and cysts and bone grafts to the jaw. Dental treatment when due to an accidental injury to naturally healthy teeth (treatment related to accidents must be provided within 12 months of the date of injury).	Deductible and Coinsurance	Deductible and Coinsurance
Organ and Tissue Transplantation	Deductible and Coinsurance	Deductible and Coinsurance
Ostomy Supplies	Deductible and Coinsurance	Deductible and Coinsurance

Other Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Physician Professional Services Inpatient and Outpatient services, such as, surgery, surgical assistant, anesthesia, inpatient hospital visits and other non-surgical services	Deductible and Coinsurance	Deductible and Coinsurance
Pregnancy, Maternity and Newborn Care • Pregnancy and maternity (Payment for prenatal and postnatal care is included in the payment for the delivery)	Deductible and Coinsurance	Deductible and Coinsurance
• Newborn care	Deductible and Coinsurance	Deductible and Coinsurance
NOTE: Newborns are covered at birth, subject to the plan's enrollment provisions.		
Radiation Therapy and Chemotherapy	Deductible and Coinsurance	Deductible and Coinsurance
Radiology (x-ray) Services and other Diagnostic Test	Deductible and Coinsurance	Deductible and Coinsurance
Rehabilitation Services – Inpatient Facility	Deductible and Coinsurance	Deductible and Coinsurance
Rehabilitation Services • Cardiac rehabilitation (limited to 18 sessions per diagnosis during the preceding four months of certain cardiac diagnosis)	Deductible and Coinsurance	Deductible and Coinsurance
• Pulmonary Rehabilitation (Chronic lung disease is limited to 18 sessions per diagnosis, not to exceed 18 sessions per Calendar Year. Lung, heart-lung transplants and lung volume are limited to 18 sessions following referral and prior to surgery plus 18 sessions within six months of discharge from hospital following surgery.)	Deductible and Coinsurance	Deductible and Coinsurance
Renal Dialysis	Deductible and Coinsurance	Deductible and Coinsurance
Respiratory Care (limited to 60 days per Calendar Year)	Deductible and Coinsurance	Deductible and Coinsurance

Other Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Sexual Dysfunction	Not Covered	Not Covered
Skilled Nursing Facility (limited to 60 days per Calendar Year)	Deductible and Coinsurance	Deductible and Coinsurance
Sleep Studies	Deductible and Coinsurance	Deductible and Coinsurance
Temporomandibular and Craniomandibular Joint Disorder	Deductible and Coinsurance	Deductible and Coinsurance
Therapy & Manipulations • Physical, occupational or speech therapy services, chiropractic or osteopathic physiotherapy (combined limit to 60 sessions per Calendar Year) • Chiropractic or osteopathic manipulative treatments or adjustments (combined limit to 30 sessions per Calendar Year)	Deductible and Coinsurance Deductible and Coinsurance	Deductible and Coinsurance Deductible and Coinsurance
Vision Exams • Diagnostic (to diagnose an illness) • Preventive (routine exam including refraction)	See Physician Office Services Not Covered	See Physician Office Services Not Covered
Wigs	Not Covered	Not Covered
All Other Covered Services	Deductible and Coinsurance	Deductible and Coinsurance

Prescription Drugs	In-network Provider	Out-of-network Provider
Prescription Drug Deductible (the amount the Covered Person pays each Calendar Year for Covered Prescription Drugs before the Prescription Drug Copayments and/or Coinsurance are applicable)		
• Individual	Not Applicable	
• Family	Not Applicable	
Retail – per 30-day supply		
• Generic drugs (including non-preferred contraceptives)	25% Coinsurance, $5 minimum Copay, $25 maximum Copay	25% Coinsurance, $5 minimum Copay, $25 maximum Copay + 25% Penalty
• Preferred Brand Name Drugs	25% Coinsurance, $40 minimum Copay, $80 maximum Copay	25% Coinsurance, $40 minimum Copay, $80 maximum Copay + 25% Penalty
• Non-preferred Brand Name Drugs	50% Coinsurance, $70 minimum Copay, $110 maximum Copay	50% Coinsurance, $70 minimum Copay, $110 maximum Copay + 25% Penalty
Mail order – per 180-day supply		
• Generic drugs (including non-preferred contraceptives)	25% Coinsurance, $25 minimum Copay, $125 maximum Copay	Not Covered
• Preferred Brand Name Drugs	25% Coinsurance, $200 minimum Copay, $400 maximum Copay	Not Covered
• Non-preferred Brand Name Drugs	50% Coinsurance, $350 minimum Copay, $550 maximum Copay	Not Covered
Diabetic Supplies and Insulin		
• Generic	20% Coinsurance	20% Coinsurance + 25% Penalty
• Formulary Brand Name	20% Coinsurance	20% Coinsurance + 25% Penalty
• Non-formulary Brand Name	30% Coinsurance	30% Coinsurance + 25% Penalty
Specialty drugs	25% Coinsurance, $60 minimum Copay, $120 maximum Copay	50% Coinsurance, $170 minimum Copay, $340 maximum Copay
Contraceptives		
• Preferred		
- Generic	Plan Pays 100%	25% Penalty
- Brand Name	Plan Pays 100%	25% Penalty
• Non-preferred		
- Generic	Same as any other Generic Drugs	
- Brand Name	Same as any other Non-preferred Brand Name	
Infertility FDA approved prescription drugs to promote fertility	Not Covered	Not Covered
Nicotine Addiction FDA approved prescription drugs and over-the-counter nicotine addiction drugs and deterrents	Plan Pays 100%	25% Penalty
Obesity FDA approved prescription drugs	Not Covered	Not Covered

IMPORTANT TELEPHONE NUMBERS

Member Services
Omaha and Toll-free 1-877-721-2583

Coordination of Benefits
Omaha 402-390-1840
Toll-free 1-800-462-2924

Subrogation
Omaha 402-390-1847
Toll-free 1-800-662-3554

Workers' Compensation
Omaha 402-398-3615
Toll-free 1-800-821-4786

Certification
Omaha 402-390-1870
Toll-free 1-800-247-1103

BlueCard Provider Information
Toll-free 1-800-810-BLUE (2583)
Website . . . . . www.bcbs.com

Network Pharmacy Locator
Toll-free 1-877-800-0746

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INTRODUCTION

Welcome

This document is your Certificate of Coverage. It has been written to help you understand your Group health coverage with Blue Cross and Blue Shield of Nebraska (BCBSNE), an independent licensee of the Blue Cross and Blue Shield Association.

This Certificate of Coverage is only a partial description of the benefits, exclusions, limitations, and other terms of the Master Group Contract to which it refers. It describes the more important parts of that document in a general way. It is not, and should not be considered a contract or any part of one. The Master Group Contract controls the coverage for your Group.

The Master Group Contract is made in and governed by the laws of the State of Nebraska. Please note that this Certificate of Coverage may not list all the benefits provided by the laws of your state if you do not reside in Nebraska. Please read this Certificate of Coverage carefully.

Please share the information found in this Certificate of Coverage with your Eligible Dependents. Additional copies of this document or your Schedule of Benefits and/or your Schedule of Benefits Summary are available from the BCBSNE Member Services Department.

How To Use This Document
For your convenience, defined terms are capitalized throughout this document. For an explanation of a defined term, refer to the Section titled "Definitions."

Please take some time to read this document and become familiar with it. As you read this Certificate of Coverage you will find that many of the sections of the document are related to other sections. You may not have all the information you need by reading just one section. We encourage you to review the benefits and limitations by reading the Schedule of Benefits Summary and the sections titled "Benefit Descriptions" and "Exclusions," If you have a question about your coverage or Claim, please contact BCBSNE Member Services Department.

About Your I.D. Card
BCBSNE will issue you an identification card (I.D. card). Your I.D. number is a unique alpha numeric combination. Present your I.D. card to your health care provider when you receive Services. With your BCBSNE I.D. card, Hospitals and Physicians can identify your coverage and will usually submit Claims for you.

If you want extra cards for covered family members or need to replace a lost card, please contact BCBSNE Member Services Department, or you may access through the website, www.nebraskablue.com.

What's A Schedule Of Benefits?
Your Schedule of Benefits is a personalized document that provides you with a basic description of your coverage. It also shows the membership option that applies to you.

We also provide a Schedule of Benefits Summary. It includes information about deductibles and cost-sharing amounts, benefit limits and other coverage details.

Your Rights And Responsibilities As A Blue Cross And Blue Shield Of Nebraska Member

You have the right to:

- Be treated with respect and dignity.
- Privacy of your personal health information that we maintain, following state and federal laws.
- Receive information about the benefits, limitations and exclusions of your health plan, including how to access our network of hospitals, physicians and other health care providers.
- Work with your doctor and other health care professionals about decisions regarding your treatment.
- Discuss all of your treatment options, regardless of cost or benefits coverage.
- Make a complaint or file an appeal about your health plan, any care you receive or any benefit determination your health plan makes.
- Make recommendations to us about this rights and responsibility policy.
- Give us suggestions about how we can better serve you and other members.

You have the responsibility to:

- Read and be familiar with your health plan coverage information and what your plan covers and doesn't cover, or ask for help if you need it.
- If your plan has different In-network and Out-of-network benefits, understand how your choice of an In-network or Out-of-network Provider will impact what you pay out of your own pocket, or ask for help if you need it.
- Give us all the information we need to process your claims and provide you with the benefits you're entitled to under your plan.
- Give all health care providers the information they need to appropriately treat you.
- Advise us of any changes that affect you or your family, such as birth, marriage/divorce or change of address.

About The Plan

This Group health plan is a Preferred Provider Organization (PPO) health benefit plan, insured by Blue Cross and Blue Shield of Nebraska (BCBSNE).

Preferred Provider (PPO) networks have been established by BCBSNE through contracts with a panel of Hospitals, Physicians and other health care providers who have agreed to furnish medical Services to you and your family in a manner that will help manage health care costs. These providers are referred to as "In-network" or "Preferred Providers."

The In-network (Preferred) Provider network name for your health plan is shown on your I.D. Card.

Blue Cross and Blue Shield Plans in other states (referred to as "Host Blue") have also contracted with health care providers in their geographic areas who are referred to as "Preferred Providers."

Use of the network is voluntary, and selection of a health care provider is always your choice. If you choose to use providers who do not participate in BCBSNE's or the Host Blue's network for non-emergency situations, you can expect to pay more than your applicable Coinsurance, Copayment and/or Deductible amounts. After this health plan pays its required portion of the bill, Out-of-network Providers may bill you for any amount not paid. This balance billing does not happen when you use In-network or Preferred Providers because these providers have agreed to accept a discounted payment for Services with no additional billing to you other than your applicable Coinsurance, Copayment and Deductible amounts. In-network Providers will also file claims for you.

For help in locating In-network Providers please visit BCBSNE online at www.nebraskablue.com. You may also call Member Services using the toll-free number on your I.D. card or refer to the Important Telephone Numbers in the front of this book. If you would like a printed provider list, BCBSNE will furnish one without charge.

For help in locating a Preferred Provider in another Blue Cross and/or Blue Shield Service Area, including providers outside the U.S., you may call the special toll-free number of the Blue Cross and Blue Shield BlueCard Program (1-800-810-2583) for assistance.

How The Plan Components Work

Your Deductible, Copayment, Coinsurance (cost-sharing) and Out-of-pocket Limit are shown on your Schedule of Benefits Summary. The following is an explanation of each.

Allowable Charge — An amount BCBSNE uses to calculate the payment of Covered Services. This amount will be based on either the Contracted Amount for In-network Providers or the Out-of-network Allowance for Out-of-network Providers.

Coinsurance — This is the percentage you must pay for Covered Services, after the Deductible is applied.

Copayment (Copay) — A fixed dollar amount payable by the Covered Person for a Covered Service.

Deductible* — You are responsible for your annual expenses until you reach the Plan's Deductible. After the Deductible is met, benefits for the rest of that calendar year will not be subject to any further Deductible. In-network and Out-of-network Deductible amounts are separate and do not cross-accumulate.

Copays and charges for Non-covered Services or amounts in excess of the Allowable Charge do not count toward your Deductible.

Out-of-pocket Limit* — This limit is the maximum amount of cost-sharing each Covered Person or Membership Unit must pay in a calendar year. The In-network and Out-of-network Out-of-pocket Limits are separate and do not cross-accumulate.

Certain kinds of charges do not count toward your Out-of-pocket Limit. For example:

- Charges in excess of the Allowable Charge;
- Charges for Noncovered Services;
- Penalties for failure to comply with Certification requirements;
- Penalty amounts under the Prescription Drug Program, or cost-sharing paid with a pharmaceutical discount or copay card.

**If you have a family or multiple party membership, your plan may have either an Aggregate or an Embedded Deductible and/or Out-of-pocket Limit. Your Schedule of Benefits Summary will indicate whether your plan has an Aggregate or an Embedded amount. See the section "Definitions" for an explanation of these terms.*

Utilization Review — Benefits are available under this Group health plan for **Medically Necessary** and **Scientifically Validated** Services. Services provided by all health care providers are subject to utilization review by BCBSNE. Services will not automatically be considered Medically Necessary because they have been ordered or provided by a Physician. BCBSNE will determine whether Services provided are Medically Necessary under the terms of the plan, and if benefits are available.

Certification Requirements — Prior Certification is required for all Inpatient Hospital admissions, as well as certain surgical procedures, and specialized Services and supplies. In-network Hospitals will notify BCBSNE of an Inpatient admission. However, when you are admitted as an Inpatient to an Out-of-network Hospital, or to a Hospital outside the state of Nebraska, it is your responsibility to see that BCBSNE is notified of your admission. For more information, please refer to the section of this book titled "Certification Requirements."

Continuity of Care — In the event a Covered Person is receiving an active course of treatment for certain types of care from an In-network Provider on the date that BCBSNE's contracting agreement with that provider is terminated, the provider will continue to render Covered Services to the Covered Person, and the contracting agreement shall continue to apply to those Covered Services after the termination takes effect, for a defined period of time. The types of care that qualify and the length of time that the contracting agreement shall continue to apply are stated in the BCBSNE Provider Policies and Procedures Manual. The terms of the Provider Policies and Procedures Manual may be updated by BCBSNE from time to time. For additional information, you may contact BCBSNE Member Services Department.

For more definitions, please refer to the section of this book titled "Definitions."

How The Network Works

Using In-network Providers:

- Present I.D. card and pay Copayment (when applicable)
- Receive highest level of benefit
- Provider files claims for you
- Provider accepts insurance payment as payment in full (except Deductible, Copayment and/or Coinsurance amounts)
- No balance billing

Using Out-of-network Providers:

- You may be required to pay full cost at time of Service
- You may be reimbursed at a lower benefit level
- You may have to file claims
- You're responsible for amounts that exceed the Allowable Charge

Remember, if more than one Physician is involved in your care, it is important for you to check the status of each provider.

Exception

If you receive initial, short-term (48 hours or less) Inpatient or Outpatient care for an Emergency Medical Condition at an Out-of-network Hospital or by an Out-of-network Provider, benefits for those Covered Services will be paid subject to the In-network cost-sharing amounts. Benefits for Inpatient Covered Services will continue to be paid at the In-network level, as long as they are for an Emergency Medical Condition. To continue to receive the In-network cost-sharing benefit level for Outpatient care after the initial care has been provided, you must use an In-network Provider. In addition, any Covered Services provided by an Out-of-network Urgent Care Physician and/or other Out-of-network professional Provider will be paid subject to the In-network cost-sharing level when the corresponding facility charges are paid subject to the In-network benefit level.

NOTE: You will still be responsible for Noncovered Services and any amounts over the Allowable Charge when you receive Services from an Out-of-network Provider.

Be Informed

Out-of-network Providers' charges may be higher than the benefit amount allowed by this health plan. You may contact BCBSNE Member Services Department concerning allowable benefit amounts in Nebraska for specific procedures. Your request must specify the Service or procedure, including any Service or procedure code(s) or diagnosis-related group, and the provider's estimated charge.

Out-of-Area Services

BCBSNE has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. These relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross and Blue Shield Association ("Association"). Whenever you access health care services outside the geographic area BCBSNE serves, the claim for those services may be processed through one of these Inter-Plan Arrangements.

When you access care outside BCBSNE's service area, you will receive it from one of two kinds of providers. Most providers ("participating providers") contract with the local Blue Cross and Blue Shield Licensee in that geographic area ("Host Blue"). Some providers ("non-participating providers") don't contract with the Host Blue. We explain below how we pay both kinds of providers.

Inter-Plan Arrangements Eligibility - Claim Types — All claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for dental care benefits (except when paid as medical benefits), and any prescription drug programs or vision care benefits that may be administered by a third party contracted by BCBSNE to provide the specific service or services.

BlueCard® Program
Under the BlueCard® Program, when you receive Covered Services within the geographic area served by a Host Blue, BCBSNE will remain responsible for doing what we agreed to in the Contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating providers.

When you receive Covered Services outside BCBSNE's service area and the claim is processed through the BlueCard Program, the amount you pay for Covered Services is calculated based on the lower of:

- The billed charges for your Covered Services, or
- The negotiated price that the Host Blue makes available to BCBSNE.

Often, this "negotiated price" will consist of a simple discount which reflects an actual price that the Host Blue pays to your health care provider. Sometimes, it is an estimated price that takes into account special arrangements with your health care provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of health care providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price BCBSNE used for your claim because they will not be applied after a claim has already been paid.

Negotiated (non-BlueCard® Program) Arrangements
With respect to one or more Host Blues, instead of using the BlueCard Program, BCBSNE may process your claims for Covered Services through Negotiated Arrangements for National Accounts.

The amount you pay for Covered Services under this arrangement will be calculated based on the negotiated price or the lower of either billed covered charges for Covered Services or the negotiated price (refer to the description of negotiated price under BlueCard® Program) made available to BCBSNE by the Host Blue.

If reference-based benefits, which are service-specific benefit dollar limits for specific procedures, based on a Host Blue's local market rates, are made available to you, you will be responsible for the amount that the health care provider bills above the specific reference benefit limit for the given procedure. For a participating provider, that amount will be the difference between the negotiated price and the reference benefit limit. For a non-participating provider, that amount will be the difference between the provider's billed charge and the reference benefit limit. Where a reference benefit limit is greater than either a negotiated price or a provider's billed charge, you will incur no liability, other than related patient cost-sharing under the Contract.

Special Cases – Value-Based Programs

- *BlueCard Program:* If you receive Covered Services under a Value-Based Program inside a Host Blue's service area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement except when a Host Blue passes these fees to BCBSNE through average pricing or fee schedule adjustments.
- *Negotiated (non-BlueCard Program) Arrangements:* If BCBSNE has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to your Group on your behalf, BCBSNE will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees noted above for the BlueCard Program.

Inter-Plan Programs – Federal/State Taxes/Surcharges/Fees
Federal or state laws or regulations may require a surcharge, tax or other fee that applies to insured accounts. If applicable, BCBSNE will include any such surcharge, tax or fee as part of the claim charge passed on to you.

Non-Participating Providers Outside Our Service Area
Subscriber Liability Calculation — When Covered Services are provided outside of BCBSNE's service area by non-participating providers, the amount you pay for such Services will normally be based on either the Host Blue's non-participating provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be responsible for the difference between the amount that the non-participating provider bills and the payment BCBSNE will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

If you need emergency care, BCBSNE will cover you at the highest level that federal regulations allow. You will have to pay any Deductibles, Coinsurance, Copayments, and charges for Noncovered Services, and any excess charge over the amount payable under the Contract.

Exceptions — In certain situations, BCBSNE may use other payment bases, such as billed charges for Covered Services, the payment BCBSNE would make if the health care Services had been obtained within BCBSNE's service area, or a special negotiated payment, to determine the amount BCBSNE will pay for Services provided by non-participating providers. In these situations, you may be liable for the difference between the amount that the non-participating provider bills and the payment BCBSNE will make for the Covered Services set forth in this paragraph.

Blue Cross Blue Shield Global Core®
If you are outside the United States, (hereinafter "BlueCard service area"), you may be able to take advantage of Blue Cross Blue Shield Global Core® when accessing Covered Services. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although Blue Cross Blue Shield Global Core assists you with accessing a network of inpatient, outpatient and professional providers, the network is not served by Host Blue. As such, when you receive care from providers outside the BlueCard service area, you will typically have to pay the providers and submit the claims yourself to obtain reimbursement for these services. If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, you should call the Blue Cross Blue Shield Global Core Service Center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

- *Inpatient Services:* In most cases, if you contact the Blue Cross Blue Shield Global Core Service Center for assistance, hospitals will not require you to pay for covered inpatient services, except for your cost-share amounts. In such cases, the hospital will submit your claim to the Service Center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for Covered Services. You must contact BCBSNE to obtain certification for non-emergency inpatient services.
- *Outpatient Services:* Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for Covered Services.
- *Submitting a Blue Cross Blue Shield Global Core Claim:* When you pay for Covered Services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global Core Program claim form and send the claim form with the provider's itemized bill(s) to the Service Center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from BCBSNE, the Service Center or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the Blue Cross Blue Shield Global Core Service Center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week.

CERTIFICATION REQUIREMENTS

Certification Process

BCBSNE requires that all Hospital stays, certain surgical procedures, and specialized Services and supplies be Certified prior to receipt of such Services or supplies. Ultimately, it is your responsibility to see that Certification occurs; however, a Hospital or Provider may initiate the Certification.

When BCBSNE receives a request for Certification, the appropriateness of the setting and the level of medical care as well as the timing and duration of the admission is assessed by BCBSNE (or by persons designated by BCBSNE).

To initiate the Certification process, BCBSNE must be contacted by the hospital or physician, or you or your family member, or someone acting on behalf of you or your family member. Notification of the intended receipt of Services may be made by telephone or in writing. We may require that the Certification include written documentation from the attending Physician, dentist or other medical provider demonstrating the Medical Necessity of the procedure or Service and the location where the Service will be provided.

In the case of an ongoing Inpatient admission, the care should continue to be Certified in order to assure that it is being provided in the most appropriate setting.

Please remember that Certification does not guarantee payment. All other Group plan provisions apply. For example: Copayments, Deductibles, Coinsurance, eligibility and exclusions.

Benefits Requiring Certification

The following Services, supplies or drugs must be Certified:

- Inpatient Hospital admissions;
- Inpatient Physical Rehabilitation;
- Long Term Acute Care;
- Skilled nursing facility care;
- Organ and tissue transplants;
- Hospice Care;
- Skilled nursing care in the home;
- Subsequent purchases of Durable Medical Equipment, or DME identified on the Certification/Preauthorization list;
- Prescription drugs (certain drugs as defined by BCBSNE);
- Services subject to surgical, radiology or other preauthorization programs as defined by BCBSNE; and
- Other Services as may be specifically stated elsewhere in this booklet.

A list of Services subject to Certification or preauthorization may be obtained at www.nebraskablue.com. Certification and preauthorization requirements are subject to change.

Certification Exceptions

Maternity

Federal law provides for a length of stay of up to 48 hours following a normal vaginal delivery and 96 hours following a cesarean section unless otherwise agreed to by the Covered Person and her Physician. Certification is not required for an initial maternity admission. However, Certification is required if the hospitalization extends beyond these times.

Emergencies

BCBSNE must be notified of an admission for an Emergency Medical Condition within 24 hours of the admission or the next business day. If Certification is not received, the 24-hour period prior to the time of admission and the 24-hour period after such admission will be reviewed to determine if the Covered Person's condition and treatment would have hindered his or her ability to provide notice.

NOTE: *Admission through the emergency room does not necessarily constitute an emergency admission.*

Effect on Benefits

Failure to comply with the Certification requirements may result in a penalty or denial of benefits and unanticipated costs associated with the incurred expenses.

Note: Certain surgical, radiology or other preauthorization programs require that benefit approval be obtained prior to the service being provided, with failure to do so resulting in a denial of benefits for the Service.

If Services are not properly Certified and benefits are reduced or denied, you are responsible for paying any amount due. However if the Hospital, Inpatient facility or Physician is a Contracting Provider with BCBSNE, they are liable for their Services which are determined by BCBSNE to be not Medically Necessary, (or for denial due to failure to Certify/preauthorize if required), unless you have agreed in writing to be responsible for such Services, or the provider has documented in the medical record that you were notified of the Certification determination. Any such reductions in benefits are not considered when computing your Deductible or your Out-of-pocket Limit.

Benefits are not payable for Services determined to be not Medically Necessary.

This section provides a general overview of covered health care Services. If there is a conflict between this document and the Master Group Contract, the Contract will govern. Please refer also to your Schedule of Benefits Summary.

What's Covered

The following list includes examples of the Services that are covered when Medically Necessary care is provided by an Approved Provider:

- *Advanced diagnostic imaging;*
- *Allergy testing, serum and injections;*
- *Ambulance Services;*
- *Anesthesia;*
- *Assistant surgeon* benefits for surgical procedures specifically identified by BCBSNE;
- *Autism spectrum disorders* (See Additional Information in this section)*;*
- *Blood, blood plasma, blood derivatives or blood fractionates, including administration and processing,* unless donated and for which there is not a charge;
- *Cardiac rehabilitation* when in an accredited program and approved by BCBSNE;
- *Chemotherapy* (except as excluded or limited in relation to certain transplant procedures;
- *Chiropractic care (subject to scope of practice regulations);*
- *Circumcision;*
- *Clinical trials, for approved individuals, including routine patient costs in connection with the clinical trial, consistent with Plan benefits,* as described in the ACA;
- *Cochlear implants or bone anchored hearing aids, which includes the pre-implant evaluation, implant system, surgery and post surgical fitting;*
- *Colorectal cancer screening and related Services;*
- *Contraceptive supplies and Services* (unless otherwise covered under the Rx Nebraska Prescription Drug Program and/or not covered under the medical plan);
- *Dialysis;*
- *Diabetic education* including self-management training and patient management*;*
- *Durable Medical Equipment (DME) rental or initial purchase (whichever costs less),* when prescribed by a Physician and determined by BCBSNE to be Medically Necessary. (See Additional Information in this section);
- *Emergency care;*
- *Eyeglasses or contact lenses when ordered by a Physician* because of a change in prescription as a direct result of a covered intraocular surgery or ocular injury (must be within 12 months of the surgery or injury);
- *Habilitative Services;*
- *Home health aide Services* when ordered by a Physician and are part of a treatment plan developed by the home health agency and approved by BCBSNE (See Additional Information in this section);
- *Home infusion therapy;*
- *Hospice Services* when Certified by BCBSNE (See Additional Information in this section);
- *Hospital Services* such as nursing care, drugs, medicines, therapies, x-rays (radiology) and laboratory (pathology) tests;
- *Immunizations;*
- *Inpatient Physician care;*
- *Inpatient Physical Rehabilitation* (See Additional Information in this section);
- *Mammography;*
- *Manipulative treatment or adjustments;*
- *Mastectomy bras* (limited to four per year)*;*
- *Maternity care* (See Additional Information in this section);
- *Mental Illness care on an Inpatient, Outpatient and Emergency Care basis* (See Additional Information in this section);
- *Newborn care* (See Additional Information in this section);
- *Nursing Services* in the home which require the skill, proficiency and training of a registered nurse (R.N.) or a licensed practical nurse (L.P.N.) (See Additional Information in this section);
- *Occupational therapy*;
- *Oral surgery, dental treatment and TMJ services* (See Additional Information in this section);
- *Orthotics* for preventing complications associated with diabetes;
- *Osteopathic care;*
- *Ostomy supplies;*
- *Outpatient (ambulatory) surgery;*
- *Outpatient x-ray, radiology, laboratory and pathology charges*;
- *Oxygen;*
- *Pacemakers;*
- *Pap smears*;
- *Physical therapy;*
- *Physician visits;*
- *Podiatric appliances necessary for the prevention of complications associated with diabetes;*
- *Preadmission testing;*
- *Preventive Care Services* (see Preventive Care Services in this section for additional information);
- *Prosthetic appliances;*
- *Pulmonary rehabilitation* when in an accredited program and when approved by BCBSNE;
- *Radiation therapy* (except as excluded or limited in relation to certain transplant procedures);

- *Renal dialysis*, including all charges for covered home dialysis equipment and covered disposable supplies, and dialysis training or counseling;
- *Respiratory care;*
- *Room and board*, including cardiac care and intensive care room for an Inpatient stay;
- *Skilled Nursing facility care;*
- *Sleep studies;*
- *Speech therapy;*
- *Sterilization;*
- *Substance Dependence and Abuse Treatment;*
- *Surgical care* (the Allowable Charge includes preoperative care and postoperative care, and may include reductions for procedures involving multiple Physicians or multiple or bilateral surgical procedures);
- *Surgical dressings;*
- *Telehealth Services* (See Additional Information in this section)*;*
- *Transplants* (See Additional Information in this section);
- *Urgent Care Facility Services.*

COVERED SERVICES - ADDITIONAL INFORMATION

This section provides general information with regard to Covered Services. If your benefits differ from what is described in this section, those differences will be described on your Schedule of Benefits Summary and/or at the end of this section, or the amendment at the back of this book.

Ambulance Services

Benefits are available, subject to the Copay, Deductible and/or Coinsurance amounts outlined in the Schedule of Benefits Summary, when ambulance services are provided to a Covered Person for:

- transportation to the nearest facility for appropriate care for an Emergency Medical Condition;
- transportation from a facility where emergent care was obtained or from an Inpatient acute care facility to the nearest facility where appropriate care can be provided, whether it is a lesser or greater level of specific care. Benefits are also available for transporting the Covered Person who is bedridden, to a facility for treatment or to his or her place of residence, subject to preauthorization and medical necessity;
- transporting a respirator-dependent person; and
- transportation to and from the nearest appropriate facility for testing and/or procedures that are not available at the present facility.

Anesthesia Services

Benefits are payable for anesthesia Services by a Physician or Certified nurse anesthetist. The amount payable for the anesthesia will include the usual preoperative and postoperative visits and the necessary management of the patient, during and after the administration. Payment will not be made for supervision of the administration. Benefits are not available for local infiltration or the administration of anesthesia by the attending or assisting surgeon (except spinal, saddle or caudal blocks for Pregnancy, or general anesthesia for covered oral surgery and dental procedures).

Autism Spectrum Disorders

Benefits are available for Covered Services for the screening, diagnosis and treatment of autism spectrum disorders for Covered Persons up to age 21 which may include behavioral health treatment such as applied behavior analysis. Benefits are subject to the applicable Copay, Deductible and/or Coinsurance amounts for other Mental Illness Services. Autism Spectrum Disorder Services must be Certified.

Definitions

The following definitions apply to autism spectrum disorders.

Applied behavior analysis: the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior.

Autism spectrum disorder: any of the pervasive developmental disorders or autism spectrum disorder as defined by the most recent Diagnostic and Statistical Manual of Mental Disorders.

Behavior analyst: a Certified provider, which may include a Board Certified Behavior analyst approved by the Behavioral Analyst Certification Board, as defined in BCBSNE's medical policy.

Behavioral health treatment: counseling and treatment programs, including applied behavior analysis that are:

- necessary to develop, maintain, or restore to the maximum extent practicable, the functioning of an individual; and
- provided or supervised either in person or by telehealth, by a behavior analyst certified by a national certifying organization or a Licensed Psychologist if the Services performed are within the boundaries of the psychologist's competency.

Treatment: evidence-based care, including related equipment, that is prescribed or ordered for an individual diagnosed with an autism spectrum disorder by a Licensed Physician or a Licensed Psychologist, within the scope of his or her practice, including:

- behavioral health treatment;
- pharmacy care;
- psychiatric care;
- psychological care; and
- therapeutic care.

NOTE: *Except in the case of Inpatient Services, BCBSNE reserves the right to request a review of treatment of autism spectrum disorders once every six months, unless the Covered Person's Licensed Physician or Licensed Psychologist agrees to more frequent reviews.*

Drugs Administered In An Outpatient Setting

When indicated on your Schedule of Benefits Summary, certain prescription drugs and other Covered Services administered in an Outpatient setting (such as home, Physician's office or other Outpatient setting, except a Hospital emergency room) are only payable under the Rx Nebraska Prescription Drug Program.

NOTE: *Please check your Schedule of Benefits Summary to determine if this provision applies to you.*

Durable Medical Equipment (DME)

Benefits are available for rental or initial purchase (whichever costs less) for covered DME when prescribed by a Physician. Benefits for rental of DME shall not exceed the cost of purchasing the equipment unless otherwise approved by BCBSNE.

Benefits will be available for subsequent purchases of covered DME when:

- there is a significant change in the Covered Person's condition;
- the Covered Person grows;
- the item cannot be repaired and/or the cost of repairs exceeds the expense of purchasing a second piece of equipment;
- the item is five or more years old (equipment may be replaced earlier if Certified by BCBSNE);
- or as otherwise determined by BCBSNE to be reasonable and necessary.

In addition, reimbursement will only be made to a DME or medical supply company for Medically Necessary repair, adjustment and maintenance of purchased DME, as determined appropriate by BCBSNE. Benefits are not available for DME which is rented or purchased from, or used while confined to a Hospital, skilled nursing facility, intermediate care facility, a nursing home or other Licensed residential facility if such equipment is usually supplied by the facility.

NOTE: *Oxygen and equipment for its administration, respiratory therapy, ventilation equipment, apnea monitors and continuous positive airway pressure devices (CPAP) may be subject to review of the rental versus purchase provision by BCBSNE.*

Home Health Aide, Skilled Nursing Care And Hospice

Unless otherwise stated in this document or an amendment to this document, benefits are available subject to the Copay, Deductible and/or Coinsurance and benefit limits outlined in the Schedule of Benefits Summary for the following Medically Necessary home health aide, respiratory care, Skilled Nursing Care, and Hospice Services provided to a Covered Person.

Home Health Aide

Benefits are available for Medically Necessary Physician ordered home health aide Services provided in the home by a licensed or Medicare-Certified home health agency. Covered Services include personal care services such as:

- bathing;
- feeding; and
- household cleaning duties.

Benefits are only available for home health aide Services when they are related to active and specific medical, surgical or psychiatric treatment which requires the skills of a registered nurse.

Respiratory Care

Respiratory care Services must be ordered by a Physician, be performed in the home, and must related to active and specific medical or surgical treatment which requires the skill of a registered nurse or respiratory therapist. These Services include, but are not limited to: airway maintenance, chest physiotherapy, delivery of medications, oxygen therapy, obtaining laboratory samples and pulmonary function testing. Services must be provided by a Licensed or Medicare-Certified home health agency.

Skilled Nursing Care
Nursing care must be Physician ordered and the patient must need care which requires the skill, proficiency and training of a registered nurse (RN) or a Licensed practical nurse (LPN). **Skilled Nursing Care must be Certified.**

Benefits will not be provided for:
- nursing care in excess of any benefit limit;
- nursing care which is primarily for the convenience of the patient or the patient's family;
- time spent bathing, feeding, transporting, exercising or moving the patient, giving oral medication or acting as a companion, sitter, or homemaker;
- care provided by a nurse who is an immediate relative by blood, marriage or adoption, or a member of the Covered Person's household; and
- care provided in a Hospital, a skilled nursing facility, intermediate care facility, or a sub-acute care or rehabilitation facility.

Hospice Services
Hospice is a program of care provided for a person diagnosed as terminally ill and his/her family. The Covered Person must have a life expectancy of six months or less and Services must be ordered by a Physician, and be appropriate for palliative support or management of a terminal illness. **Hospice Services must be Certified.**

The following Covered Services provided by a Medicare-certified Hospice:
- Hospice nursing Services provided in the home;
- Inpatient Hospice care;
- respite care, which is short-term Inpatient care necessary in order to give temporary relief to the person who regularly assists with the care at home. Respite care may be provided in the Hospice's designated Inpatient unit that is affiliated with the Hospice providing Services to the Covered Person, which may be a Skilled Nursing Facility or a Hospital;
- medical social Services, provided by a medical social worker employed by the Hospice, which are directly related to the Covered Person's medical condition;
- crisis care, which is extended Skilled Nursing Care for up to 24 hours per day in lieu of a Medically Necessary Inpatient hospitalization; and
- bereavement counseling for a covered family member of the deceased Covered Person who was the recipient of Hospice Services. The counseling Services must be provided within six months of the death.

Hospital And Facility Services

Inpatient and Long Term Acute Care
Benefits are available for Inpatient Covered Services such as room and board, treatment rooms, diagnostic Services, drugs, medicines and other ancillary Services provided by the Hospital.

If an intensive care, cardiac care or similar type room is used during a 24-hour period, only one room charge will be payable, and benefits will be based on the most intensive care provided during that period.

NOTE: *If benefits are denied for Hospital room and board, all other Inpatient Services are denied.*

Skilled Nursing Facility Care
Benefits are available subject to Medically Necessary criteria, and to any limit stated in the Schedule of Benefits Summary. After the exhaustion of the stated limit, all Services provided in the skilled nursing facility will be denied. The care must be provided in a Licensed or Medicare-certified skilled nursing facility or in a part of Hospital with designated skilled nursing or swing beds, licensed to provide room, board, 24-hour-a-day Skilled Nursing Care and other related non-Custodial Services. The care must be ordered by a Physician and the patient must be receiving Skilled Nursing Care. **Skilled nursing facility care must be Certified.**

Skilled nursing facility care does not include:
- supportive Services for a stabilized condition;
- care which can be learned and given by unlicensed or uncertified medical personnel;
- routine health care Services;
- general maintenance or supervision of routine daily activities; and
- routine administration of oral or prescription drugs.

Inpatient Physical Rehabilitation
Benefits are available for Covered Hospital and Physician Services for Inpatient care when provided as part of a Physical Rehabilitation admission. In addition, Covered Services will include the following when part of the rehabilitation admission:
- recreational therapy;
- social service counseling;
- prosthetic devices and fitting; and
- psychological testing.

The facility must be accredited for Comprehensive Inpatient Rehabilitation by the Commission on the Accreditation of Rehabilitation Facilities (CARF), or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or appropriately Certified by BCBSNE.

Outpatient Hospital Or Facility Services
Benefits are available for Covered Outpatient Services provided by a Hospital, Ambulatory Surgical Facility, Urgent Care Facility or other Outpatient facility. An observation stay is considered an Outpatient Service.

Emergency Room Care
When you receive care in the emergency room, benefits will be provided subject to the applicable Copay, Deductible and/or Coinsurance shown on the Schedule of Benefits Summary. If you receive care at an Out-of-network Hospital emergency room or by an Out-of-network Provider, benefits for Covered Services may be provided at the In-network benefit level. You will still be responsible for amounts in excess of the Allowable Charge when you receive Services from an Out-of-network Provider.

If Emergency Care results in a Covered Person being admitted to the Hospital, BCBSNE must be notified of the admission in accordance with the Certification requirements for emergencies. (Please refer to "Certification Requirements.")

If a Copayment is applicable to the Emergency Room facility charge, it will be waived if the patient is admitted within 24 hours for the same diagnosis.

EMERGENCY ROOMS ARE EXPENSIVE
Hospital emergency rooms are very expensive because they are specifically staffed and equipped to handle accidents, injuries and other emergencies. Using them for preventive care (or as a substitute for the family physician) can cost you time and money.

Cardiac and Pulmonary Rehabilitation Services — Outpatient
Cardiac or Pulmonary Rehabilitation is defined as the use of various modalities of treatment to improve cardiac or pulmonary function as well as tissue perfusion and oxygenation through which selected patients are restored to and maintained at either a pre-illness level of activity or a new and appropriate level of adjustment. Cardiac and pulmonary rehabilitation programs must be accredited by JCAHO, or otherwise approved by BCBSNE.

- **Covered Outpatient Cardiac or Pulmonary Rehabilitation.** The following Services are also covered when provided as part of an Outpatient rehabilitation program:
  - initial rehabilitation evaluation;
  - exercise sessions;
  - concurrent monitoring during the exercise session for high risk patients; and
  - Physician Services which are otherwise defined as Covered Services.
- **Cardiac Rehabilitation Criteria.** Benefits are available at any therapeutic level, up to 18 sessions per diagnosis or condition.
- **Pulmonary Rehabilitation Criteria.** Benefits are available for Services provided prior to and following a lung transplant, heart-lung transplant, lung volume reduction surgery and for severe chronic lung disease patients, as reviewed and determined by BCBSNE. Pulmonary rehabilitation Services must be under the continuing supervision of a Physician and in a Hospital environment. Pulmonary rehabilitation requires Certification.
- **Pulmonary Rehabilitation Limits.** Unless otherwise shown on the Schedule of Benefits Summary, the following limits apply:
  - chronic lung disease patients are limited to 18 sessions (including follow-up home sessions) initially and after significant changes in clinical status. No more than 18 sessions will be covered in a calendar year;
  - lung transplant, heart-lung transplant and lung volume reduction surgery patients are limited to 18 sessions following referral and prior to surgery plus 18 sessions within six months of discharge from the hospital following surgery.

Maternity and Newborn Care

Maternity Care
Maternity benefits are available to you, a covered spouse or an Eligible Dependent daughter unless otherwise indicated in the Master Group Contract.

Benefits for covered Hospital, surgical and medical care related to Pregnancy includes all related Services for prenatal care, postnatal care, delivery, and complications of Pregnancy or interruptions of Pregnancy. Charges for pre-natal, post-natal and delivery Services are payable as a total (global) charge, per American Medical Association Current Procedural Terminology (CPT) terms, codes and related guidance. Charges for additional Services outside the total (global) maternity charge, such as radiology, pathology and other diagnostic Services are payable as for any other Service.

Covered Services include obstetrical care provided by and within the scope of practice of a certified nurse midwife.

Postpartum depression, psychosis or any other Mental Illness are not considered complications of Pregnancy under this part. Benefits for this type of condition are provided in the same manner as all other Mental Illness Services.

Newborn Care
Benefits are available at birth for Covered Services for an eligible newborn infant. Covered Services include:

- room and board, including any ancillary Services;
- screening tests, including the initial newborn hearing exam;
- Physician Services for a newborn well infant while hospitalized, including circumcision;
- newborn screening Services for an infant born at home; and
- Medically Necessary definitive medical or surgical treatment.

Benefits for Covered Services will be subject to the child's individual cost-sharing amounts, unless otherwise stated. For information on adding a newborn to your coverage, refer to the section titled "Eligibility and Enrollment."

Statement of Rights Under The Newborns' and Mothers' Health Protection Act
Under federal law, benefits may not be restricted for any Hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, benefits may be paid for a shorter stay if the mother's or newborn's attending provider, after consulting with the mother, discharges the mother or newborn earlier.

Also, under federal law, a plan may not set the level of benefits or out-of-pocket costs so that any later portion of the 48 hour (or 96 hour) stay is treated in a manner less favorable than any earlier portion of the stay. In addition, a plan may not require the provider to obtain authorization from the plan for prescribing a length of stay of up to 48 hours (or 96 hours).

Mental Illness, Substance Dependence And Abuse Benefits

Benefits are payable for covered Hospital and Physician Services, including mental health Services, psychological or alcoholism and drug counseling Services by and within the scope of practice of a:

- qualified Physician or Licensed Psychologist;
- Licensed Special Psychologist, Licensed clinical social worker, Licensed professional counselor or Licensed mental health practitioner; or
- auxiliary providers who are supervised, and billed for, by a qualified Physician or Licensed Psychologist or as otherwise permitted by state law.

All licensing or certification shall be by the appropriate state authority. Appropriate supervision and consultation requirements also shall be provided by state law.

Benefits for covered Services are subject to the applicable Copay, Deductible and/or Coinsurance, as indicated on your Schedule of Benefits Summary.

Inpatient Care
Benefits for Inpatient admissions must be Certified by BCBSNE.

A person shall be considered to be receiving Inpatient treatment if he or she is confined to a Hospital or a Substance Dependence and Abuse treatment center that provides medical management including 24-hour nursing care. Services provided by a facility that does not meet this criteria are considered part of a Residential Treatment Program.

Facilities must be Licensed by the Department of Health and Human Services, Regulation and Licensure (or equivalent state agency), or accredited by the Joint Commission on Accreditation of Rehabilitation Facilities (CARF) or Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Residential Treatment Services
Benefits are available for Covered Services and room and board provided as part of a Residential Treatment Program for treatment of Mental Illness and Substance Dependence and Abuse.

Benefits for Residential Treatment Center Services are available subject to Certification and Medical Necessity criteria and Utilization Management. If Certification is not obtained and the Services requested do not meet BCBSNE's Medical Necessity criteria, coverage for those Services may be denied.

In addition to the EXCLUSIONS stated in this certificate, benefits are not available for;

- Services that are not Medically Necessary, including:
  - treatment not necessarily directed toward alleviation or prevention of an acute condition, and
  - expected to be of long duration without any reasonably predictable date of termination;
- education, socialization, delinquency or Custodial Care;
- stress reduction classes and pastoral counseling;
- foster homes, halfway houses, group homes and treatment group homes;
- Inpatient confinement for environmental change or similar treatment; and
- support therapies, including personal counseling, cruises, wilderness programs, adventure therapy, residential therapeutic camps, and bright light therapy.

Outpatient Care
Benefits are available, subject to the applicable Copay, Deductible and/or Coinsurance amount indicated on your Schedule of Benefits Summary for Outpatient treatment of Mental Illness and Substance Dependence and Abuse.

A person who is not admitted for Inpatient care, but is receiving treatment in the Outpatient department of a Hospital, in an observation room, in an Ambulatory Surgical Facility, Urgent Care Facility, a Physician's office, or home shall be considered to be receiving Outpatient Care.

Outpatient Covered Services include:
- psychological therapy and/or Substance Dependence and Abuse counseling/rehabilitation provided by an Approved Provider;
- office visit or clinic visit, Consultation, or emergency room visit;
- an evaluation and assessment;
- medication checks;
- an Outpatient day, or partial hospitalization program for Mental Illness or a Substance Dependence and Abuse treatment program, that offers all-inclusive services for each Outpatient treatment day;
- biofeedback training for treatment of Mental Illness;
- ambulance services provided for the treatment of Mental Illness and Substance Dependence and Abuse;
- laboratory and diagnostic Services; and
- psychiatric/psychological testing.

Day treatment, partial care and Outpatient programs must be provided in a Hospital or facility which is Licensed by the Department of Health and Human Services Regulation and Licensure or accredited by the Commission on the Accreditation of Rehabilitation Facilities (CARF).

Emergency Care
Benefits are also available, subject to the applicable Emergency Care Copay, Deductible and/or Coinsurance indicated in your Schedule of Benefits Summary, for any Covered Services provided in a Hospital emergency room setting for the treatment of Mental Illness and Substance Dependence and Abuse.

Oral Surgery and Dentistry

Limited benefits are available for oral surgery and dentistry. Benefits for Covered Services are available subject to any benefit maximums and the Copay, Deductible and/or Coinsurance as indicated on your Schedule of Benefits Summary.

Covered Oral Surgery and Dentistry Services
Unless otherwise indicated on your Schedule of Benefits Summary, the Plan provides benefits for the following Medically Necessary Services:
- Incision and drainage of abscesses, and other non-surgical treatment of infections *(excluding periodontic or endodontic treatment of infections)*;
- Excision of exostoses, tumors and cysts, *whether or not related to the temporomandibular joint of the jaw (TMJ)*;
- Diagnostic or surgical procedures involving bone or joint of the face, neck or head, including osteotomies, for treatment of TMJ or craniomandibular disorder;
- Reduction of a complete dislocation or fracture of the TMJ required as a direct result of an accident*****. *Benefits are limited to treatment provided within 12 months of the injury*.
- Services, supplies or appliances for dental treatment of natural healthy teeth required as the direct result of an accidental injury*****. *Benefits are limited to treatment provided within 12 months of the injury*. *Benefits are not available for orthodontics or dental implants;*
- Medically Necessary hospitalization and general anesthesia in order for the Covered Person to safely receive dental care, including Covered Persons who are under eight years of age or developmentally disabled.

******Please note*, damage to teeth that occurs as a result of eating, chewing or biting is not considered an "accident." Benefits are not available for Services resulting from these types of injuries.

Dental Related Hospital Charges
Benefits are also available for the following charges if determined by BCBSNE to be Medically Necessary when related to Covered Services for oral surgery and dentistry or when the Services are essential to safeguard the health of the patient who has a specific nondental physical and/or organic impairment, regardless of whether the admission is for covered or noncovered dental procedures:
- Hospital Inpatient Services;
- Hospital Outpatient Services; or
- Ambulatory facility Services.

Organ and Tissue Transplants

Benefits are available to a Covered Person who is a transplant recipient for Medically Necessary Covered Services relating to or resulting from a transplant of these body organs or tissues:
- liver;
- heart;
- single and double lung;
- lobar lung;
- heart-lung;

- heart valve (heterograft);
- kidney;
- kidney-pancreas;
- pancreas;
- bone graft;
- cornea;
- parathyroid;
- small intestine;
- small intestine and liver;
- small intestine and multiple viscera; or
- bone marrow transplants, including autologous and allogeneic stem cell transplants.

The applicable Copay, Deductible and/or Coinsurance are indicated on your Schedule of Benefits Summary.

Additional Covered Transplant Services
Benefits are also available for the following Medically Necessary Covered Services directly related to or resulting from a covered transplant:

- Hospital, medical, surgical or other Covered Services provided to a donor (including treatment of complications) are included as part of the recipient's coverage;
- Services provided for the evaluation of organs or tissue including, but not limited to, the determination of tissue matches;
- Services provided for the removal of organs or tissue from nonliving donors; and
- Service provided for the transportation and storage of donated human organs or tissues.

Physician Services

Benefits are payable for Covered Services provided by a Physician, including an oral surgeon, Certified nurse midwife, Certified nurse practitioner, chiropractic practitioner or a Certified Physician assistant, within the Provider's scope of practice. Covered Services include:

- Inpatient, Outpatient, office and home visits;
- surgical and assistant surgical Services;
- anesthesia;
- radiology, pathology, and other diagnostic Services;
- radiation therapy and chemotherapy;
- FDA-approved drugs, IV solutions, vaccines, biologicals and medicines administered in the office; and
- allergy serums and injections, except as specifically excluded.

Services performed in a Convenient Care/Retail Clinic or performed by a Physician assistant are covered in the same manner as a Primary Care Physician.

Physician Office

Benefits for the following Covered Services provided in a Primary Care of Specialist Physician's office are payable subject to the cost-sharing amounts shown on the Schedule of Benefits Summary.

Covered Physician Office Visits
The office visit benefit provision of this plan includes:

- a Physician office visit;
- an initial visit to diagnose Pregnancy;
- Consultations;
- psychological therapy and/or Substance Dependence and Abuse counseling/rehabilitation; and
- medication checks.

Covered Office Services
Unless otherwise stated in this document or an amendment to this document, Services and supplies covered under the office services benefit provision of this plan include:

- x-ray, laboratory and pathology services, including diagnostic pap smears and mammograms, performed in the Physician's office;
- supplies used to treat the patient during the office visit;
- drugs administered to the patient during the office visit;
- hearing examination due to illness or injury;
- vision examination, excluding eye refractions, due to illness or injury; and
- allergy testing, injections and serums, except as specifically excluded.

Non-Covered Under Office Service Benefit
Although these Services may be covered under other provisions, generally the office service benefit provision does not include:

- Preventive Services;
- Services for Pregnancy, except the initial office visit to diagnose Pregnancy;
- immunizations;
- injections;
- Sublingual allergy therapy;
- infusion therapy;
- chemotherapy infusion and chemotherapy drugs;
- radiation therapy and/or Advanced Diagnostic Imaging;
- manipulations and adjustments;
- physical, occupational or speech therapy, including cognitive training, chiropractic or osteopathic physiotherapy;
- surgical procedures and anesthesia;
- sleep studies;
- Durable Medical Equipment;

- biofeedback;
- psychological evaluations, assessments and testing;
- drugs payable only under the Rx Nebraska Prescription Drug Program (see the provision in this section titled "Drugs Administered In An Outpatient Setting" for additional information); and
- Outpatient Services received at a place of service other than a Physician's office.

Telehealth Services
Physician's Services include telehealth Services as a delivery of care method, for the diagnosis and treatment of a Covered Person's medical condition. Telehealth Services means a web-based, video or telephonic visits, calls or consultations between a Covered Person and an Approved Provider.

An Approved Provider for telehealth Services is a Licensed Physician or other professional provider that has a written agreement with BCBSNE or its third party vendor, as a designated telehealth Services network provider. The delivery and scope of telehealth Services are subject to applicable state and federal laws and regulations.

Telehealth Services are not applicable to or available for:
- reporting lab or other test results;
- office appointment requests;
- communication primarily educational in nature;
- billing, insurance or payment questions;
- Certification procedures;
- Physician to Physician consultations;
- calls or consults by telemedicine, telephone or other electronic means to another health care provider during a Covered Person's visit in a provider's office;
- Services, treatment or conditions outside the scope of the agreement between BCBSNE and its designated third-party Telehealth Service vendor.

Telehealth Services are subject to the cost-sharing amounts shown on the Benefit Summary.

NOTE: *If a Covered Person receives telehealth Services which may be covered under more than one health plan or contract, and identifies to the telehealth Services provider at the time of service that this Plan is to be used for coverage, this Plan will provide benefits as the primary coverage. When another health plan or contract is used or identified at the time of service, this Plan will become the secondary coverage pursuant to Coordination of Benefits. The Covered Person must submit a claim form and itemized statement and the other plan's Explanation of Benefits to BCBSNE reflecting the charges and cost-sharing amount paid pursuant to the other plan for benefit consideration under this Plan as the secondary coverage.*

Preventive Services
Preventive Services required by the ACA are not subject to a Copayment, Deductible and/or Coinsurance amount when provided by an In-network Provider. Such covered Preventive Services provided by an Out-of-network Provider benefits will be provided as indicated on your Schedule of Benefits Summary.

ACA-required Preventive Services include age, gender, and frequency limits. A list of these Preventive Services may be obtained by contacting the BCBSNE Member Services Department.

Benefits for Covered Services that fall outside the age, gender, and frequency limits for ACA required Preventive Services will be provided as indicated on your Schedule of Benefits Summary.

As indicated on your Schedule of Benefits Summary, benefits will also be provided for other covered Preventive Services. Such Covered Services include:
- laboratory/pathology Services, including urinalysis (UA) and complete blood count (CBC);
- hearing screenings and examinations; and
- Prostate cancer screenings (PSA).

Preventive Services do not generally include Services intended to treat an existing illness or condition.

Therapy and Manipulations
The following outpatient and/or home therapies and manipulative treatments or adjustments are covered subject to the applicable Copay, Deductible and/or Coinsurance amounts and treatment limits shown on your Schedule of Benefits Summary:
- Physical therapy by a Licensed physical therapist or Licensed physical therapist assistant who is an Approved Provider;
- Chiropractic or osteopathic physiotherapy;
- Occupational therapy by a Licensed occupational therapist or Licensed occupational therapist assistant under the supervision and billing of a Licensed occupational therapist;
- Speech therapy provided by a Licensed speech-language pathologist or registered communication assistant practicing under the supervision of a Licensed speech-language pathologist; and
- Chiropractic or osteopathic manipulative treatments or adjustments by an Approved Provider.

Therapy Services described above include Habilitative Services, which are Services and devices that help a person keep, learn, or improve skills and functioning of daily living.

NOTE: *A benefit maximum may apply to all the above Services or any combination of these Services. Check your Schedule of Benefits Summary for any applicable benefit maximums. Treatment limits for physical therapy, occupational therapy, and speech therapy are not applicable to treatment for Mental Illness or Substance Dependence and Abuse.*

A session is defined as one visit. Ongoing preventive/ maintenance therapy sessions (excluding habilitative services), treatments or adjustments are not covered once the maximum therapeutic benefit has been achieved for a given condition and continued therapy or treatments no longer result in some functional or restorative improvement.

Women's Health Act

The Women's Health and Cancer Rights Act of 1998 (Women's Health Act) includes protections for patients who elect to have breast reconstruction in connection with a mastectomy.

The law requires that certain coverage be provided, and that notice be given to Covered Persons regarding coverage for this care under the Group health plan. The Women's Health Act requires that:

A Group health plan which provides medical and surgical benefits for mastectomies shall also provide, in the case of a Covered Person who is receiving benefits in connection with a mastectomy, and who elects breast reconstruction in connection with such mastectomy, coverage for:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- physical complications resulting from all stages of the mastectomy, including lymphedemas,

in a manner determined in consultation with the attending Physician and patient.

This Group health plan is in compliance with the Women's Health Act, and provides benefits as required by the Act, subject to the Copay, Deductible and Coinsurance amounts applicable to other benefits under the plan.

EXCLUSIONS—WHAT'S NOT COVERED

Section 4

The Services, treatment and supplies listed as exclusions in this section are not covered, except where specifically provided for under another section of this Certificate, or by an Amendment to this Certificate.

Using Headings In This Section

To help you find specific exclusions more easily, headings are shown for types of Services, treatments or supplies that fall into a similar category. The actual exclusion appears under the heading.

Plan Exclusions

Benefits are not available for Services not covered by the Plan, nor for Services determined by BCBSNE to be not Medically Necessary. Benefits are not available for the Services, treatments or supplies described in this section, even if:

- recommended or prescribed by a Physician; and/or
- it is the only treatment available for the Covered Person's condition.

Non-covered services include , but are not limited to any Services for or related the following:

Alternative Treatments

- Alternative therapies:
  - Massage therapy, including rolfing;
  - Acupuncture;
  - Aromatherapy;
  - Light therapy;
  - Naturopathy; and
  - Vax-D therapy (vertebral axial decompression).
- Services provided by a massage therapist; and
- Services, drugs, medical supplies, devices or equipment which are not cost effective compared to established alternatives, or which are provided for the convenience or personal use of the Covered Person.

Comfort Or Convenience

- Personal expenses such as guest meals, television or beauty/barber services;
- Supplies, equipment or similar incidental charges for personal comfort or convenience, including:
  - batteries and battery chargers unless the device is covered by BCBSNE;
  - hot tubs, saunas, jacuzzis or whirlpools;
  - medical alert systems;
  - equipment primarily for education or a person's safety;
  - music devices, radios, personal computers or video players;
  - pillows;
  - strollers.
- Equipment for purifying, heating, cooling or other wise treating air or water;
- Exercise equipment;
- Humidifiers;
- The building, remodeling, or alteration or a residence; or
- The purchasing or customizing of vans or other vehicles.

Dental

Except as specifically described as covered, benefits are not available for:

- Bone grafts to the jaw, in relation to dental implants or preparation of the mouth for dentures;
- Care in connection with the treatment, filling, removal, repositioning or replacement of teeth, including orthodontics or implants;
- Evaluation and treatment of impacted teeth;
- Evaluation and treatment of myofascial pain;
- Osteotomies of the face, neck or head, except when specifically identified elsewhere as a Covered Service;
- Preparation of the mouth for dentures;
- Root canal therapy or care;
- Treatment of the dental occlusion by any means or for any reason;
- Treatment of the temporomandibular joint of the jaw by any means or for any reason, except when specifically identified elsewhere as a Covered Service;
- Other procedures involving the teeth or structures directly related to or supporting the teeth, including the gums and the alveolar processes; and
- Treatment of sleep disorders by a dentist, including sleep apnea, except for the fabrication of an orthotic for treatment of a sleep disorder.

Durable Medical Equipment (DME) And Supplies

- Automated external defibrillator;
- Enuresis alarm, even if prescribed by a Physician;
- Mouth guard, even if prescribed by a Physician;
- Non-wearable external defibrillator;
- Rental or purchase from or use of DME while the patient is confined to a Hospital, skilled nursing facility, an intermediate care facility, a nursing home or any other licensed residential facility if such equipment is usually supplied by the facility;
- Repair, maintenance or adjustment of DME, except as specifically identified as covered, or provided by other than a DME or medical supply company; and

- Repair or replacement of an item of DME due to misuse, malicious damage, gross neglect or to replace lost or stolen items.

Experimental Or Investigative
- Services considered by BCBSNE to be Investigative, or for any directly related Services.
- Services for medical treatment and/or drugs, whether compensated or not, that are directly related to, or resulting from the Covered Person's participation in a voluntary, investigative test or research program or study, unless authorized by BCBSNE.

Foot Care
- Orthopedic shoes, except initial purchase when permanently attached to a brace;
- Orthotics for the foot, except podiatric appliances necessary for the prevention of complications associated with diabetes, or when necessary to treat a congenital anomaly, as determined by BCBSNE; and
- Treatment or removal of corns, callosities, or the cutting or trimming of nails, except as Medically Necessary for preventing complications associated with diabetes.

Mental Illness And Substance Dependency/Abuse
- Custodial care;
- Programs for co-dependency; employee assistance; probation; prevention; educational or self-help;
- Inpatient or outpatient services ordered by the court that are determined by BCBSNE to be not medically necessary;
- Programs that treat obesity, gambling or nicotine addiction, except when specifically identified elsewhere as a Covered Service;
- Residential Treatment Programs or Services, except as specifically provided under the Plan; long-term rehabilitation programs, including residential Cognitive Training programs;
- Services by a non-approved provider;
- Services not within the scope of practice of the provider (Licensing or certification is by the appropriate state authority. Supervision and consultation requirements are governed by the state law.); and
- Services, supplies, equipment, procedures, drugs or programs for treatment of nicotine addiction, except when identified elsewhere as a Covered Service.

Nutrition
- Dietary counseling, except diabetes management as provided by the plan;
- Enteral feedings, even if the sole source of nutrition; and
- Nutrition care, nutritional supplements, FDA-exempt infant formulas, supplies, electrolytes or other nutritional substances, including but not limited to Neocate, Vivonex, Elecare, Cyclinex-1, ProPhree, vitamins, minerals, elements, foods of any kind (including high protein and low carbohydrate foods) and other over-the-counter nutritional substances.

Physical Appearance
- Cosmetic Services, except for Covered Services:
  – required as a result of a traumatic injury;
  – to correct a congenital abnormality when the defect severely impairs or impedes normal essential functions; or
  – to correct a scar or deformity resulting from cancer or from non-Cosmetic surgery.

  Reconstructive surgery is available only when required to restore, reconstruct or correct any bodily function that was lost, impaired or damaged as a result of injury or illness. Benefits are not payable for treatment of complications, unless the treatment is normally covered under the Plan.

  The Cosmetic exclusion applies regardless of the underlying cause of the condition or any expectation that the Cosmetic procedure may be psychologically or developmentally beneficial to the Covered Person.

  Examples include but are not limited to:
  – Dermabrasion;
  – Liposuction;
  – Breast reduction (unless medically necessary) or breast augmentation;
  – Protruding ears;
  – Spider veins;
  – Tattoo removal or revision; and
  – Telangiectasias.
- Treatment and monitoring for obesity or weight reduction, regardless of diagnosis.
  Examples include:
  – Health and athletic club memberships;
  – Physical conditioning programs such as athletic training, body-building exercise, fitness, flexibility and diversion or general motivation; and
  – Weight loss programs.
- Weight reduction surgery.

Providers

- Canceled appointment: Charges for failure to cancel a scheduled appointment.
- Claim forms/records/administrative fees. This includes: Charges made for filling out claim forms or furnishing any records or information; special charges such as dispensing fees; admission charges. Physician's charges for Hospital discharge Services; after-hour charges over and above the routine charge; administrative fees; technical support or utilization review charges which are normally considered to be within the charge for a Service.
- Custodial care, domiciliary care, rest cures, or Services provided by personal care attendants.
- Immediate family: Charges for Services provided by a person who is a member of the Covered Person's immediate family by blood, marriage or adoption.
- Services provided in or by:
  a) a Veterans Administration Hospital where the care is for a condition related to military service, or
  b) any non-Participating Hospital or other institution which is owned, operated or controlled by any federal government agency, except where care is provided to nonactive duty Covered Persons in medical facilities.
- Inadequate documentation: Charges received when there is inadequate documentation that a Service was provided.
- Non-approved facility: A health care facility that does not meet the licensing or Accreditation Standards required by BCBSNE.
- Non-approved provider: Charges for Services by a non-approved provider.
- Out-of-Hospital: Charges made while the patient is temporarily out of the Hospital.
- Overhead expenses: Charges for any office or facility overhead expenses including, but not limited to, staff charges, copying fees, facsimile fees and office supplies.
- Scope of practice: Charges for Services by a health care provider which are not within the scope of practice of such provider.
- Services provided by a massage therapist.
- Standby: Hospital or Physician charges for standby availability.

Reproductive Services

- Pregnancy assistance treatments, which include but are not limited to, infertility treatment and related Services, in addition to:
  - Assisted Reproductive Technology (ART), such as artificial insemination, sperm washing, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), and in vitro fertilization;
  - Embryo transfer procedures;
  - Drug and/or hormonal therapy for fertility enhancement;
  - Ultrasounds, lab work and other testing in conjunction with infertility treatment;
  - Reversal of voluntary sterilization;
  - Surrogate parenting, donor eggs, donor sperm and host uterus; and
  - Storage and retrieval of all reproductive materials. (Diagnostic testing done to determine the diagnosis of infertility, treatment of polycystic ovary disease, and treatment of endometriosis are not considered to be infertility treatment.)
- Surrogate mother Services.
- Voluntary abortions unless the attending Physician certifies that the abortion was necessary to safeguard the life of the woman, or that the unborn child's viability was threatened by continuation of the Pregnancy. Services for any medical complication arising from a voluntary abortion are not excluded from coverage.

Services Payable Under Another Plan

- Services available at government expense, except as follows:
  If payment is required by state or federal law, the obligation to provide benefits will be reduced by the amount of payments the patient is eligible for under such program (except Medicaid).

  With respect to persons entitled to Medicare Part A and Eligible for Part B benefits, the obligation to provide benefits will be reduced by the amount of payment or benefits such person receives from Medicare. This provision will not apply if the patient is still actively at work or is an Eligible Dependent of a Subscriber who is actively at work and has elected this Plan as primary, or as otherwise provided by federal law. Services provided for renal dialysis and kidney transplant Services will also be provided pursuant to federal law.

- Services arising out of the course of employment, whether or not the patient fails to assert or waives his or her right to Workers' Compensation or Employers' Liability Law. This includes Services determined to be work-related under a Workers' Compensation law, or under a Workers' Compensation Managed Care Plan, but which are not payable because of noncompliance with such law or Plan. Any charges incurred as a result of or in the course of employment for an employer that is not legally required to carry Workers' Compensation coverage and that does not provide Workers' Compensation coverage will be covered.

Transplants

- Donor charges other than those identified as covered under "Organ and Tissue Transplants" in the section titled "Benefit Descriptions;"
- Purchased human organs or tissue;
- Implantation of an artificial/mechanical organ into a human recipient, excluding pacemakers, LVADs, or other devices when specifically approved by BCBSNE; and
- Transplantation of any nonhuman organ or tissue to a human recipient.

Travel

- Lodging or travel expenses incurred by the patient or the provider, even though directed by a Physician for the purpose of obtaining medical treatment, except covered ambulance Services or other expenses specifically identified as covered by the plan.

Vision And Hearing

- Eyeglasses or contact lenses, eye exercises, visual therapy or visual training (orthoptics), except when specifically identified elsewhere as a Covered Service;
- Preventive vision examinations or care, extended vision care or exam packages and screening eye examinations, including eye refractions, except when specifically identified elsewhere as a Covered Service;
- Screening audiological tests (except as covered under Preventive Services); external and surgically implantable devices (except cochlear implants and bone anchored hearing aids as otherwise covered under this plan) and combination external/implantable devices to improve hearing, including audiant bone conductors or hearing aids and their fitting; and
- Surgical, laser or nonsurgical procedures or alterations of the refractive character of the eye including but not limited to correction of myopia, hyperopia or astigmatism. In addition, benefits are not available for:
  - Charges for related Services; and
  - Eyeglasses or contact lenses following the surgery.

Other Exclusions And Limitations

- Services, including related diagnostic testing, which are primarily:
  - recreational, such as music or art therapy;
  - educational;
  - work-hardening therapy; vocational training;
  - medical and nonmedical self-care;
  - self-help training;
- Interest, sales or other taxes or surcharges on Covered Services, drugs, supplies or DME, other than those surcharges or assessments made directly upon employers or third party payers;
- Genetic treatment or engineering; any service performed to alter or create changes in genetic structure;
- Genetic testing, unless scientifically validated by BCBSNE medical policy, or as required by law. Coverage for genetic counseling is limited to one visit prior to genetic testing and one visit following a covered genetic test;
- Food antigens, skin titration, cytotoxicity testing, treatment of non-specific candida sensitivity and urine auto injections;
- Snoring, the reduction or elimination of, when that is the primary purpose of treatment;
- Calls or consults by telephone or other electronic means, video or internet transmissions, and telemedicine, except in conformance with BCBSNE policies and procedures;
- Blood, blood plasma or blood derivatives or fractionates, or Services by or for blood donors, except administrative and processing charges for blood used for a Covered Person furnished to a Hospital by the American Red Cross, county blood bank, or other organization that does not charge for blood;
- Wigs, hair prostheses and hair transplants, regardless of the reason for the hair loss;
- Hair analysis, including evaluation of alopecia or age-related hair loss;

- Services provided to or for:
  - any dependent when coverage is provided by a Single Membership, except when benefits are specifically provided by the plan for a newborn or adopted child;
  - any person who does not qualify as an Eligible Dependent;
  - any Covered Person before his or her effective date of coverage, or after the effective date of cancellation or termination of coverage.
- Military service related illness or injury;
- Services for which there is no legal obligation to pay, including:
  - Services for which no charge would be made if coverage did not exist;
  - any charge above the charge that would have been made if no coverage existed; or
  - any service which is normally furnished without charge.
- Charges in excess of the Contracted Amount;
- Charges made separately for Services and/or procedures, supplies and materials when they are considered to be included within the charge for a total Service payable, or if the charge is payable to another provider;

  EXCEPTION: If such charges are made separately when they are considered to be included within the charge for a total Service performed by a BCBSNE In-network Provider, then this amount is not the patient's liability.

- Employer required Services as a condition of employment including, but not limited to immunizations, blood testing, work physicals and drug tests;
- Charges made pursuant to a Covered Person's engagement in an illegal occupation or commission of or attempt to commit a felony;
- Electron beam computed tomography for vascular screening, including but not limited to screening for cardiovascular, cerebrovascular and peripheral vascular disease;
- Private Duty Nursing;
- Long-term rehabilitation therapy, including residential Cognitive Training programs;
- Respite care when not covered as part of a covered Hospice benefit;
- Home health aide, skilled nursing care or Hospice related Services as follows:
  - Services performed by volunteers;
  - pastoral Services, or legal or financial counseling Services;
  - Services primarily for the convenience of the Covered Person, or a person other than the Covered Person;
  - home delivered meals.
- Shipping and handling charges;
- Services provided at any of the following, except Covered Services provided at a health fair approved by BCBSNE:
  - day care;
  - school;
  - library;
  - church; or
  - employee worksite.
- Services otherwise covered under the Plan when:
  - required solely for purposes of camp, travel, career, employment, insurance, marriage or adoption;
  - related to judicial or administrative proceedings or orders;
  - conducted for the purpose of medical research; or
  - required to obtain or maintain a license of any type.
- Foreign language and sign language Services;
- Driving tests or exams;
- Autopsies;
- Sexual arousal disorders or erectile dysfunction treatment, including but not limited to Services, procedures, supplies or drugs regardless of the cause;
- Daycare; and
- Services provided under a direct primary care agreement.

Prescription Drug Benefits are subject to the applicable Copay, Deductible and/or Coinsurance amounts shown in the Schedule of Benefits Summary. All covered prescription drug products must be Medically Necessary, and:

- be FDA approved,*
- be evaluated for coverage by the Pharmacy and Therapeutics Committee of BCBSNE or the Pharmacy Benefit Manager;
- be dispensed by a registered pharmacist, and
- require a Physician's or Dentist's prescription.

**Specific non-FDA-approved drugs may be covered, based on clinical guidelines or evidence as determined by the Pharmacy and Therapeutics Committee, or as required by law.*

A Copay, Deductible and/or Coinsurance will be assessed for each prescribed drug, supply and/or unit.

Covered prescription drug products also include insulin and diabetic supplies, including: needles, syringes, test strips, lancet/lancet devices, alcohol wipes/swabs, glucose/sugar test tablets and insulin pump supplies.

Your prescription drug benefit is based on a tiered benefit design that features multiple levels of cost-sharing for different prescription classifications. The tiers may include classifications such as Generic and Brand-name Drugs, Specialty Drugs, and preferred and non-preferred drugs. Sub-classifications may be based on cost or other factors. For example, a formulary list classifies drugs as Generic and Brand Name, that classification may include sub-categories or preferred and non-preferred drugs. The formulary list(s), and a list of designated Specialty Drugs, is available at www.nebraskablue.com, or you may contact the BCBSNE Member Services Department.

Whenever appropriate, Generic Drugs will be used to fill prescriptions. If a bioequivalent Generic Drug is available and has multiple manufacturers, or meets other criteria as determined by the PBM or Us, reimbursement for the drug dispensed will be based on the price of the Generic Drug, unless prohibited by law. If the Covered Person requests a Brand name Drug when a Generic Drug equivalent is available, the Covered Person will be required to pay a penalty equal to the difference in cost between the Brand Name Drug and the Generic Drug. This penalty will be in addition to the applicable Copay, Deductible and Coinsurance.

NOTE: *Prepackaging by the manufacturer may limit the quantity dispensed to an amount which is less than the maximum dispensing amount available under your coverage. If that happens, benefits will be provided in compliance with the manufacturer's packaging guidelines.*

Additional terms and provisions for the Rx Nebraska Prescription Drug Program are stated at the end of this section.

Accessing Benefits

If the prescription or supply is purchased at an In-network pharmacy, and you present your BCBSNE identification card to the pharmacist at the time of purchase, you will only be required to pay your financial liability at the time the prescription is filled. The Schedule of Benefits Summary shows your financial liability and the dispensing amount for each benefit tier.

If the covered prescription is filled at an Out-of-network Pharmacy, or if you do not present your I.D. card at the time of purchase at an In-network Pharmacy, you will be required to pay the pharmacy's usual retail price. You must file a claim with BCBSNE. Eligible claims will be reimbursed based on the Allowance for the drug less the applicable Copay, Deductible and/or Coinsurance and a penalty.

Other Coverage: If a Covered Person has prescription drug coverage under more than one health plan, Coordination of Benefits provisions will apply. No penalty will be imposed for submission of a paper claim when BCBSNE is paying as the secondary payer.

To locate participating Rx Nebraska pharmacies nationwide, call toll-free 1-877-800-0746.

Services NOT Covered Under the Rx Nebraska Drug Coverage Program

In addition to the Services and supplies listed in the section titled "Exclusions - What's Not Covered," the following are not covered:

- Abortifacients, including but not limited to Mifeprex (Mifepristone);
- Cosmetic alteration drugs, health and beauty aids for such things as the promotion of hair growth/restoration, control perspiration, to enhance athletic performance or improve natural appearance;
- Diagnostic agents (except diabetic test strips), general anesthetics and bulk powders/chemicals.
- Diet, weight loss or appetite suppressant drugs (Anorexics), dietary and herbal or nutritional supplements;
- Drugs or medicinals for treatment of fertility/infertility *unless such drugs are covered under an amendment for infertility treatment and related services*;
- DME or devices of any type including, but not limited to contraceptive devices, therapeutic devices and supplies or artificial appliances;

- Home infusion therapy;
- Insulin pumps and continuous glucose monitoring devices;
- Investigative drugs or drugs classified by the FDA as experimental;
- Non-sedating oral antihistamines or antihistamine decongestant combination;
- Nutrition care, nutritional supplements and substances;
- Ostomy supplies;
- Over-the-counter medications, including non-prescription medications and non-prescription vitamins, *unless certain over-the-counter/non-prescription medications are covered under an amendment;*
- Prescription medications determined by the FDA as having no clinical value (ex: DESI indicator class 06); or determined by the Pharmacy and Therapeutics Committee to have insufficient or unfavorable safety and/or efficacy.
- Prescription medications purchased in a foreign country, unless the covered person is living in another country or needs prescription medications to treat an emergency medical condition arising while he or she is traveling in a foreign country or otherwise mandated by federal legislation. (Evidence of residency or emergency medical condition must be provided with the claim);
- Prescription medications that have (or are comprised of) therapeutically equivalent over-the-counter non-prescription products, except for insulin, diabetic test strips, glucose monitors, and insulin pump supplies unless otherwise required by law. This limitation may apply to specific drugs or categories of prescription drugs.
- Prescription medications prescribed, dispensed and intended for use in an Inpatient setting;
- Repackaged medications;
- Services, drugs and medical supplies which are not cost effective compared to established alternatives or which are provided for convenience or personal use;
- Sexual or erectile dysfunction drugs, aids or treatment;
- Supplies and Pharmaceutical aids other than designated injectable, diabetic, and insulin pump supplies. Insulin pump batteries are not covered under your prescription drug benefits.
- Unit dose packaging, institutional packs or samples of covered prescription drug products; and
- Other drugs and/or injectables that are not covered as determined by BCBSNE.

Limitations

- Any cost-sharing for prescription drugs paid with a pharmaceutical discount or copay card will not apply to the Out-of-pocket Limit;
- Amounts in excess of the supply limit (day or quantity) for covered prescriptions are not covered.
- Certain prescription drugs, based on the route or method of administration, may be payable only under the medical provisions of the Plan, and not under the prescription drug coverage. This includes but is not limited to intravenous, intrathecal, intravesical and epidural routes of administration.
- Certain prescription drug products administered in an Outpatient setting are only payable under the Prescription Drug Program, as determined by BCBSNE. A list of these drugs is available at www.nebraskablue. com, or by contacting the BCBSNE Member Services Department at the number shown on the back of your I.D. card.
- Compounded medications must contain at least one FDA approved drug, and compounded medications that include non-FDA approved ingredients or ingredients that do not require a prescription are not covered. Compound ingredients that are not FDA-approved are not covered.
- Injectables are limited to Claims from providers who are contracting with Prime Therapeutics and filed as a pharmacy claim.
- Lost, destroyed or stolen medications are limited to one replacement per prescription per calendar year.
- Excessive pattern of drug usage. In the event a Covered Person's usage of prescription drugs during a six month period indicates an excessive pattern of drug usage that is not Medically Necessary (as determined by BCBSNE's Drug Utilization Review Program), the Covered Person will be limited to one Participating Pharmacy of his/her choice for obtaining covered prescription drugs. If such a limitation applies to the Covered Person, benefits will not be available for prescription drugs obtained from any other pharmacy.
- Orally administered anticancer medication used for killing or slowing the growth of cancerous cells will be paid no less favorable than intravenously administered or injected anticancer medications covered under the medical provisions of the Plan.

Preauthorization

The Prescription Nebraska Drug Coverage Program requires preauthorization for certain prescriptions to determine if benefits will be available.

Preauthorization is required for the following (but not limited to):

Preferred brand and non-preferred proton pump inhibitors (PPIs) - PPIs are used to help reduce stomach acid and provide relief from the symptoms of heartburn, ulcers, and gastroesophageal reflux disease (GERD).

Benefits for preferred generic PPIs do not require preauthorization.

NOTE: *If you are currently taking a non-formulary PPI or a formulary brand PPI, preauthorization is necessary to determine if you meet the criteria for continued benefits.*

GI protective NSAIDs - The GI protective NSAID program manages the use of costly non-steroidal anti-inflammatory drugs (NSAIDs) used to treat inflammation and reduce pain. These drugs work the same as drugs such as naproxen and ibuprofen.

Patients whose medical history and current medical condition do not indicate that use of a GI protective NSAIDs is required need to try traditional NSAIDs first. Benefits for gastroprotective NSAIDs will be available if the Covered Person's medical condition warrants it.

Note: Preauthorization is also required for other prescriptions as determined by BCBSNE - For more information on prescription medications requiring preauthorization, visit the BCBSNE website (www.nebraskablue.com) or call the Member Services Department at the phone number shown on the back of your I.D. card.

Requesting Preauthorization: A written request to BCBSNE must be made prior to the initial purchase of the prescription. This request must be accompanied by appropriate documentation from the Covered Person's physician, dentist or other medical provider demonstrating the medical necessity of the drug. This written request should be directed to:

Blue Cross and Blue Shield of Nebraska
Attention: Pharmacy
P.O. Box 3248
Omaha, Nebraska 68180-0001

Preauthorization forms can be found on the BCBSNE website at www.nebraskablue.com.

Upon receipt of the necessary information, BCBSNE will respond in writing advising the provider and the Covered Person whether or not benefits are available.

NOTE: *The limitation, preauthorization and formulary lists may be updated at any time without notice. Additional information about your RX Nebraska pharmacy benefits can be found on the BCBSNE website at www.nebraskablue.com.*

Definitions

The following terms are specifically used in conjunction with the Rx Nebraska Prescription Drug Program.

Allowance: The amount determined by BCBSNE to be payable to the Covered Person who has used an Out-of-network Pharmacy for a Covered Service. The Allowance may be one of the following:

1. the lesser of the usual retail price or the applicable Contract Amount payable for similar Services by similar In-network Pharmacies; or
2. as otherwise determined by BCBSNE or our Pharmacy Benefit Manager to be appropriate based on industry standards for similar Covered Services.

Brand Name Drug: Single source and multisource brand drugs as set forth in the Medi-Span Master Drug Database File or such other recognized source relied upon by the Pharmacy Benefit Manager or BCBSNE**.** All products identified as "brand-name" by the manufacturer, pharmacy or the provider may not be classified as Brand Name Drugs by the PBM of BCBSNE.

Compound Medication: A prescribed medication in which the ingredients are combined, mixed or altered specifically to meet the needs of a patient. A covered Compound Medication must contain at least one FDA-approved prescription ingredient.

Extended Supply Network: A limited network of retail In-network Pharmacies, for which Covered Prescription retail purchases in excess of 30 days may be purchased.

Formulary: A list of pharmaceutical products, which represents the current clinical judgment of physicians and other experts in the diagnosis and treatment of disease and preservation of health. This list is provided to In-network Pharmacies, Covered Persons, Physicians, and other health care providers and is available on-line at www.nebraskablue.com, or by contacting BCBSNE Member Services. BCBSNE reserves the right to change the formulary at any time without prior notice in compliance with federal law.

Generic Drug: A Generic Drug as set forth in the Medi-Span Master Drug Database File or such nationally recognized source relied upon by the Pharmacy Benefit Manager or BCBSNE. All products identified as "generic" by a manufacturer, pharmacy, or provider may not be classified as Generic Drugs by the Pharmacy Benefit Manager or BCBSNE.

In-network Pharmacies: Licensed pharmacies that have entered into written agreements with the Pharmacy Benefit Manager as designated by BCBSNE. The prescription drug coverage for your Plan may include more than one level of In-network (Preferred) Pharmacies.

Out-of-network Pharmacies: Licensed pharmacies that have not entered into written agreements with the Pharmacy Benefit Manager as designated by BCBSNE.

Pharmacy Benefit Manager (PBM): Prime Therapeutics, LLC, (Prime) has been retained by BCBSNE to administer the Rx Nebraska Prescription Drug Program.

Pharmacy and Therapeutics Committee: The PBM/BCBSNE panel of physicians, pharmacists and other health care professionals who are responsible for pharmacy management activities such as managing and updating the Formulary.

Specialty Drugs: Designated complex self-administered injectable and oral drugs that have very specific manufacturing storage, and dilution requirements, used to treat serious or chronic medical conditions such as multiple sclerosis, rheumatoid arthritis, hemophilia, hepatitis C, Crohn's disease, and anemia. These drugs are generally covered up to a 30-day supply. Specialty Drugs may only be available through a designated Specialty Pharmacy.

Specialty Pharmacy: A licensed pharmacy designated by BCBSNE or the Pharmacy Benefit Manager to provide Specialty Drugs.

Who's Eligible

The Plan's eligibility requirements are specified in the Master Group Contract between BCBSNE and your employer. We refer to the individual who enrolls for the coverage or the "employee" as a Subscriber. Dependents are generally your spouse and children; in order to be an Eligible Dependent, they must meet the definition of an Eligible Dependent.

NOTE: If two eligible persons in the same employer group are married to each other, each person and/or their Eligible Dependents may not enroll under more than one membership unit. If two eligible person have a parent/child relationship and both are employed by the same employer group, the parent and child may elect to enroll as two employees or the parent may enroll as an employee with dependent coverage.

Initial Enrollment

Subscribers and dependents must enroll within 31 days of their initial eligibility or during a special enrollment period, or late enrollment provisions may apply.

Special Enrollment

A special enrollment period of 31 days is allowed for:

- enrollment of eligible persons due to marriage, birth, adoption or placement for adoption;
- enrollment of eligible persons not previously covered under this plan due to having had other coverage at the time it was previously offered, and who have lost that other coverage due to:
  - exhaustion of COBRA continuation coverage, or
  - a loss of eligibility, including loss due to death, divorce, legal separation, termination of employment or reduction in hours, or due to the plan no longer offering benefits to the class of individuals that includes the person (when the other coverage was not COBRA), or
  - moving out of the service area of an HMO or other arrangement that only provides benefits to individuals who reside, live or work in the service area, or
  - the employer ceasing to make contribution for the other coverage (when the other coverage was not COBRA).

A special enrollment period of 60 days is allowed for:

- Enrollment of eligible persons who were covered under Medicaid or State Child Health Insurance Program (SCHIP), which has been terminated due to loss of eligibility.
- Enrollment of eligible persons who have become eligible for premium assistance for this group health plan coverage under Medicaid or SCHIP.

The Subscriber must enroll (or already be enrolled) in order to enroll his or her dependents in this plan. In the case of a marriage, birth or adoption, a Subscriber who is eligible, but who has not previously enrolled, may enroll at this time with or without the newly eligible dependent. Likewise an eligible spouse who has not previously enrolled, may enroll as a special enrollee with or without a new dependent child. Please contact your Human Resource Department for additional information.

Late Enrollment/Open Enrollment

A "late enrollee" is defined as a Subscriber or dependent who does not timely enroll, or does not enroll for coverage within the first period in which he or she is eligible to enroll. Late enrollment is only allowed during the group's open enrollment period. A person who enrolls for coverage during a "special enrollment period" is not considered a "late enrollee." For additional information on the open enrollment period, please contact your Human Resource Department.

Adding A Dependent

Dependents may enroll if you, the eligible employee, are covered under the Plan. In order to add a dependent, he or she must meet the definition of an Eligible Dependent. Unless otherwise stated in an amendment, the definition of an Eligible Dependent is as stated in the section of this book titled "Definitions."

Effective Date Of Coverage

Provided that an appropriate membership option is in place and, if applicable, any additional premium is paid, the effective date of coverage will be as follows:

Marriage: The first day of the month following receipt of the enrollment form.

Newborn Children: Coverage will begin at birth for a newborn child of a Subscriber or Eligible Dependent for a period of 31 days. In order to continue coverage, the newborn must meet the definition of an Eligible Dependent and be enrolled as a special enrollee within the 31-day period.

Adopted Children: Coverage will be provided for 31 days from the earlier of the date the child is placed for adoption or the date a court order grants custody to the adoptive parents regardless of the membership option. (In order to avoid claim delays, you must notify BCBSNE of the adoption within 31 days of the placement.) In order to continue coverage, the adopted child(ren) must be enrolled as a special enrollee within the 31-day period.

Loss of other Coverage: The effective date of coverage for persons enrolling as a special enrollee following a loss of other coverage will be no later than the first day of month following the loss of other coverage.

Qualified Medical Child Support Orders (QMCSO)

A QMCSO is a court order that requires an employee to provide medical coverage for his or her children (called alternate recipients) in situations involving divorce, legal separation, or paternity disputes. The order may direct the Group health plan to enroll the child(ren), and also creates a right for the alternate recipient to receive plan information, submit claims, and receive benefits for services.

QMCSOs are specifically defined under the law, and are required to include certain information in order to be considered "qualified." A National Medical Support Notice received by the employer or plan from a state agency, regarding coverage for a child, will also be treated as a QMCSO. The Plan Administrator or its designee, will review the Order or Notice to determine whether it is qualified, and make a coverage determination. The Plan Administrator or its designee will notify affected employees and the alternate recipient(s) if a QMCSO is received.

You have the right to request a copy of the Plan's procedures governing QMCSO determinations from the Plan Administrator, at no charge.

Active Employees Age 65 And Over

Federal law affects the way employers provide coverage to eligible active employees and their spouses who are 65 and over. These active employees and their spouses ages 65 and over may generally continue full coverage under the employer Group plan as primary coverage, and Medicare (if elected) as secondary coverage. Under this law, if the employee elects Medicare as their primary carrier, the group plan may not pay as secondary coverage and will be terminated. This law applies to employers with 20 or more employees. Please check with your employer regarding whether your Group is subject to this federal law.

Family Medical Leave Act (FMLA)

The Family Medical Leave Act of 1993, as amended, requires that subject to certain limitations, most employers of 50 or more persons must offer continued coverage to eligible employees and their covered dependents, while the employee is on an approved FMLA leave of absence. In addition, an employee who has terminated his/her Group health coverage while on an approved FMLA leave is entitled to reenroll for Group health coverage upon return to work. Please check with your employer for details regarding your eligibility under FMLA.

If You Receive Covered Services From An In-network Provider

Contracting Providers and many other Hospitals and Physicians will file the Claim to BCBSNE on your behalf. Out-of-state Contracting Providers will file a Claim with their local Blue Cross and Blue Shield plan for processing through the BlueCard Program. When we receive a Claim from a Contracting Provider, payment will be made directly to the provider, unless otherwise provided under state or federal law. You are responsible for meeting any applicable Deductible and paying any applicable Copay and/or Coinsurance amounts. You may be asked to pay amounts that are your liability at the time of service, or the provider may bill you for those amounts.

Filing A Claim

You must file your own Claim if your health care provider is not a Contracting Provider and does not file for you. You can obtain a Claim form by contacting BCBSNE's Member Services Department, or you can find a form on the website: www.nebraskablue.com.

All submitted Claims must include:

- correct BCBSNE ID number, including the alpha prefix;
- name of patient;
- the date and time of an accident or onset of an illness, and whether or not it occurred at work;
- diagnosis;
- an itemized statement of services, including the date of service, description and charge for the service;
- complete name, address and professional status (M.D., R.N., etc.) of the health care provider;
- prescription number, if applicable;
- the name and identification number of other insurance, including Medicare; and
- the primary plan's explanation of benefits (EOB), if applicable.

Claims cannot be processed if they are incomplete, and may be denied for "lack of information" if required information is not received.

Claims should be filed by a Provider or a Covered Person within 120 days after the date of Service. If a Nebraska Contracting Provider does not file a claim within 120 days, the Claim will be the Provider's liability. If a claim for a non-Contracting Provider is not filed within 120 days, benefits will be denied. If a claim is not filed by the Covered Person within 15 months of the date of Service (except in the absence of legal capacity), benefits will not be allowed. All claims for Services by non-Contracting Providers that are filed beyond the claim filing time are the Covered Person's responsibility.

In Nebraska, Claim forms should be sent to:

Blue Cross and Blue Shield of Nebraska
P.O. Box 3248
Omaha, Nebraska 68180-0001

If health care Services are provided in a state other than Nebraska, Claims should be filed to the Blue Cross and Blue Shield plan servicing the area where the Services were received. If you need assistance in locating the plan, please contact BCBSNE's Member Services Department.

Payment Of Benefits For Non-Contracting Provider Claims

Payment will be made, at BCBSNE's option, to the Covered Person, to his or her estate, to the provider, or as required by state or federal law. Benefits may also be paid to an alternate recipient or custodial parent, if pursuant to a QMCSO.

No assignment, whether made before or after Services are provided, of any amount payable according to this Group benefit plan shall be recognized or accepted as binding upon BCBSNE, unless otherwise provided by state or federal law.

Payment For Services That Are The Covered Person's Responsibility

Under certain circumstances, if BCBSNE pays the provider amounts that are your responsibility, such as Copays, Deductibles, or Coinsurance, we may collect such amounts from you. You agree that BCBSNE has the right to collect such amounts from you.

Claim Determinations

A "Claim" may be classified as a "Preservice" or "Postservice."

Preservice Claims - In some cases, under the terms of the health plan, the Covered Person is required to certify benefits in advance of a Service being provided, or benefits for the Service may be reduced or denied. This required request for a benefit is a "Preservice Claim." Preservice Claim determinations that are not Urgent Care Claims will be made with 15 calendar days of receipt, unless an extension is needed to obtain necessary information. If an extension is needed, BCBSNE will provide the Covered Person and/or his or her provider with notice prior to the expiration of the initial 15-day period. If additional information is requested, the Covered Person or his or her provider may be given up to 45 calendar days from receipt of notice to submit the specified information. A Claim determination will be made within 15 days of receipt of the information, or the end of the extension period.

(See the section of this book titled "Certification Requirements" for more information on certifying benefits.)

Urgent Care - If your Preservice Claim is one for Urgent Care, the determination will be made within 72 hours of receipt of the Claim, unless further information is needed. If additional information is necessary, the Covered Person or his or her provider will be given no less than 48 hours to provide the specified information. Notification of the decision will be provided not later than 48 hours after the earlier of: our receipt of the information, or the end of the period allowed to submit the information.

Concurrent Care - If you request to extend a course of treatment beyond the care previously approved and it involves urgent care, a decision will be made within 24 hours of the request, if you submitted the request at least 24 hours before the course of treatment expires. In all other cases, the request for an extension will be decided as appropriate for Preservice and Postservice Claims.

Postservice Claims - A Postservice Claim is any Claim that is not a Preservice Claim. In most cases, a Postservice Claim is a request for benefits or reimbursement of expenses for medical care that has been provided to a Covered Person. The instructions for filing a Postservice Claim are outlined earlier in this section. Upon receipt of a completed Claim form, a Postservice Claim will be processed within 30 days, unless additional information is needed. If additional information is requested, the Covered Person may be given not less than 45 days to submit the necessary information. A Claim determination will be made within 15 days of receipt of the information, or the expiration of the 45-day extension period. You will receive an EOB when a Claim is processed which explains the manner in which your Claim was handled.

Explanation Of Benefits

Every time a Claim is processed for you, an Explanation of Benefits (EOB) form will be sent. The front page of the EOB provides you with a summary of the payment including:

- the patient's name and the Claim number;
- the name of the individual or institution that was paid for the Service;
- the total charge associated with the Claim;
- the covered amount;
- any amount previously processed by this plan, Medicare or another insurance company;
- the amount(s) that you are responsible to pay the provider;
- the total Deductible and/or Coinsurance that you have accumulated to date; and
- other general messages.

A more detailed breakdown of the charges including provider discounts, amount paid, and cost sharing amounts (e.g. noncovered charges, Deductible and Copays) are shown on the back of your EOB.

Also included on your EOB is information regarding your right to appeal a benefit determination, or request additional information.

Save your EOBs in the event that you need them for other insurance or for tax purposes.

APPEAL PROCEDURES

Section 8

BCBSNE has the discretionary authority to determine eligibility for benefits under the health Plan, and to construe and interpret the terms of the Plan, consistent with the terms of the master group contract.

You have the right to seek and obtain a review of "adverse benefit determinations" arising under this health Plan.

Appeal Procedure Definitions

Adverse Benefit Determination: A determination by BCBSNE or its Utilization Review designee, of the denial, reduction, or termination of a benefit, or a failure to provide or make payment (in whole or in part) of a benefit. This includes any such determination that is based on:

- the application of Utilization Review;
- a determination that the Service is Investigative;
- a determination that the Service is not Medically Necessary or appropriate;
- an individual's eligibility for coverage or to participate in a plan.

An Adverse Benefit Determination also includes any rescission of coverage, which is defined as a cancellation or discontinuance of coverage that has a retroactive effect, except if for failure to timely pay required premiums or contribution for coverage.

Final Internal Adverse Benefit Determination: An Adverse Benefit Determination that has been upheld by BCBSNE, or its Utilization Review designee, at the completion of the internal appeal process as described in this document.

Preservice Claim(s): Any Claim for a benefit under the Plan with respect to which the terms of the Contract require approval of the benefit in advance of obtaining medical care, and failure to do so will cause benefits to be denied or reduced.

Postservice Claim(s): Any Claim that is not a Preservice Claim.

Urgent Care Claim: A Claim for medical care or treatment for which the application of the time periods for making non-urgent care determinations:

- could seriously jeopardize the life or health of the Covered Person or the ability of the Covered Person to regain maximum function; or
- would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Claim.

How To Appeal An Adverse Benefit Determination

A Covered Person or a person acting on his/her behalf (the "claimant") is entitled to an opportunity to appeal initial or final Adverse Benefit Determinations.

Internal Appeal

A request for an internal appeal must be submitted within 6 months of the date the Claim was processed, or Adverse Benefit Determination was made. The written request for an appeal should state that it is a request for an appeal and, if possible, include a copy of the Explanation of Benefits (EOB). The appeal should also include:

- the name of the person submitting the appeal and his/her relationship to the patient;
- the reason for the appeal;
- any information that might help resolve the issue; and
- the date of service/Claim.

The written appeal should be sent to:

Blue Cross and Blue Shield of Nebraska
P.O. Box 3248
Omaha, Nebraska 68180-0001

We will provide the claimant notice of receipt of the request within 3 days. The notice will include the name, address and telephone number of a person to contact regarding coordination of the review. The claimant does not have the right to attend the appeal review, but may submit additional information for consideration.

Preservice or Postservice Claim Appeal: A written notice of the appeal determination will be provided to the claimant as follows:

- Preservice Claims (other than Urgent Care), within 15 calendar days after receipt.
- Postservice Claims involving an Adverse Benefit Determination based on Medical Necessity, Investigative determination or utilization review, within 15 calendar days after receipt.
- All other Post Service Claims, within 15 calendar days after receipt, unless additional time is needed and written notice is provided to the claimant on or before the 15th day, in which case the decision will be provided within 30 calendar days after receipt.

The decision made pursuant to this appeal will be considered a Final Adverse Benefit Determination.

Expedited Appeal: When the appeal is related to an Urgent Care Claim, an expedited appeal may be requested. In the case of an expedited appeal, the request may be submitted in writing or orally. All information, including the decision, will be submitted by the most expeditious method available. BCBSNE will make an expedited review decision within 72 hours after the appeal is received. Written notification of the decision will be sent within the 72-hour period.

Concurrent Care denials must be appealed within 24 hours of the denial. A Concurrent Care denial will be handled as an expedited appeal. If the appeal is requested within the 24-hour time period, coverage will continue for health care services pending notification of the review decision.

NOTE: When an adverse appeal determination involves medical judgment, upon receipt of a written request, the identity of the health care professionals who reviewed the appeal will be provided to the claimant.

Rights To Documentation

You have the right to have access to, and request copies of, the documentation relevant to the Claim and Adverse Benefit Determination(s), including any new evidence or rationale considered or relied upon in connection with the Claim on review. In addition, supporting material or additional comments, may be submitted by the claimant for consideration during the appeal process.

External Review

Standard External Review: If the claimant has exhausted internal appeal reviews, an external review by an Independent Review Organization (IRO) may be requested for review of an Adverse Benefit Determination or Final Internal Adverse Benefits Determination which was based on a judgment as to the Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of the health care Service or treatment. The request must be submitted in writing within four months after receipt of the Final Internal Adverse Benefit Determination. (An Adverse Benefit Determination based on an individual's eligibility for coverage or to participate in a plan is not eligible for External Review.)

The Covered Person will be required to authorize the release of any of his or her protected health information , including medical records, which may be needed for the purposes of the External Review.

The request for an External Review may be submitted electronically, by facsimile, or U.S. mail, as stated on the Final Internal Adverse Benefit Determination notice (letter). The request should be submitted to:

Nebraska Department of Insurance
P.O. Box 82089
Lincoln, Nebraska 68501-2089
www.doi.nebraska.gov

Upon receipt of the request, the Nebraska Department of Insurance (NDOI) will forward the request to BCBSNE to conduct a preliminary review to determine if it is complete and whether it is eligible for external review, consistent with applicable law. BCBSNE will conduct this review within 5 business days of receipt, and notify the NDOI and the Covered Person of the outcome within one business day. If it is determined that the request is not complete, or is not eligible for external review, the claimant will be notified of the reason for ineligibility, or advised of the information needed to make the request complete. The NDOI may determine that the request is eligible notwithstanding BCBSNE's determination, consistent with state law.

If the external review request is eligible for review, the NDOI will assign an IRO to conduct the review, and notify BCBSNE and the claimant of the assignment within one business day. BCBSNE will forward all documentation and information used to make the initial Adverse or Final Internal Adverse Benefit Determination to the IRO within 5 business days. If the claimant wishes to submit additional information to the IRO for consideration, they will be given the opportunity to do so. The IRO will provide BCBSNE with any information submitted by the claimant, to allow BCBSNE an opportunity to reconsider its original determination.

The IRO will complete its review and provide the claimant with written notification of its decision within 45 calendar days of receipt. No deference shall be given to the prior internal appeal determination made by BCBSNE.

Expedited External Review: An expedited External Review of an Adverse Benefit Determination for an Urgent Care Claim may be request at the same time a claimant requests an expedited internal appeal if the denial:

- involves an Urgent Care Claim; or
- it was based on a determination that the requested Service or treatment is Investigative, if the Covered Person's treating Physician certifies in writing that the Service or treatment would be significantly less effective if not promptly initiated.

However, the claimant must first exhaust the internal appeal process unless BCBSNE agrees to waive this requirement, or as otherwise directed by the IRO, consistent with state law.

An expedited External Review may also be requested following a Final Internal Adverse Benefit Determination, if:

- the Covered Person has a medical condition where the time frame for completion of a standard External Review would seriously jeopardize his/her life, health, or ability to regain maximum function.
- the Final Internal Adverse Benefit Determination concerns an admission; availability of care; continued stay, or heath care Service for which the Covered Person has received emergency services, but has not been discharged from a facility.
- the Final Internal Adverse Benefit Determination is based on a determination that the requested Service or treatment is Investigative, if the Covered Person's Treating Physician certifies in writing that the Service or treatment would be significantly less effective is not promptly initiated.

The process for coordination of the expedited request between the NDOI and BCBSNE and the IRO will be done promptly upon receipt, by telephone, facsimile, or the most expeditious manner available. The expedited external review decision will be made by the IRO within 72 hours after receipt of the request, or as otherwise provided by law. If notification of the decision was not in writing, the IRO will provide the decision in writing within 48 hours after the notification.

The decision of the IRO is the final review decision and is binding on BCBSNE and the claimant, except to the extent that the claimant may have other remedies available under applicable federal or state law. Once an external review decision has been made, the Covered Person or his/her representative may not file a subsequent request for an external review involving the same Adverse Benefit Determination.

Nebraska Department Of Insurance Assistance

The Nebraska Department of Insurance may be contacted for assistance with the appeal and external review process at any time at:

Nebraska Department of Insurance
P.O. Box 82089
Lincoln, Nebraska 68501-2089
(877) 564-7323

If you have a general complaint or inquiry regarding your coverage with BCBSNE, you may call our Member Services Department at the number on your I.D. card. If you feel that your complaint is not resolved through our internal complaint process, or if our performance does not meet your expectations, you may contact the Nebraska Department of Insurance at the address or phone number listed above.

ERISA Rights

If the Group health Plan is subject to ERISA, Section 502(a) of the Act provides the claimant with the right to bring a civil action. The Group health Plan may have other voluntary alternative dispute resolution options. The claimant may contact the local U.S. Department of Labor office and/or the state regulatory agency for information.

COORDINATION OF BENEFITS

Section 9

When You have Coverage Under More Than One Plan

This Plan includes a Coordination of Benefits (COB) provision. This provision establishes a uniform order in which the Plans pay their claims, limits duplication of benefits and provides for transfer of information between the Plans.

When Coordination Of Benefits Applies

COB provisions apply when a Covered Person has coverage under more than one health Plan. The order of benefit determination rules described in this section determine which Plan will pay as the primary Plan without regard to any benefits that might be payable by another Plan.

Definitions

For the purpose of this section, the terms are defined as:

Allowable Expense: A health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense.

The amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of Plan provisions include second surgical options, recertification of admissions, and preferred provider arrangements.

Closed Panel Plan: A Plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

Custodial Parent: The parent awarded custody by a court decree or, in the absence of a court decree, the parent with whom the child resides more than one half of the calendar year excluding temporary visitation.

Plan: Any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

a. Plan includes: group insurance and non-group insurance contracts and subscriber contracts, health maintenance organization (HMO) contracts, Closed Panel Plans; other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits coverage in motor vehicle "no-fault" and traditional "fault" type contracts; group and non-group insurance contracts and subscriber contract that pay or reimburse for the cost of dental care; and Medicare or any other federal governmental Plan, as permitted by law.

b. Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage other than the medical benefits coverage in motor vehicle "no fault" and traditional "fault" contracts; uninsured or underinsured coverage under a motor vehicle policy; specified disease or specified accident coverage; limited benefit health coverage, as defined in state law; school accident coverage; disability income insurance; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; and coverage under other federal governmental Plans, unless permitted by law.

Each contract for coverage under a. or b. is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

Primary Plan: The Plan that will determine payment for its benefits first before those of any other Plan without considering any other Plan's benefits.

Secondary Plan: The Plan that will determine its benefits after those of another Plan and may reduce the benefits so that all Plan benefits do not exceed 100% of the total Allowable Expense.

This Plan: The part of the contract providing health care benefits to which the COB provision applies and which may be reduced because of the benefits of other Plans. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

Order Of Benefit Determination Rules

1. The Primary Plan pays or provides its benefits according to its terms or coverage and without regard to the benefits under any other Plan.
2. A Plan that does not contain a coordination of benefits provision that is consistent with this Part is always primary unless the provisions of both Plans stated that the complying Plan is primary.
3. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.
4. For COB provisions related specifically to telehealth services, please see the Physician Services telehealth section.
5. Each Plan determines its order of benefits using the first of the following rules that apply:

Subscriber And Dependent. The Plan that covers the person as other than a dependent, such as a subscriber/policyholder/employee, is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent and primary to the Plan covering the person as a subscriber, then the order of benefits between the two Plans is reversed so that the Plan covering the person as a subscriber is the Secondary Plan and the other Plan is the Primary Plan.

Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:

For a dependent child whose parents are married or are living together, whether or not they have ever been married, the Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan. If both parents have the same birthday, the Plan that has covered the parents the longest is the Primary Plan (birthday rule).

For a dependent child whose parents are divorced, or separated or not living together, whether or not they have ever been married, if a court decree states that one of the parents is responsible for the child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, the Plan of that parent's spouse is primary. This rule applies to Plan years beginning after the Plan is given notice of the court decree.

If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the order of benefits shall be determined by the "birthday rule" stated above.

If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the order of benefits shall be determined by the "birthday rule" stated above.

If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

- The Plan covering the Custodial Parent;
- The Plan covering the spouse of the Custodial Parent;
- The Plan covering the non-custodial parent; and then
- The Plan covering the spouse of the non-custodial parent.

For a dependent child covered under more than one Plan of individuals who are not parents of the child, the above provisions shall apply as if those individuals were the parents.

For a dependent child covered under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule before for "Longer or Shorter Length of Coverage" applies. In the event the dependent child's coverage under the spouse's plan began on the same date as her or her coverage under the parent's plan(s), the order of benefits shall be determined by applying the "birthday rule" above, to the dependent child's parent(s) and the dependent's spouse.

Active Employee, Retired Or Laid-Off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither retired nor laid off, is the Primary Plan. The Plan covering that same person as a retired or laid-off employee is the Secondary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the first rule (Subscriber and Dependent) can determine the order of benefits.

COBRA Or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as a subscriber/member/employee/retiree or covering the person as a dependent of a subscriber/member/employee/retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the first rule (Subscriber and Dependent) can determine the order of benefits.

Longer Or Shorter Length Of Coverage. The Plan that has covered the person longer is the Primary Plan and the Plan that has covered the person the shorter period of time is the Secondary Plan. The start of a new Plan does not include a change in the amount or scope of a Plan's benefits; a change in the entity that pays, provides or administers the Plan's benefits; or a change from one type of Plan to another, such as from a single employer Plan to a multiple employer Plan.

If the above rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the Primary Plan.

Administration Of Coordination Of Benefits

The order of benefit determination rules govern the order in which each Plan will pay a Claim for benefits. The Plan that pays first is called the Primary Plan. The Plan that pays after the Primary Plan is called the Secondary Plan.

If This Plan is the Primary Plan, there shall be no reduction of benefits. Benefits will be paid without regard to the benefits of any other Plan.

If This Plan is the Secondary Plan, it may reduce its benefits so that the total benefits paid or provided by all Plans for any Claim are not more than the total Allowable Expenses. In determining the amount to be paid for any Claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the Claim do not exceed the total Allowable Expense for that Claim. In addition, the Secondary Plan shall credit to its Plan Deductible any amounts it would have credited to its Deductible in the absence of other health coverage. Also, if the Primary Plan is medical payments coverage under a motor vehicle policy, the Secondary Plan shall credit payments from the motor vehicle insurance policy to deductibles, copayment and coinsurance after discounts under the health plan.

Miscellaneous Provisions

If these COB rules do not specifically address a particular situation, We may, at Our discretion, rely on the National Association of Insurance Commissioners Coordination of Benefits Model Regulation as an interpretive guide.

To properly administer these COB rules, certain facts are needed. This Plan may obtain or release information to any insurance company, organization or person. BCBSNE need not notify, or obtain the consent of any person to do so. Any person who claims benefits under This Plan agrees to furnish the information that may be necessary to apply COB rules and determine benefits.

If another Plan pays benefits that should have been paid under This Plan, This Plan may reimburse the other Plan amounts determined to be necessary. Amounts paid to other Plans in this manner will be considered benefits paid under This Plan and This Plan is released from liability for any such amounts.

If the amount of the benefits paid by This Plan exceeds the amount it should have paid, This Plan has the right to recover any excess from any other insurer, any other organization, or any person to or for whom such amounts were paid, including Covered Persons under This plan.

Termination Of Coverage

Coverage under your group health plan will terminate on the earliest of the following dates:

- The date the entire Contract is terminated.
- When you are no longer eligible for coverage due to termination of employment.
- When you cease to be eligible under the health plan; or a dependent ceases to be an Eligible Dependent.
- When BCBSNE receives a request from you or the employer to terminate coverage for you or a dependent.
- The last date for which premium is paid.
- Another date as specified by your employer.

Please contact your employer for details regarding the specific date coverage under the Group health plan will be terminated.

You and/or your Eligible Dependents may be eligible to continue coverage under the Group health plan as detailed in this section.

Continuation Of Coverage Under The Federal Continuation Law

If you terminate your employment, or if a dependent loses coverage due to certain "Qualifying Events," continued coverage under the Group health plan may be available. Payment for continued coverage under the federal continuation law is at the employee's or dependent's own expense. Please contact your employer for details regarding eligibility.

What Is The Federal Continuation Law?

The Consolidated Omnibus Budget Reconciliation Act (COBRA), is a federal law which provides that a Covered Person who would lose coverage due to the occurrence of a "Qualifying Event," may elect to continue coverage under the Group health plan. A person who is eligible to continue coverage is called a "Qualified Beneficiary." A Qualified Beneficiary also includes a child born to, or placed for adoption with the Covered Person during the period of COBRA coverage. Please share the information found in this section with your Eligible Dependents.

Termination Of Employment Or Reduction In Hours — COBRA provides that if you should lose eligibility for coverage due to:

- voluntary or involuntary termination of employment (other than gross misconduct);
- a lay-off for economic reasons; or
- a reduction in work hours,

you and your covered dependents may be able to continue the Group coverage at your own expense for up to 18 months. Your employer is required to notify the Plan Administrator within 30 days. The Plan Administrator will send the Qualified Beneficiaries a COBRA notification within 14 days after receiving notice from the employer.

Disability — If a Qualified Beneficiary is determined by the Social Security Administration to have been disabled any time during the first 60 days of COBRA continuation coverage, the COBRA coverage period for the disabled individual and his or her related beneficiaries may be extended to 29 months instead of 18 months when loss of coverage is due to termination or reduction in hours of employment. You must provide written notice of the disability determination to the plan within 18 months of becoming eligible for COBRA and no later than 60 days after the date of the Social Security Administration's determination.

If the Social Security Administration determines that you or the dependent are no longer disabled, the extended continuation of coverage period (19th through 29th month) will be terminated the month that begins more than 30 days after the determination. You must notify the plan within 30 days of a determination that an individual is no longer disabled.

Change In Dependent Status, Divorce/Separation Or Medicare Entitlement — COBRA requires that continued coverage under the Group health plan be offered to your covered spouse and eligible children if they would otherwise lose coverage as a result of:

- divorce or legal separation;
- a child losing dependent status; or
- the employee becoming entitled to Medicare.

When one of these circumstances occur, you or the dependent are obligated to notify the employer or Plan Administrator within 60 days. Failure to provide timely and proper notice may result in the loss of the right to COBRA.

After receiving a timely notice of such an event, and eligibility has been determined, your employer or the Plan Administrator will send the Qualified Beneficiary an election form and the information needed to apply for coverage. Coverage may be continued at the individual's expense for up to 36 months.

Your Death — If you should die while you are covered under this Group health plan, continued coverage is available to your spouse and Eligible Dependents.

COBRA provides that subject to certain limitations, your surviving spouse and children may continue the Group health coverage at their own expense for up to 36 months. Federal law requires your employer to send the surviving family members instructions as to how to apply for continued coverage if they are eligible.

Special Provisions — If an employer files Chapter 11 bankruptcy, special provisions regarding COBRA continuation coverage may apply for the retiree or deceased retiree's surviving spouse and dependent children. Please check with your employer for details.

Electing COBRA Coverage

Qualified beneficiaries will be sent a written notice of the right to continue health coverage and an election form(s).

Reminder: *In the case of a divorce or legal separation, or if a child loses dependent status, you must notify your employer or Plan Administrator of this Qualifying Event within 60 days. Failure to provide timely and proper notice may result in the loss of the right to COBRA coverage.*

Qualified Beneficiaries must complete and return the COBRA election form in order to continue coverage. The notice will include instructions for completing and returning the form. The election form must be received by the later of:

- 60 days after the day health coverage would otherwise end, or
- 60 days after the notice is sent to you by the employer or Plan Administrator.

COBRA continuation coverage may only begin on the day after coverage under the Group plan would otherwise end. The required premium, including any retroactive premium, must be paid from the day coverage would have otherwise ended. The premium must be paid within 45 days after the day continued coverage is elected. Succeeding premiums must be paid monthly within 30 days of the premium due date. The COBRA notice and election form will inform you or your dependents of the monthly premium amount, and to whom such premium should be paid.

Second Qualifying Event — In the event your family experiences another Qualifying Event while receiving an 18-month period of COBRA coverage (or the extended 29-month period), your covered spouse and dependents are eligible to extend the original COBRA coverage period to a maximum of 36 months if notice of the second event is properly given to the employer or Plan Administrator. This extension may be available to the spouse and children receiving continuation coverage if: a) you die; b) you become entitled to Medicare; c) you get divorced or legally separated; or d) the dependent child is no longer eligible as a dependent, but only if the second event would have caused the spouse or child to lose coverage under the plan had the first Qualifying Event not occurred. In all of these cases, you or the dependent must notify the employer or Plan Administrator within 60 days of the second Qualifying Event.

Termination Of COBRA Coverage — A Qualified Beneficiary's COBRA continuation coverage will end at midnight on the earliest of:

- the day your employer ceases to provide any Group health plan to any employee;
- the day the premium is due and unpaid;
- the day the individual first becomes covered under any other Group health plan (after the COBRA election);
- the day the individual again becomes covered as an employee or dependent under the policy;
- the day an insured person becomes entitled to benefits under Medicare (after COBRA election); or
- the day health insurance has been continued for the maximum period of time allowed (18, 29 or 36 months).

NOTE: *In the event more than one continuous provision applies, the periods of continued coverage may run concurrently, but never for more than 36 months.*

Uniformed Services Employment And Reemployment Rights (Military Leave)

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) requires that continued coverage under an employer Group health plan be offered to an employee and covered dependents if coverage would otherwise be lost due to a military leave.

Continuation Of Group Health Coverage:
If coverage under your employee Group health plan ends because of service in the uniformed services, you may elect to continue health coverage for yourself and your covered dependents, until the earlier of:

- 24 consecutive months from the date active duty began; or
- the day after the date on which you fail to apply for, or return to employment, in accordance with USERRA.

You are responsible for payment of the required premium to continue coverage. If the leave for military service is less than 31 days, your required premium is the standard employee share of the applicable premium; for a leave in excess of 30 days, the required premium shall be no more than 102% of the total premium applicable for your membership option. Your employer will inform you of the amount and procedure for payment of premiums.

A Covered Person's continued coverage under these USERRA provisions will end at midnight on the earliest of:

- the day the employer ceases to provide any Group health plan for its employees;
- the day premium is due and unpaid;
- the day a Covered Person again becomes covered under the plan;
- the day coverage has been continued for the period of time stated above.

Reemployment
Following service in the uniformed services, an employee may be eligible to apply for reemployment with the employer in accordance with USERRA. Such reemployment includes the right to reenroll for Group health coverage provided by the employer, with no new waiting periods imposed.

Please contact your employer for further information regarding your rights under USERRA.

Continuation Of Coverage For Children To Age 30

You may elect to continue coverage to age 30 for a dependent child who would otherwise lose coverage when he or she meets the plan's limiting age provided the child was covered as an Eligible Dependent at the time such coverage would have terminated.

In order to elect continuation coverage, you must request an election form from Blue Cross and Blue Shield of Nebraska. The completed form must be returned no sooner than 31 days prior to or no later than 31 days after the date on which the child would otherwise lose coverage. You should also notify your employer of your decision to continue coverage for your child.

Payment For Continuation Coverage
The premium for continuation coverage will be equal to the full, unsubsidized single adult premium. You are responsible for paying the full premium each month. The first month's premium must be paid to the Group through which your coverage is provided no later than 31 days after the date the child's coverage would have terminated.

Termination Of Continuation Coverage
Continuation coverage will terminate if:

- We do not receive the monthly payment on a timely basis;
- You request coverage to be terminated;
- Your coverage with BCBSNE terminates;
- The covered child:
  - marries;
  - is no longer a resident of Nebraska;
  - receives coverage under another health benefit plan or self-funded employee benefit plan; or
  - attains age 30.

Continuation coverage will terminate at the end of the month in which any event listed above occurs. Coverage may not be reinstated once it has been terminated.

Plan Document

This document provides an overview of your benefits. It is not intended to be a complete description of every detail of the Group health Plan. The terms of the Group health Plan are governed by the Master Group Application, any Subgroup applications, the enrollment information, the Master Group Contract, addenda, attachments or endorsements. If there is a discrepancy or conflict between this document and the Plan documents, the Plan documents will govern.

Fraud Or Misrepresentation

A Covered Person's coverage may be canceled or rescinded for fraud or intentional misrepresentation of material fact about a claim or eligibility for this coverage.

If coverage is rescinded, the amount of premium paid will be reduced by any benefits that were paid, and will be refunded. If benefits paid exceed the premium received, We may recover the difference.

Subrogation

Subrogation is the right to recover benefits paid for Covered Services provided as the result of Injury or Illness which was caused by another person or organization. When benefits are paid under the Master Group Contract, BCBSNE shall be subrogated to all of the Covered Person's right of recovery against any person or organization to the extent of the benefits paid. The Subscriber, the Covered Person or the person who has the right to recover for a Covered Person (usually a parent or spouse), agrees to make reimbursement to BCBSNE if payment is received from the person who caused the Illness or Injury or from that person's liability carrier.

Subrogation does not apply to medical payments made under the medical payments coverage of the Covered Person's own individual automobile policy (Coordination of Benefits is applicable to those payments). In addition, subrogation does not apply to payments made under the underinsured or uninsured provisions of the Covered Person's own automobile policy.

This subrogation shall be a first priority lien on the full or partial proceeds of any settlement, judgment, or other payment recovered by or on behalf of the Covered Person, whether or not there has been full compensation for all his or her losses or as provided by applicable law. BCBSNE's rights shall not be defeated by allocating the proceeds to nonmedical damages.

Contractual Right To Reimbursement

If a Covered Person receives full or partial proceeds from any other source for Covered Services for an Illness or Injury, BCBSNE has a contractual right of reimbursement to the extent benefits were paid under the Contract for the same Illness or Injury. This contractual right to reimbursement shall be a first priority lien against any proceeds recovered by the Covered Person, whether or not the Covered Person has been fully compensated for all his or her losses, or as provided by applicable state law.

Such proceeds may include any settlement; judgment; payments made under auto insurance (except the Covered Person's auto medical payments or uninsured/underinsured coverage); individual or group no fault auto insurance; another person's uninsured, underinsured insurance; or proceeds otherwise paid by a third party. This contractual right to reimbursement is in addition to and separate from the subrogation right. Our rights shall not be defeated by allocating the proceeds to nonmedical damages.

When BCBSNE recovers proceeds under this contractual right to reimbursement for all or a part of the Claim, amounts previously credited to a Covered Person's Deductible or Coinsurance liability may be removed. Future Claims will be subject to the reinstated Deductible or Coinsurance.

No adult Subscriber may assign any rights to recover medical expenses from any third party to any minor or other dependent of the adult Subscriber or to any other person, without the express written consent of BCBSNE. The right to recover, whether by subrogation or reimbursement, shall apply to settlements or recoveries of deceased persons, minor dependents of a Subscriber, incompetent or disabled Subscribers, or their incompetent or disabled Eligible Dependents.

The Subscriber agrees to fully cooperate and assist in any way necessary to recover such payments, including but not limited to notifying BCBSNE of a claim or lawsuit filed on his or her behalf, or on behalf of any Eligible Dependent for an Injury or Illness. The Subscriber, Eligible Dependent or an authorized representative shall contact BCBSNE prior to settling any claim or lawsuit to obtain an updated itemization of its subrogation Claim or reimbursement amount due. Upon receiving any proceeds, the Subscriber, Eligible Dependent or an authorized representative must hold such proceeds in trust until such time as the proceeds can be transferred to BCBSNE. The party holding the funds that rightfully belong to BCBSNE shall not interrupt or prejudice BCBSNE's recovery of such payments.

Costs incurred in enforcing these provisions shall also be recovered, including, but not limited to, attorneys' fees, litigation and court costs, and other expenses.

Workers' Compensation

Benefits are not available for Services provided for Injuries or Illnesses arising out of and in the course of employment, whether or not the Covered Person fails to assert or waives his or her right to Workers' Compensation or Employer Liability Law. The employer is required to furnish or pay for such Services or a settlement can be made, pursuant to Workers' Compensation laws. (See also the section of this book titled "Exclusions—What's Not Covered.")

If a Covered Person enters into a lump-sum settlement which include compensation for past or future medical expenses for an Injury or Illness, payment will not be made under the Group plan for Services related to that Injury or Illness.

Benefits are not payable for services determined to be not compensable due to noncompliance with terms, rules and conditions under Workers' Compensation laws, or in a Certified or otherwise Licensed Workers' Compensation Managed Care Plan. In addition, benefits are not payable for Services that are related to the work Injury or Illness, but are determined to be not necessary or reasonable by the employer or Workers' Compensation carrier.

In certain instances, benefits for such Services are paid in error under the Group health Plan. If payment is received by the Covered Person for such Services, reimbursement must be made. This reimbursement may be refunded from any recovery made from the employer, or the employer's Workers' Compensation carrier, as permitted by law. Reimbursement must be made directly by the Subscriber when benefits are paid in error due to his or her failure to comply with the terms, rules and conditions of Workers' compensation laws, or a Certified or Licensed Workers' Compensation Managed Care Plan.

Legal Actions

The Subscriber cannot bring a legal action to recover under the Contract for at least 60 days after written proof of loss is given to Us. The Subscriber cannot start a legal action after three years from the date written proof of loss is required.

Your ERISA Rights

If your Group health Plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), as a participant in this Group health Plan, you are entitled to certain rights and protections under this law.

ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the plan, including insurance contracts, and collective bargaining agreements, and a copy of the latest annual report filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts, collective bargaining agreements, copies of the latest annual report and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue health coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event (COBRA). You or your dependents may have to pay for such coverage. Review your Summary Plan Description and the documents governing the Plan for the rules regarding your COBRA continuation rights.

Prudent Actions By Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

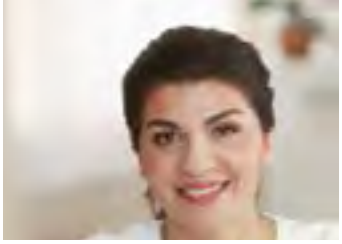
Enforce Your Rights

- If your Claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.
- Under ERISA , there are steps you can take to enforce the above rights. For instance, if you request a copy of the plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.
- If you have a Claim or benefits which is denied or ignored in whole or in part, you may file suit in a state or federal court. If you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in a federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay these costs and fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs or fees, for example, if it finds your Claim is frivolous.

Assistance With Your Questions

If You have any questions about your plan, you should contact the Plan Administrator. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.



ACA: The Patient Protection and Affordable Care Act and implement regulations and sub-regulatory guidance.

Advanced Diagnostics Imaging: Highly developed technologies that use computerized imaging or radio isotropic enhancements to play a decisive role in diagnostics, such as computed tomography (CT) scans, magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), MRI of the breast, magnetic resonance spectroscopy (MRS),functional brain MRI (MRI), positron emission tomography (PET) scans, single photon emission computed tomography (SPECT) scans and other nuclear medicines.

Adverse Benefit Determination: A determination by BCBSNE or its Utilization Review designee, of the denial, reduction, or termination of a benefit, or a failure to provide or make payment (in whole or in part) of a benefit. This includes any such determination that is based on:

1. the application of Utilization Review;
2. a determination that the Service is Investigative;
3. a determination that the Service is not Medically Necessary or appropriate;
4. an individual's eligibility for coverage or to participate in a plan.

An adverse benefit determination also includes any rescission of coverage, which is defined as a cancellation or discontinuance of coverage that has a retroactive effect, except if for failure to timely pay required premiums or contribution for coverage.

Aggregate Deductible and/or Out-of-pocket Limit: Aggregate Deductible means the entire family amount must be met before benefits are available. Aggregate Out-of-pocket Limit means the entire family amount must be met before cost-sharing is no longer applicable. Family members may combine their Covered expenses to satisfy the family amounts.

Alcoholism or Drug Abuse (Substance Abuse) Treatment Center: A facility Licensed by the Department of Health and Human Services Regulation and Licensure (or equivalent state agency) or accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the Commission on the Accreditation of Rehabilitation Facilities (CARF). Such facilities are not Licensed as a Hospital, but provide Inpatient or Outpatient care, treatment, Services, maintenance, accommodation or board in a group setting primarily and exclusively for individuals having any type of dependency or addiction to the use of alcohol or drugs.

Allowable Charge: An amount used by BCBSNE to calculate payment of Covered Services. This amount will be based on either the Contracted Amount for In-network Providers or the Out-of-network Allowance for Out-of-network Providers.

Ambulatory Surgical Facility: A Certified facility that provides surgical treatment to patients not requiring inpatient hospitalization. Such facility must be Licensed as a health clinic as defined by state statutes, but shall not include the offices of private Physicians or dentists whether for individual or group practice.

Approved Clinical Trials: A phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is one of the following:

1. a federally funded or approved trial.
2. a clinically trial conducted under an FDA investigational new drug application.
3. a drug trial that is exempt from the requirement of an FDA investigational new drug application.

Routine patient costs for purposes of an Approved Clinical Trial shall mean Covered Services: a) for which benefits are payable absent a clinical trial; b) required solely for providing the experimental or investigative service or monitoring its effect, or preventing complications; and c) needed for reasonable and necessary care arising from the provision of an experimental or investigative service.

Approved Provider: A Licensed practitioner of the healing arts who provides Covered Services within the scope of his or her License or a Licensed or Certified facility or other health care provider, payable according to the terms of the Contract, Nebraska law or pursuant to the direction of BCBSNE.

Auxiliary Provider: A Certified social worker, psychiatric registered nurse, Certified alcohol and drug abuse counselor or other Approved Provider who is performing Services within his or her scope of practice and who is supervised, and billed for, by a qualified Physician or Licensed Psychologist, or as otherwise permitted by state law. Certified Master Social Workers or Certified Professional Counselors performing mental health Services who are not Licensed Mental Health Practitioners are included in this definition.

BCBSNE: Blue Cross and Blue Shield of Nebraska

BlueCard Program: This Blue Cross and Blue Shield Association (BCBSA) program is a collection of policies, provisions and guidelines that enables BCBSNE to process Claims incurred by

Covered Persons residing or traveling outside its Service Area by utilizing the discounts negotiated by the Host Blue plan and its Contracting Providers.

Certificate of Coverage: A summary of the terms of this Contract provided to the Subscriber by BCBSNE.

Certification (Certify And Certified): A determination by BCBSNE or Our designee, that an admission, extension of stay or other health or dental care Service has been reviewed and, based on the information provided, meets the clinical requirements for Medical Necessity, appropriateness, level of care, or effectiveness under the auspices of the applicable health benefit plan. Preauthorization requirements are included within this term.

Certification also refers to successful voluntary compliance with certain prerequisite qualifications specified by regulatory entities. Agencies and programs may be deemed to be in compliance when they are accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Commission on the Accreditation of Rehabilitation Facilities (CARF), American Association for Ambulatory Health Care (AAAHC), American Association for Accreditation of Ambulatory Plastic Surgery Facilities (AAAAPSF), Medicare or as otherwise provided in the Contract provisions or state law.

Claim: A request for benefits under this Plan.

Cognitive Training: A rehabilitative intervention aimed at retraining or facilitating the recovery of mental and information processing skills including perception, problem-solving, memory storage and retrieval, language organization and expression.

Coinsurance: The percentage amount the Covered Person must pay for Covered Services.

Congenital Abnormality: A condition existing at birth which is outside the broad range of normal, such as cleft palate, birthmarks, webbed fingers or toes. Normal variations in size and shape of the organ such as protruding ears are not considered a Congenital Abnormality.

Contract: The agreement between BCBSNE and the Group which includes the Contract and any endorsements; the Master Group Application, any Subgroup Application, addenda, and the individual enrollment information of Subscribers and their Eligible Dependents.

Contracted Amount: The Allowable Charge agreed to by BCBSNE or an Host Blue plan and Contracting Providers for Covered Services received by a Covered Person.

Contracting Provider: An In-Network Provider, a Blue Cross and Blue Shield of Nebraska Participating Provider, or a BlueCard Program Preferred or Participating Provider.

Convenient Care/Retail Clinic: A medical clinic located in a retail location such as a grocery or drug store, where a Provider offers treatment of minor medical conditions, immunizations and physicals without an appointment.

Copayment (Copay): A fixed dollar amount of the Allowable charge, payable by the Covered Person for a Covered Service, as indicated in the Master Group Application and/or Schedule of Benefits Summary. Copayments are separate from and do not accumulate to the Deductible.

Cosmetic: Any Services provided to improve or change the patient's physical appearance or characteristics, from which no significant improvement in physiologic function can be expected, regardless of emotional or psychological factors.

Covered Person: Any person entitled to benefits for Covered Services pursuant to the Contract underwritten and administered by BCBSNE.

Covered Services: Hospital, medical or surgical procedures, treatments, drugs, supplies, Durable Medical Equipment, or other health, mental health or dental care, including any single Service or combination of Services, for which benefits are payable, while the Contract is in effect.

Creditable Coverage: Coverage of the individual under any of the following: (a) a group health plan, as defined by HIPAA; (b) health insurance coverage consisting of medical care offered by a health insurance issuer in the group or individual market; (c) Part A or Part B of Medicare; (d) Medicaid, other than coverage consisting solely of benefits under section 1928 (for pediatric immunizations); (e) Title 10 U.S.C. Chapter 55 (medical and dental care of the uniformed services); (f) a medical care program of the Indian Health Service or a tribal organization; (g) a State health benefits risk pool; (h) the Federal Employees Health Benefits Program; (i) a public health plan, which means a plan providing health coverage that is established by a State, the U.S. government, or a foreign country, or a political subdivision thereof; (j) a health plan of the Peace Corps, or (k) a State Children's Health Insurance Program (SCHIP).

Creditable Coverage does not include coverage described in HIPAA as "excepted benefits," including: coverage only for accidents; disability income coverage; liability insurance, including general liability and automobile liability and any supplement thereto; credit only insurance; or coverage for on-site medical clinics.

Other excepted benefits include: limited scope dental or vision coverage or long term care coverage; non coordinated coverages offered separately, such as specified disease or illness policies, hospital or other fixed indemnity insurance; and supplemental benefits such as Medicare Supplemental health insurance, TRICARE supplemental programs or other similar supplemental coverage.

Custodial Care: The level of care that consists primarily of assisting with the activities of daily living such as bathing, continence, dressing, transferring and eating. The purpose of such care is to maintain and support the existing level of care and preserve health from further decline.

Custodial Care includes:

1. care given to a Covered Person who:
   a. is mentally or physically disabled; and
   b. needs a protected, monitored or controlled environment or assistance to support the basics of daily living, in an institution or at home; and
   c. may be ventilator dependent or require routine catheter maintenance.
2. health-related Services that are provided for the primary purpose of meeting the personal needs of the Covered Person or maintaining a level of function (even if the specific Services are considered to be skilled Services), as opposed to improving that function to an extent that might allow for a more independent existence;
3. Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively, such as recording pulse, temperature, and respiration; supervising medications that can usually be self-administered; or administration and monitoring of feeding systems.

Deductible: An amount of Allowable Charges which the Covered Person must pay each calendar year for Covered Services before benefits are payable by the Contract.

Durable Medical Equipment: Equipment and supplies which treat an Illness or Injury, to improve the functioning of a particular body part, or to prevent further deterioration of the Covered Person's medical condition. Such equipment and supplies must be designed and used primarily to treat conditions which are medical in nature, and able to withstand repeated use. Durable Medical Equipment includes such items as prosthetic devices that replace a limb or body part, orthopedic braces, crutches and wheelchairs. It does not include sporting or athletic equipment or items purchased for the convenience of the family.

Eligibility Waiting Period: Applicable to new Subscribers only, the period between the first day of employment and the first date of coverage under the Contract. This period may include the probationary period indicated in the Master Group Application.

Eligible Dependent:

1. The spouse of the Subscriber unless the marriage has been ended by a legal, effective decree of dissolution, divorce or separation.
2. Children to age 26.

   "Children" means:
   - the Subscriber's biological and adopted sons and daughters;
   - a grandchild who lives with the Subscriber in a regular child-parent relationship where the grandchild receives no support or maintenance from the parent and where the Subscriber is a court-appointed guardian of the grandchild;
   - a stepchild (i.e. the son or daughter of the Subscriber's current spouse); or
   - a child, other than a grandchild or stepchild, for whom the Subscriber is a court-appointed guardian, but does not include a foster child.

3. Reaching age 26 will not end the covered child's coverage under the plan as long as the child is, and remains both:
   a. incapable of self-sustaining employment, or of returning to school as a full-time student, by reason of mental or physical handicap; and
   b. dependent upon the Subscriber for support and maintenance.

   Proof of the requirements stated above must be received from the Subscriber within 31 days of the child's reaching age 26 and after that, as required (but not more often than yearly after two years of such handicap). Determination of eligibility under this provision will be made by BCBSNE. Any extended coverage under this paragraph will be subject to all other provisions of the Contract.

Embedded Deductible and/or Out-of-pocket Limit: An embedded amount means that no one family member contributes more than the individual amount to satisfy the family amount under a multi-person membership unit.

Emergency Care: Any Covered Services provided in a Hospital emergency room setting.

Emergency Medical Condition: A medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including, but not limited to, severe pain that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in: 1) placing the health of the person afflicted with such condition in serious jeopardy or, in the case of a behavioral condition, placing the health of such persons or others in serious jeopardy, 2) serious impairment to such person's bodily functions, 3) serious impairment of any bodily organ or part of such person, or 4) serious disfigurement of such person.

Essential Health Benefits: The ACA identifies ten categories of Covered Services as Essential Health Benefits: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Final Internal Adverse Benefit Determination: An Adverse Benefit Determination that has been upheld by BCBSNE, or its Utilization Review designee, at the completion of the internal appeal process as set forth herein.

Group: The employer/entity providing group health coverage under the Contract for its employees/participants.

Habilitative Services: Services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Not all Services are habilitative. Examples of Services that are not habilitative, and not covered under this provision, include but are not limited to: Custodial Care; day care; recreational care; Residential treatment; respite care; social services; vocational training; applied behavioral analysis; or Services provided under any state or federal special education program, including services provided through a school system, for which there is no charge to the person.

Hospice: A program of care provided for persons diagnosed as terminally ill and their families.

Hospital: A Hospital is an institution or facility duly Licensed by the State of Nebraska or the state in which it is located, which provides medical, surgical, diagnostic and treatment Services with 24 hour per day nursing Services, to two or more nonrelated persons with an Illness, Injury or Pregnancy, under the supervision of a staff of Physicians Licensed to practice medicine and surgery.

Host Blue (Plan): A Blue Cross and/or a Blue Shield Plan in another Blue Cross and Blue Shield Association Service Area, which administers Claims through the BlueCard Program for Nebraska Covered Persons residing or traveling in that service area.

Illness: A condition which deviates from or disrupts normal bodily functions or body tissues in an abnormal way, and is manifested by a characteristic set of signs or symptoms.

Independent Laboratory: A freestanding facility offering radiology and pathology Services which is not part of a Hospital and is Licensed by the proper authority in the state in which it is located.

Injury: Physical harm or damage inflicted to the body from an external force.

In-network Hospital, Physician Or Other Provider: A Licensed practitioner of the healing arts, a Licensed facility or other qualified provider of health care Services who has contracted with Us to provide Services as a part of a Preferred Provider network in Nebraska.

Inpatient: A Covered Person admitted to a Hospital or other institutional facility for bed occupancy to receive Services consisting of active medical and nursing care to treat conditions requiring continuous nursing intervention of such an intensity that it cannot be safely or effectively provided in any other setting.

Investigative: A technology, a drug, biological product, device, diagnostic, treatment or procedure is investigative if it has not been Scientifically Validated. BCBSNE will determine whether a technology is Investigative.

Late Enrollee: An individual who does not enroll for coverage during the first period in which he or she is eligible, or during a Special Enrollment Period.

Licensure (Licensed): Permission to engage in a health profession that would otherwise be unlawful in the state where Services are performed, and which is granted to individuals who meet prerequisite qualifications. Licensure protects a given scope of practice and the title.

Long Term Acute Care (LTAC): Specialized acute Hospital care for medically complex patients who are critically ill, have multi-system complications and/or failures, and require hospitalization in a facility offering specialized treatment programs and aggressive clinical and therapeutic intervention on a 24-hour/seven-day-a-week basis.

Master Group Application: A form completed by the Group which indicates the health coverage options and provisions chosen by the Group.

Medicaid: Grants to states for Medical Assistance Programs, Title XIX of the Social Security Act, as amended.

Medically Necessary (or used as "Medical Necessity"): Health care Services ordered by a Treating Physician exercising prudent clinical judgment, provided to a Covered Person for the purposes of prevention, evaluation, diagnosis or treatment of that Covered Person's Illness, Injury or Pregnancy, that are:

1. consistent with the prevailing professionally recognized standards of medical practice; and, known to be effective in improving health care outcomes for the condition for which it is recommended or prescribed. Effectiveness will be determined by validation based upon scientific evidence, professional standards and consideration of expert opinion; and
2. clinically appropriate in terms of type, frequency, extent, site and duration for the prevention, diagnosis or treatment of the Covered Person's Illness, Injury or Pregnancy. The most appropriate setting and the most appropriate level of Service is that setting and that level of Service, considering the potential benefits and harms to the patient. When this test is applied to the care of an Inpatient, the Covered Person's medical symptoms and conditions must require that treatment cannot be safely provided in a less intensive medical setting; and
3. not more costly than alternative interventions, including no intervention, and are at least as likely to produce equivalent therapeutic or diagnostic results as to the prevention, diagnosis or treatment of the patient's Illness, Injury or Pregnancy, without adversely affecting the Covered Person's medical condition; and
4. not provided primarily for the convenience of the following:
    a. the Covered Person;
    b. the Physician;
    c. the Covered Person 's family;
    d. any other person or health care provider; and
5. not considered unnecessarily repetitive when performed in combination with other prevention, evaluation, diagnoses or treatment procedures.

BCBSNE will determine whether Services are Medically Necessary. Services will not automatically be considered Medically Necessary because they have been ordered or provided by a Treating Physician.

Medicare: Health Insurance for the Aged and Disabled, Title XVIII of the Social Security Act, as amended.

Membership Unit: The category of persons to be provided benefits, pursuant to the Subscriber's enrollment.

1. Single Membership: This option provides benefits for Covered Services provided to the Subscriber only.
2. Subscriber-Spouse Membership: This option provides benefits for Covered Services provided to the Subscriber and his or her spouse.
3. Single Parent Membership: This option provides benefits for Covered Services provided to the Subscriber and his or her Eligible Dependent children, but not to a spouse.
4. Family Membership: This option provides benefits for Covered Services provided to the Subscriber and his or her Eligible Dependents.

Other Membership Units may be chosen by the Group and will be defined in the Master Group Application. If other Membership Units are chosen, a Subscriber may select from those Membership Units as defined by the Group.

Mental Health Services Provider: A qualified Physician, Licensed Psychologist, Licensed Special Psychologist, and Licensed Mental Health Practitioners. A Mental Health Practitioner may also be a Licensed Professional Counselor or a Licensed Clinical Social Worker who is duly Certified/Licensed for such practice by state law. It also includes, for purposes

of the Contract, Auxiliary Providers supervised, and billed for, by a professional as permitted by state law. All mental health Services must be provided under appropriate supervision and consultation requirements as set forth by state law.

Licensed Psychologist: A person Licensed to engage in the practice of psychology in this or another jurisdiction. The terms Certified, registered, chartered, or any other term chosen by a jurisdiction to authorize the autonomous practice of psychology shall be considered equivalent terms.

Licensed Special Psychologist: A person who has a doctoral degree in psychology from an institution of higher education accredited by the American Psychological Association but who is not Certified in clinical psychology. Such person shall be issued a special License to practice psychology that continues to require supervision by a Licensed Psychologist or qualified Physician for any practice that involves major mental and emotional disorders. This psychologist may provide mental health Services without supervision.

Licensed Mental Health Practitioner: A person Licensed to provide treatment, assessment, psychotherapy, counseling, or equivalent activities to individuals, families or groups for behavioral, cognitive, social, mental, or emotional disorders, including interpersonal or personal situations. Mental health practice shall include the initial assessment of organic mental or emotional disorders (as defined by state law), for the purpose of referral to, or consultation with a qualified Physician or a Licensed Psychologist.

Mental health practice shall not include the practice of psychology or medicine, prescribing drugs or electroconvulsive therapy, treating physical disease, Injury, or deformity, diagnosing major Mental Illness or disorder except in consultation with a qualified Physician or a Licensed Psychologist, measuring personality or intelligence for the purpose of diagnosis or treatment planning, using psychotherapy with individuals suspected of having major mental or emotional disorders except in consultation with a qualified Physician or Licensed Psychologist, or using psychotherapy to treat the concomitants of organic Illness except in consultation with a qualified Physician or Licensed Psychologist.

Mental Illness: A pathological state of mind producing clinically significant psychological or physiological symptoms (distress) together with impairment in one or more major areas of functioning (disability) wherein improvement can reasonably be anticipated with therapy, and which is a condition listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM IV or any subsequent version).

Noncovered Services: Services that are not payable under the Contract.

Out-of-network Allowance: An amount BCBSNE uses to calculate payment for Covered Services to an Out-of-network Provider. This amount will be determined by BCBSNE or by the Host Blue plan for out-of-area providers.

Out-of-network Provider: A provider of health care Services who has not contracted with BCBSNE to provide Services as a part of a Preferred Provider network in Nebraska.

Out-of-pocket Limit: The maximum amount of cost-share each Covered Person or Membership Unit must pay in a calendar year before benefits are payable without application of a cost-share amount. The Out-of-pocket Limit includes Deductible, Coinsurance and Copayment amounts for medical and pharmacy Services, unless otherwise indicated. The Out-of-pocket Limit does not include premium amounts, amounts over the Allowable Charge, or penalties for failure to comply with Certification requirements or as imposed under the Rx Nebraska Prescription Drug Program.

Outpatient: A person who is not admitted for Inpatient care, but is treated in the Outpatient department of a Hospital, in an observation room, in an Ambulatory Surgical Facility, Urgent Care Facility, a Physician's office, or at home. Ambulance Services are also considered Outpatient.

Outpatient Program: An organized set of resources and Services for a Substance Abusive or mentally ill population, administered by a Certified provider, which is directed toward the accomplishment of a designed set of objectives. Day treatment, partial care and Outpatient Programs which provide primary treatment for Mental Illness or Substance Abuse must be provided in a facility which is Licensed by the Department of Health and Human Services Regulation and Licensure, (or equivalent state agency) or accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the Commission on the Accreditation of Rehabilitation Facilities (CARF).

This definition does not include programs of co-dependency, family intervention, employee assistance, probation, prevention, educational or self-help programs, or programs which treat obesity, gambling, or nicotine addiction. It also does not include Residential Treatment Programs or day rehabilitation programs for Mental Illness, or Residential Treatment Programs, halfway house or methadone maintenance programs for Substance Abuse. Benefits will not be provided for programs or services ordered by the Court that are not Medically Necessary as determined by BCBSNE.

Physical Rehabilitation: The restoration of a person who was disabled as the result of an Injury or an acute physical impairment to a level of function which allows that person to live as independently as possible. A person is disabled when such person has physical disabilities and needs active assistance to perform the normal activities of daily living, such as eating, dressing, personal hygiene, ambulation and changing body position.

Physician: Any person holding a License and duly authorized to practice medicine and surgery.

Plan Administrator: The administrator of the Plan as defined by the Employee Retirement Income Security Act (ERISA).

Postservice Claim: Any Claim which is not a Preservice Claim.

Preferred Provider Organization: A panel of Hospitals, Physicians and other health care providers who belong to a network of Preferred Providers, which agrees to more effectively manage health care costs.

Preferred Provider: A health care provider (Hospital, Physician or other health care provider) who has contracted to provide Services as a part of the network in Nebraska, or if in another state, who is a Preferred Provider with the BlueCard Program PPO network.

Pregnancy: Includes obstetrics, abortions, threatened abortions, miscarriages, premature deliveries, ectopic pregnancies, cesarean sections or other conditions or complications caused by Pregnancy. For purposes of this Plan, Pregnancy also includes a condition or complication caused by Pregnancy, but separate from, and not part of the Pregnancy. It occurs prior to the end of the Pregnancy, and is adversely affected by it. Postpartum depression and similar diagnoses are not considered complications of Pregnancy.

Preservice Claim(s): Any Claim for a benefit under the Contract with respect to which the terms of the Contract require approval of the benefit in advance of obtaining medical care and failure to do so will cause benefits to be denied or reduced.

Preventive (Services): Services which focus on the prevention of disease and health maintenance, including the early diagnosis of disease, discovery and identification of high risk for a specific problem, and interventions to avert a health problem in nonsymptomatic individuals.

Primary Care Physician: A Physician who has a majority of his or her practice in the fields of internal or general medicine, obstetrics/gynecology, general pediatrics or family practice.

Private Duty Nursing: Continuous nursing care (beyond the accepted BCBSNE definition of a skilled nursing visit) in homes or facilities. Private Duty Nursing is primarily non-skilled in nature but may include skilled Services and is generally provided to chronically ill patients over the long term.

Qualified Beneficiary: Under COBRA, an individual who must in certain circumstances, be offered the opportunity to elect COBRA coverage under a group health plan. The term generally includes a covered employee's spouse or dependent children who were covered under the group health plan on the day before a Qualifying Event, as well as a covered employee who was covered under the group health plan on the day before a Qualifying Event that is a termination of employment or a reduction in hours. The term also includes a child born to or adopted by a covered employee during a period of COBRA coverage.

Qualifying Event: The circumstances that entitle persons to elect COBRA coverage.

Residential Treatment Program: Services or a program for persons with behavioral health disorders organized and staffed to provide both general and specialized nonhospital-based interdisciplinary Inpatient services 24 hours a day, seven days a week with oversight by a Physician. Residential treatment may be provided in freestanding, nonhospital-based facilities or in units of larger entities, such as a wing of a Hospital. Residential Treatment Programs may include nonhospital addiction treatment centers, intermediate care facilities, psychiatric treatment centers, or other nonmedical settings.

Schedule of Benefits: A summarized personal document which provides information such as Copayments, Deductibles, percentages payable, special benefits, maximums and limitations of coverage, and the type of Membership Unit selected. This term also includes the Schedule of Benefits Summary.

Schedule of Benefits Summary: See Schedule of Benefits.

Scientifically Validated: A technology, a drug, biological product, device, diagnostic, treatment or procedure is Scientifically Validated if it meets all of the factors set forth below:

1. Technologies, drugs, biological products, devices and diagnostics must have final approval from the appropriate government regulatory bodies. A drug or biological product must have final approval from the Food and Drug Administration (FDA). A device must have final approval from the FDA for those specific indications and methods of use that is being evaluated. FDA or other governmental approval is only one of the factors necessary to determine Scientific Validity.
2. The Scientific Evidence must permit conclusions concerning the effect of the technology on health outcomes. The evidence should consist of well-designed and well-conducted investigations published in peer-reviewed journals. The quality of the body of studies and the consistency of the results are considered in evaluating the evidence.

   The evidence should demonstrate that the technology can measure or alter the physiological changes related to a disease, injury, Illness or condition. In addition there should be evidence based on established medical facts that such measurement or alteration affects the health outcomes.

   Opinions and evaluations by national medical associations, consensus panels or other technology evaluation bodies are evaluated according to the scientific quality of the supporting evidence and rationale. Our evidence includes, but is not limited to: Blue Cross and Blue Shield Association Technology Evaluation Center technology evaluations; Hayes Directory of New Medical Technologies' Status; Centers for Medicare and Medicaid Services (CMS) Technology Assessments and United States Food and Drug Administration (FDA) approvals.
3. The technology must improve the health outcome.
4. The technology must improve the net health outcome as much as or more than established alternatives.
5. The improvement must be attainable outside the investigational settings.

BCBSNE will determine whether a technology is Scientifically Validated.

Services: Hospital, medical or surgical procedures, treatments, drugs, supplies, Durable Medical Equipment, or other health, mental health or dental care, including any single service or combination of such services.

Service Area: The geographic area in which a Blue Cross and Blue Shield plan is authorized to use the Blue Cross and Blue Shield brands pursuant to its license agreement with Blue Cross and Blue Shield Association.

Skilled Nursing Care: A level of care that includes services that can only be performed safely and correctly by a licensed nurse (either a registered nurse or a Licensed practical nurse).

Special Enrollee: An eligible person who enrolls for coverage during a Special Enrollment Period.

Special Enrollment Period: A period of time during which a Special Enrollee is allowed to enroll because of a loss of coverage, an adoption, placement for adoption, birth or marriage, without being considered a Late Enrollee, subject to certain criteria as further described in the Contract.

Specialist: A Physician who has a majority of his or her practice in fields other than internal or general medicine, obstetrics/gynecology, general pediatrics or family practice.

Subscriber: An individual who enrolls for health coverage and is named on an identification card issued pursuant to the Contract, and who is:

1. An employee hired by an employer who makes application for health coverage for its employee.
2. A member of an association that makes application for health coverage for its members.
3. A retiree qualified to receive benefits as defined in the Master Group Application.

Substance Dependence and Abuse: Alcoholism, drug abuse and nicotine dependence or addiction.

Substance Dependence And Abuse Treatment Center: A facility Licensed by the Department of Health and Human Services Regulation and Licensure, (or equivalent state agency), accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the Commission on the Accreditation of Rehabilitation Facilities (CARF). Such facility is not Licensed as a Hospital, but provides Inpatient or Outpatient care, treatment, Services, maintenance, accommodation or board in a group setting primarily and exclusively for individuals having any type of Substance Dependence or Abuse.

Treating Physician: A Physician who has personally evaluated the Covered Person. This may include a Physician or oral surgeon, a Certified nurse midwife, a Certified nurse practitioner or Certified Physician's assistant, within the practitioner's scope of practice.

Urgent Care Claim: A Claim for medical care or treatment for which the application of time periods for making non-urgent care determinations:

1. could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or
2. would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Claim.

Urgent Care Facility: A facility, other than a Hospital, that provides covered health Services that are required to prevent serious deterioration of a Covered Person's health, and that are required as a result of an unforeseen sickness, Injury or the onset of acute or severe symptoms.

Value-Based Program: Also known as patient-focused care, a Value-Based program is an outcomes-based payment arrangement and/or a coordinated care model facilitated with one of more local providers that is evaluated against cost and quality metrics/factors and is reflected in provider payment. Value-based (patient-focused) Programs may include, but are not limited to, Accountable Care Organizations, Global Payment/Total Cost of Care arrangements, Patient Centered Medical Homes and Shared Savings arrangements.

We, Our or Us: Blue Cross and Blue Shield of Nebraska (BCBSNE).

Work-hardening Therapy: Physical therapy or similar Services provided primarily for strengthening an individual for purposes of his or her employment.

AMENDMENT

THIS IS AN AMENDMENT TO YOUR CERTIFICATE OF COVERAGE. PLEASE READ IT CAREFULLY. THIS AMENDMENT BECOMES A PART OF YOUR CERTIFICATE OF COVERAGE AND SHOULD BE ATTACHED TO IT.


Steven S. Martin, President
and Chief Executive Officer

THE PLAN AND HOW IT WORKS

Deductible Carry-over Credit — If the total charges for Covered Services for a calendar year are less than the required Deductible, such covered charges incurred during October, November and December of that year, may be carried over and applied against the Deductible for the next calendar year.

CERTIFICATION REQUIREMENTS

The list of Services, supplies or drugs requiring Certification is amended to add the following surgical procedures:

- total knee;
- total hip; and
- back surgery.

BENEFIT DESCRIPTIONS

The section of this document entiltled "Benefit Descriptions" is amended to removed the age 21 limit for autism spectrum disorder benefits.

The Oral Surgery and Dentisty Benefits are amended to include the following covered services:

- evaluation and treatment of impacted teeth;
- Services for the treatment of TMJ or craniomandibular disorder;
- bone grafts to the jaw, including preparation of the mouth for dentures;
- osteotomy performed for a gross congenital abnormality of the jaw which can not be treated solely by orthodontic treatment or appliances; and
- dental implants when related to trauma (within one year of injury if osseous growth pattern has been completed, otherwise coverage will be extended for one year following completion of osseous growth pattern providing that coverage is still in effect at the time of treatment), cancer and other tumor, benign cysts, and for persons from puberty through age 23 with two or more adjacent congenitally missing teeth, provided that the Services will restore the Covered Person to a similar level of dental health and function that existed prior to the Injury by similar means of restoration;

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