



## An Overview of Your Medical, Prescription Drug and Dental Benefits



Educators Health Alliance Direct Bill Plan  
Effective Sept. 1, 2020

# HEALTH AND DENTAL PLAN OPTIONS

Exclusively for Educators Health Alliance  
Direct Bill Plan Members

EHA makes four health plan options and one dental option available to direct bill plan members. See the Schedule of Benefits Summaries (SOBS) on the following pages for a brief overview of the benefits of each option.



**You must enroll in dental coverage to be eligible for any of the health plan options.**



# OPTION 1

## Schedule of Benefits Summary

Covered services are reimbursed based on the allowable charge. Blue Cross and Blue Shield of Nebraska (BCBSNE) 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 member's responsibility. That means in-network providers, under the terms of their contract with BCBSNE, can't bill for amounts over the contracted amount. Out-of-network providers can bill for amounts over the out-of-network allowance.

Payments for Services	In Network	Out of Network
<b>In-network provider:</b> The provider network is shown on your ID card. For help in locating in-network providers, visit <a href="http://NebraskaBlue.com">NebraskaBlue.com</a> .		
<b>Deductible</b> (The amount the member pays each calendar year for covered services before the coinsurance is payable)		
Individual	\$1,050	\$2,100
Family (Embedded*)	\$2,100	\$4,200
<b>Coinsurance</b> (The percentage amount the covered person must pay for most covered services after the deductible has been met)		
Member pays	20%	40%
<b>Out-of-Pocket Limit</b> (Does not include premium, penalty and amounts not covered by the plan)		
Individual	\$4,900	\$9,800
Family (Embedded*)	\$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.

Credits toward the deductible and out-of-pocket limits will be applied to both in-network and out-of-network benefits. All other limits (days, visits, sessions, dollar amounts, etc.) do not 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) apply to:

- Physician office
- Telehealth services
- Prescription drugs
- Urgent care facility
- Emergency care

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

**Please note:** This Schedule of Benefits Summary is intended to provide you with a brief overview of your benefits. It is not a contract and should not be regarded as one. For more complete information about your plan, including benefits, exclusions and contract limitations, please refer to the master group contract. In the event there are discrepancies between this document and the contract, the terms and conditions of the contract will govern.

Covered Services – Illness or Injury	In Network	Out of Network
<b>Physician Office</b> <ul style="list-style-type: none"> <li>Primary care physician office visit</li> <li>Specialist physician office visit</li> <li>Other covered services and supplies provided in the physician’s office (with or without an office visit billed)</li> </ul>	\$35 copay \$55 copay Deductible and coinsurance	Deductible and coinsurance Deductible and coinsurance Deductible and coinsurance
Allergy injections and serum	Deductible and coinsurance	Deductible and coinsurance
Other injections	Deductible and coinsurance	Deductible and coinsurance
<p><b>Primary care physician</b> 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 <b>physician assistant</b> is covered in the same manner as a primary care physician.</p> <p><b>Specialist physician</b> is a physician who is not a primary care physician.</p> <p><b>Office visit benefits</b> for primary care and specialist physician office visit include office visits (including the initial visit to diagnose pregnancy) and consultations.</p> <p><b>Other covered services not part of the physician office benefit (Refer to the appropriate category for benefit information) include:</b> allergy injections and serum; other injections; advanced diagnostic imaging (CT, MRI, MRA, MRS, PET and SPECT scans and other nuclear medicine); pregnancy services; preventive services; radiation therapy and chemotherapy; surgery and anesthesia; therapy and manipulations; durable medical equipment; sleep studies; biofeedback; psychological evaluations, assessments and testing.</p>		
<b>Telehealth Services</b>	\$10 copay	Not covered
<b>Convenient Care/Retail Clinics (Quick Care)</b>	Same as a primary care physician	Same as a primary care physician
<b>Urgent Care Facility Services</b>	\$55 copay then deductible and coinsurance	Deductible and coinsurance
<b>Emergency Care Services</b> (services received in a hospital emergency room setting) <ul style="list-style-type: none"> <li>Facility</li> <li>Professional services (Copayment is waived if admitted to the hospital within 24 hours for the same diagnosis)</li> </ul>	\$85 copay then deductible and coinsurance Deductible and coinsurance	In-network level of benefits In-network level of benefits
<b>Outpatient Hospital or Facility Services</b> 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
<b>Inpatient Hospital or Facility Services</b> Charges for room and board, diagnostic testing, rehabilitation and other ancillary services provided on an inpatient basis	Deductible and coinsurance	Deductible and coinsurance
<b>Preventive Services</b> <ul style="list-style-type: none"> <li>Affordable Care Act (ACA) required preventive services (may be subject to limits that include, but are not limited to, age, gender, and frequency)</li> <li>ACA required covered preventive services (outside of limits)</li> <li>Other covered preventive services not required by ACA</li> </ul>	Plan pays 100% Deductible and coinsurance Plan pays 100%	Deductible and coinsurance Deductible and coinsurance Deductible and coinsurance
<b>Immunizations</b> <ul style="list-style-type: none"> <li>Pediatric (up to age 7)</li> <li>Age 7 and older</li> <li>Related to an illness</li> </ul>	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	Out of Network
<b>Inpatient Services</b>	Deductible and coinsurance	Deductible and coinsurance
<b>Outpatient Services</b> <ul style="list-style-type: none"> <li>• Office visit</li> <li>• Telehealth services</li> <li>• All other outpatient items and services</li> </ul>	Deductible and coinsurance Deductible and coinsurance Deductible and coinsurance	Deductible and coinsurance Not covered Deductible and coinsurance
<b>Emergency Care Services</b> (services received in a hospital emergency room setting) <ul style="list-style-type: none"> <li>• Facility</li> <li>• Professional services</li> </ul>	Deductible and coinsurance Deductible and coinsurance	In-network level of benefits In-network level of benefits
Other Covered Services – Illness or Injury	In Network	Out of Network
<b>Acupuncture</b>	Not covered	Not covered
<b>Advanced Diagnostic Imaging</b> (CT, MRI, MRA, MRS, PET and SPECT scans and other nuclear medicine)	Deductible and coinsurance	Deductible and coinsurance
<b>Ambulance</b> (to the nearest facility for appropriate care) <ul style="list-style-type: none"> <li>• Ground ambulance</li> <li>• Air ambulance</li> </ul>	Deductible and coinsurance Deductible and coinsurance	In-network level of benefits Deductible and coinsurance (In-network level of benefits if due to an emergency)
<b>Biofeedback</b>	Deductible and coinsurance	Deductible and coinsurance
<b>Bone Anchored Hearing Aids (BAHA) and Cochlear Implants</b>	Deductible and coinsurance	Deductible and coinsurance
<b>Dermatological Services</b>	Same as any other illness	Same as any other illness
<b>Diabetic Services</b> Services include education, self-management training, podiatric appliances and equipment	Deductible and coinsurance	Deductible and coinsurance
<b>Durable Medical Equipment and Supplies (including prosthetics)</b> (Rental or purchase, whichever is least costly; rental shall not exceed the cost of purchasing)	Deductible and coinsurance	Deductible and coinsurance
<b>Eye Glasses or Contact Lenses</b> 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
<b>Hearing Aids</b> (up to age 19 limited to \$3,000 every 48 months)	Same as any other illness	Same as any other illness
<b>Home Health Aide and Skilled Nursing</b> 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
<b>Home Infusion Therapy</b>	Deductible and coinsurance	Deductible and coinsurance
<b>Hospice Services</b>	Deductible and coinsurance	Deductible and coinsurance
<b>Independent Laboratory</b> <ul style="list-style-type: none"> <li>• Diagnostic</li> <li>• Preventive</li> </ul>	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
<b>Infertility</b> <ul style="list-style-type: none"> <li>• Services to diagnose</li> <li>• Treatment to promote fertility</li> </ul>	Same as any other illness Not covered	Same as any other illness Not covered

Other Covered Services – Illness or Injury	In Network	Out of Network
<b>Nicotine Addiction</b> <ul style="list-style-type: none"> <li>Medical services and therapy</li> <li>Nicotine addiction classes and alternative therapy, such as acupuncture</li> </ul>	Same as substance dependence and abuse Not covered	Same as substance dependence and abuse Not covered
<b>Obesity</b> <ul style="list-style-type: none"> <li>Non-surgical treatment</li> <li>Surgical treatment</li> </ul>	Not covered Not covered	Not covered Not covered
<b>Oral Surgery and Dentistry</b> 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
<b>Organ and Tissue Transplantation</b>	Deductible and coinsurance	Deductible and coinsurance
<b>Ostomy Supplies</b>	Deductible and coinsurance	Deductible and coinsurance
<b>Physician Professional Services</b> Inpatient and outpatient services, such as, surgery, surgical assistant, anesthesia, inpatient hospital visits and other non-surgical services	Deductible and coinsurance	Deductible and coinsurance
<b>Pregnancy, Maternity and Newborn Care</b> <ul style="list-style-type: none"> <li>Pregnancy and maternity (Payment for prenatal and postnatal care is included in the payment for the delivery)</li> <li>Newborn care</li> </ul> NOTE: Newborns are covered at birth, subject to the plan's enrollment provisions.	Deductible and coinsurance	Deductible and coinsurance
	Deductible and coinsurance	Deductible and coinsurance
<b>Radiation Therapy and Chemotherapy</b>	Deductible and coinsurance	Deductible and coinsurance
<b>Radiology (X-ray) Services and Other Diagnostic Test</b>	Deductible and coinsurance	Deductible and coinsurance
<b>Rehabilitation Services – Inpatient Facility</b>	Deductible and coinsurance	Deductible and coinsurance
<b>Rehabilitation Services</b> <ul style="list-style-type: none"> <li>Cardiac rehabilitation (limited to 18 sessions per diagnosis)</li> <li>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.)</li> </ul>	Deductible and coinsurance	Deductible and coinsurance
	Deductible and coinsurance	Deductible and coinsurance
<b>Renal Dialysis</b>	Deductible and coinsurance	Deductible and coinsurance
<b>Respiratory Care</b> (limited to 60 days per calendar year)	Deductible and coinsurance	Deductible and coinsurance
<b>Sexual Dysfunction</b>	Not covered	Not covered
<b>Skilled Nursing Facility</b> (limited to 60 days per calendar year)	Deductible and coinsurance	Deductible and coinsurance
<b>Sleep Studies</b>	Deductible and coinsurance	Deductible and coinsurance
<b>Temporomandibular and Craniomandibular Joint Disorder</b>	Deductible and coinsurance	Deductible and coinsurance

Other Covered Services – Illness or Injury	In Network	Out of Network
<b>Therapy and Manipulations</b> <ul style="list-style-type: none"> <li>Physical, occupational or speech therapy services, chiropractic or osteopathic physiotherapy (combined limit to 60 sessions per calendar year)</li> <li>Chiropractic or osteopathic manipulative treatments or adjustments (combined limit to 30 sessions per calendar year)</li> </ul>	Deductible and coinsurance	Deductible and coinsurance
<b>Vision Exams</b> <ul style="list-style-type: none"> <li>Diagnostic (to diagnose an illness)</li> <li>Preventive (routine exam including refraction)</li> </ul>	See physician office services Not covered	See physician office services Not covered
<b>Wigs</b>	Not covered	Not covered
<b>All Other Covered Services</b>	Deductible and coinsurance	Deductible and coinsurance

Prescription Drugs	In Network	Out of Network
<b>Prescription Drug Deductible</b> (The amount the member pays each calendar year for covered prescription drugs before the prescription drug copayments and/or coinsurance are applicable) <ul style="list-style-type: none"> <li>Individual</li> <li>Family</li> </ul>	Not applicable Not applicable	Not applicable Not applicable
<b>Retail – per 30-day supply</b> <ul style="list-style-type: none"> <li>Generic drugs/Insulin (including non-preferred contraceptives)</li> <li>Preferred brand-name drugs/Insulin</li> <li>Non-preferred brand-name drugs/Insulin</li> </ul>	25% coinsurance, \$10 minimum copay, \$40 maximum copay 25% coinsurance, \$50 minimum copay, \$100 maximum copay 50% coinsurance, \$75 minimum copay, \$150 maximum copay	25% coinsurance, \$10 minimum copay, \$40 maximum copay + 25% penalty 25% coinsurance, \$50 minimum copay, \$100 maximum copay + 25% penalty 50% coinsurance, \$75 minimum copay, \$150 maximum copay + 25% penalty
<b>Mail Order – Per 180-Day Supply</b> <ul style="list-style-type: none"> <li>Generic drugs (including non-preferred contraceptives)</li> <li>Preferred brand-name drugs</li> <li>Non-preferred brand-name drugs</li> </ul>	25% coinsurance, \$50 minimum copay, \$200 maximum copay 25% coinsurance, \$250 minimum copay, \$500 maximum copay 50% coinsurance, \$375 minimum copay, \$750 maximum copay	Not covered Not covered Not covered
<b>Diabetic Supplies</b> <ul style="list-style-type: none"> <li>Generic</li> <li>Formulary brand-name</li> <li>Non-formulary brand-name</li> </ul>	20% coinsurance 20% coinsurance 30% coinsurance	20% coinsurance + 25% penalty 20% coinsurance + 25% penalty 30% coinsurance + 25% penalty
<b>Specialty Drugs</b>	25% coinsurance, \$125 minimum copay, \$250 maximum copay	50% coinsurance, \$250 minimum copay, \$500 maximum copay
<b>Contraceptives</b> <ul style="list-style-type: none"> <li>Preferred <ul style="list-style-type: none"> <li>Generic</li> <li>Brand-name</li> </ul> </li> <li>Non-preferred <ul style="list-style-type: none"> <li>Generic</li> <li>Brand-name</li> </ul> </li> </ul>	Plan pays 100% Plan pays 100%	25% penalty 25% penalty
<b>Infertility</b> FDA approved prescription drugs to promote fertility	Not covered	Not covered
<b>Nicotine Addiction</b> FDA approved prescription drugs and over-the-counter nicotine addiction drugs and deterrents	Plan pays 100%	25% penalty
<b>Obesity</b> FDA approved prescription drugs	Not covered	Not covered

# OPTION 2

## Schedule of Benefits Summary

Covered services are reimbursed based on the allowable charge. BCBSNE 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 member's responsibility. That means in-network providers, under the terms of their contract with BCBSNE, can't bill for amounts over the contracted amount. Out-of-network providers can bill for amounts over the out-of-network allowance.

Payments for Services	In Network	Out of Network
<b>In-network provider:</b> The provider network is shown on your ID card. For help in locating in-network providers, visit <a href="http://NebraskaBlue.com">NebraskaBlue.com</a> .		
<b>Deductible</b> (The amount the member pays each calendar year for covered services before the coinsurance is payable)		
Individual	\$2,500	\$5,000
Family (Embedded*)	\$5,000	\$10,000
<b>Coinsurance</b> (The percentage amount the covered person must pay for most covered services after the deductible has been met)		
Member pays	30%	40%
<b>Out-of-Pocket Limit</b> (Does not include premium, penalty and amounts not covered by the plan)		
Individual	\$7,350	\$14,700
Family (Embedded*)	\$14,700	\$29,400

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.

Credits toward the deductible and out-of-pocket limits will be applied to both in-network and out-of-network benefits. 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) apply to:

- Physician office
- Telehealth services
- Prescription drugs
- Urgent care facility
- Emergency care

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

**Please note:** This Schedule of Benefits Summary is intended to provide you with a brief overview of your benefits. It is not a contract and should not be regarded as one. For more complete information about your plan, including benefits, exclusions and contract limitations, please refer to the master group contract. In the event there are discrepancies between this document and the contract, the terms and conditions of the contract will govern.



Covered Services – Illness or Injury	In Network	Out of Network
<b>Physician Office</b> <ul style="list-style-type: none"> <li>Primary care physician office visit</li> <li>Specialist physician office visit</li> <li>Other covered services and supplies provided in the physician's office (with or without an office visit billed)</li> </ul>	\$50 copay \$70 copay Deductible and coinsurance	Deductible and coinsurance Deductible and coinsurance Deductible and coinsurance
<ul style="list-style-type: none"> <li>Allergy injections and serum</li> </ul>	Deductible and coinsurance	Deductible and coinsurance
<ul style="list-style-type: none"> <li>Other injections</li> </ul>	Deductible and coinsurance	Deductible and coinsurance
<p><b>Primary care physician</b> 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 <b>physician assistant</b> is covered in the same manner as a primary care physician.</p> <p><b>Specialist physician</b> is a physician who is not a primary care physician.</p> <p><b>Office visit benefits</b> for primary care and specialist physician office visit include office visits (including the initial visit to diagnose pregnancy) and consultations.</p> <p><b>Other covered services not part of the physician office benefit (Refer to the appropriate category for benefit information) include:</b> allergy injections and serum; other injections; advanced diagnostic imaging (CT, MRI, MRA, MRS, PET and SPECT scans and other nuclear medicine); pregnancy services; preventive services; radiation therapy and chemotherapy; surgery and anesthesia; therapy and manipulations; durable medical equipment; sleep studies; biofeedback; psychological evaluations, assessments and testing.</p>		
<b>Telehealth Services</b>	\$15 copay	Not covered
<b>Convenient Care/Retail Clinics (Quick Care)</b>	Same as a primary care physician	Same as a primary care physician
<b>Urgent Care Facility Services</b> (a single copay applies to each urgent care visit)	\$70 copay then deductible and coinsurance	Deductible and coinsurance
<b>Emergency Care Services</b> (services received in a hospital emergency room setting) <ul style="list-style-type: none"> <li>Facility</li> <li>Professional services (Copayment is waived if admitted to the hospital within 24 hours for the same diagnosis)</li> </ul>	\$100 copay then deductible and coinsurance Deductible and coinsurance	In-network level of benefits In-network level of benefits
<b>Outpatient Hospital or Facility Services</b> 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
<b>Inpatient Hospital or Facility Services</b> Charges for room and board, diagnostic testing, rehabilitation and other ancillary services provided on an inpatient basis	Deductible and coinsurance	Deductible and coinsurance
<b>Preventive Services</b> <ul style="list-style-type: none"> <li>Affordable Care Act (ACA) required preventive services (may be subject to limits that include, but are not limited to, age, gender, and frequency)</li> <li>ACA required covered preventive services (outside of limits)</li> <li>Other covered preventive services not required by ACA</li> </ul>	Plan pays 100% Deductible and coinsurance Plan pays 100%	Deductible and coinsurance Deductible and coinsurance Deductible and coinsurance
<b>Immunizations</b> <ul style="list-style-type: none"> <li>Pediatric (up to age 7)</li> <li>Age 7 and older</li> <li>Related to an illness</li> </ul>	Plan pays 100% Plan pays 100% Same as any other illness	Coinsurance Deductible and coinsurance Same as any other illness

<b>Mental Illness and/or Substance Dependence and Abuse Covered Services</b>	<b>In Network</b>	<b>Out of Network</b>
<b>Inpatient Services</b>	Deductible and coinsurance	Deductible and coinsurance
<b>Outpatient Services</b> <ul style="list-style-type: none"> <li>• Office visit</li> <li>• Telehealth services</li> <li>• All other outpatient items and services</li> </ul>	Deductible and coinsurance Deductible and coinsurance Deductible and coinsurance	Deductible and coinsurance Not covered Deductible and coinsurance
<b>Emergency Care Services</b> (services received in a hospital emergency room setting) <ul style="list-style-type: none"> <li>• Facility</li> <li>• Professional services</li> </ul>	Deductible and coinsurance Deductible and coinsurance	In-network level of benefits In-network level of benefits
<b>Other Covered Services – Illness or Injury</b>	<b>In Network</b>	<b>Out of Network</b>
<b>Acupuncture</b>	Not covered	Not covered
<b>Advanced Diagnostic Imaging</b> (CT, MRI, MRA, MRS, PET and SPECT scans and other nuclear medicine)	Deductible and coinsurance	Deductible and coinsurance
<b>Ambulance</b> (to the nearest facility for appropriate care) <ul style="list-style-type: none"> <li>• Ground ambulance</li> <li>• Air ambulance</li> </ul>	Deductible and coinsurance Deductible and coinsurance	In-network level of benefits Deductible and coinsurance (In-network level of benefits if due to an emergency)
<b>Biofeedback</b>	Deductible and coinsurance	Deductible and coinsurance
<b>Bone Anchored Hearing Aids (BAHA) and Cochlear Implants</b>	Deductible and coinsurance	Deductible and coinsurance
<b>Dermatological Services</b>	Same as any other illness	Same as any other illness
<b>Diabetic Services</b> Services include education, self-management training, podiatric appliances and equipment	Deductible and coinsurance	Deductible and coinsurance
<b>Durable Medical Equipment and Supplies (including prosthetics)</b> (Rental or purchase, whichever is least costly; rental shall not exceed the cost of purchasing)	Deductible and coinsurance	Deductible and coinsurance
<b>Eye Glasses or Contact Lenses</b> 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
<b>Hearing Aids</b> (up to age 19 limited to \$3,000 every 48 months)	Same as any other illness	Same as any other illness
<b>Home Health Aide and Skilled Nursing</b> 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
<b>Home Infusion Therapy</b>	Deductible and coinsurance	Deductible and coinsurance
<b>Hospice Services</b>	Deductible and coinsurance	Deductible and coinsurance
<b>Independent Laboratory</b> <ul style="list-style-type: none"> <li>• Diagnostic</li> <li>• Preventive</li> </ul>	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
<b>Infertility</b> <ul style="list-style-type: none"> <li>• Services to diagnose</li> <li>• Treatment to promote fertility</li> </ul>	Same as any other illness Not covered	Same as any other illness Not covered

Other Covered Services – Illness or Injury	In Network	Out of Network
<b>Nicotine Addiction</b> <ul style="list-style-type: none"> <li>Medical services and therapy</li> <li>Nicotine addiction classes and alternative therapy, such as acupuncture</li> </ul>	Same as substance dependence and abuse Not covered	Same as substance dependence and abuse Not covered
<b>Obesity</b> <ul style="list-style-type: none"> <li>Non-surgical treatment</li> <li>Surgical treatment</li> </ul>	Not covered Not covered	Not covered Not covered
<b>Oral Surgery and Dentistry</b> 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
<b>Organ and Tissue Transplantation</b>	Deductible and coinsurance	Deductible and coinsurance
<b>Ostomy Supplies</b>	Deductible and coinsurance	Deductible and coinsurance
<b>Physician Professional Services</b> Inpatient and outpatient services, such as, surgery, surgical assistant, anesthesia, inpatient hospital visits and other non-surgical services	Deductible and coinsurance	Deductible and coinsurance
<b>Pregnancy, Maternity and Newborn Care</b> <ul style="list-style-type: none"> <li>Pregnancy and maternity (Payment for prenatal and postnatal care is included in the payment for the delivery)</li> <li>Newborn care</li> </ul> NOTE: Newborns are covered at birth, subject to the plan's enrollment provisions.	Deductible and coinsurance Deductible and coinsurance	Deductible and coinsurance Deductible and coinsurance
<b>Radiation Therapy and Chemotherapy</b>	Deductible and coinsurance	Deductible and coinsurance
<b>Radiology (X-ray) Services and Other Diagnostic Test</b>	Deductible and coinsurance	Deductible and coinsurance
<b>Rehabilitation Services – Inpatient Facility</b>	Deductible and coinsurance	Deductible and coinsurance
<b>Rehabilitation Services</b> <ul style="list-style-type: none"> <li>Cardiac rehabilitation (limited to 18 sessions per diagnosis)</li> <li>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.)</li> </ul>	Deductible and coinsurance Deductible and coinsurance	Deductible and coinsurance Deductible and coinsurance
<b>Renal Dialysis</b>	Deductible and coinsurance	Deductible and coinsurance
<b>Respiratory Care</b> (limited to 60 days per calendar year)	Deductible and coinsurance	Deductible and coinsurance
<b>Sexual Dysfunction</b>	Not covered	Not covered
<b>Skilled Nursing Facility</b> (limited to 60 days per calendar year)	Deductible and coinsurance	Deductible and coinsurance
<b>Sleep Studies</b>	Deductible and coinsurance	Deductible and coinsurance
<b>Temporomandibular and Craniomandibular Joint Disorder</b>	Deductible and coinsurance	Deductible and coinsurance

Other Covered Services – Illness or Injury	In Network	Out of Network
<b>Therapy and Manipulations</b> <ul style="list-style-type: none"> <li>Physical, occupational or speech therapy services, chiropractic or osteopathic physiotherapy (combined limit to 60 sessions per calendar year)</li> <li>Chiropractic or osteopathic manipulative treatments or adjustments (combined limit to 30 sessions per calendar year)</li> </ul>	Deductible and coinsurance	Deductible and coinsurance
<b>Vision Exams</b> <ul style="list-style-type: none"> <li>Diagnostic (to diagnose an illness)</li> <li>Preventive (routine exam including refraction)</li> </ul>	See physician office services Not covered	See physician office services Not covered
<b>Wigs</b>	Not covered	Not covered
<b>All Other Covered Services</b>	Deductible and coinsurance	Deductible and coinsurance
Prescription Drugs	In Network	Out of Network
<b>Prescription Drug Deductible</b> (The amount the member pays each calendar year for covered prescription drugs before the prescription drug copayments and/or coinsurance are applicable) <ul style="list-style-type: none"> <li>Individual</li> <li>Family</li> </ul>	Not applicable Not applicable	Not applicable Not applicable
<b>Retail – Per 30-Day Supply</b> <ul style="list-style-type: none"> <li>Generic drugs/Insulin (including non-preferred contraceptives)</li> <li>Preferred brand-name drugs/Insulin</li> <li>Non-Preferred brand-name drugs/Insulin</li> </ul>	30% coinsurance, \$12 minimum copay, \$45 maximum copay 30% coinsurance, \$55 minimum copay, \$110 maximum copay 50% coinsurance, \$75 minimum copay, \$150 maximum copay	30% coinsurance, \$12 minimum copay, \$45 maximum copay + 25% penalty 30% coinsurance, \$55 minimum copay, \$110 maximum copay + 25% penalty 50% coinsurance, \$75 minimum copay, \$150 maximum copay + 25% penalty
<b>Mail Order – Per 180-Day Supply</b> <ul style="list-style-type: none"> <li>Generic drugs (including non-preferred contraceptives)</li> <li>Preferred brand-name drugs</li> <li>Non-preferred brand-name drugs</li> </ul>	30% coinsurance, \$60 minimum copay, \$225 maximum copay 30% coinsurance, \$275 minimum copay, \$550 maximum copay 50% coinsurance, \$375 minimum copay, \$750 maximum copay	Not covered Not covered Not covered
<b>Diabetic Supplies and Insulin</b> <ul style="list-style-type: none"> <li>Generic</li> <li>Formulary brand-name</li> <li>Non-formulary brand-name</li> </ul>	20% coinsurance 20% coinsurance 30% coinsurance	20% coinsurance + 25% penalty 20% coinsurance + 25% penalty 30% coinsurance + 25% penalty
<b>Specialty Drugs</b>	25% coinsurance, \$125 minimum copay, \$250 maximum copay	50% coinsurance, \$250 minimum copay, \$500 maximum copay
<b>Contraceptives</b> <ul style="list-style-type: none"> <li>Preferred <ul style="list-style-type: none"> <li>Generic</li> <li>Brand-name</li> </ul> </li> <li>Non-preferred <ul style="list-style-type: none"> <li>Generic</li> <li>Brand-name</li> </ul> </li> </ul>	Plan pays 100% Plan pays 100%	25% penalty 25% penalty
<b>Infertility</b> FDA approved prescription drugs to promote fertility	Not covered	Not covered
<b>Nicotine Addiction</b> FDA approved prescription drugs and over-the-counter nicotine addiction drugs and deterrents	Plan pays 100%	25% penalty
<b>Obesity</b> FDA approved prescription drugs	Not covered	Not covered

# OPTION 3 Qualified High Deductible Health Plan (QHDHP)

## Schedule of Benefits Summary

Covered services are reimbursed based on the allowable charge. BCBSNE 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 member’s responsibility. That means in-network providers, under the terms of their contract with BCBSNE, can’t bill for amounts over the contracted amount. Out-of-network providers can bill for amounts over the out-of-network allowance.

Payments for Services	In Network	Out of Network
<b>In-network provider:</b> The provider network is shown on your ID card. For help in locating in-network providers, visit <a href="http://NebraskaBlue.com">NebraskaBlue.com</a> .		
<b>Deductible</b> (The amount the member pays each calendar year for covered services before the coinsurance is payable)		
Individual	\$3,600	\$7,200
Family (Aggregate*)	\$7,050	\$14,100
<b>Coinsurance</b> (The percentage amount the covered person must pay for most covered services after the deductible has been met)		
Member pays	10%	20%
<b>Out-of-Pocket Limit</b> (Does not include premium, penalty and amounts not covered by the plan)		
Individual	\$4,250	\$12,700
Family (Aggregate*)	\$8,150	\$25,400

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.

Credits toward the deductible and out-of-pocket limits will be applied to both in-network and out-of-network benefits. All other limits (days, visits, sessions, dollar amounts, etc.) do not 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.

\* Aggregate – If you have single coverage, you only need to satisfy the individual deductible and out-of-pocket limit. If you have family coverage the individual amounts do not apply - the entire family deductible must be met prior to any benefits becoming available, and the entire family out-of-pocket must be met before cost-sharing no longer applies. Family members may combine their covered expenses to satisfy the required family deductible and out-of-pocket amounts.

**Copayment(s) apply to:**

- This plan has no medical or prescription drug copays

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

The deductible must be met each calendar year before copays and coinsurance are applicable.

**Please note:** This Schedule of Benefits Summary is intended to provide you with a brief overview of your benefits. It is not a contract and should not be regarded as one. For more complete information about your plan, including benefits, exclusions and contract limitations, please refer to the master group contract. In the event there are discrepancies between this document and the contract, the terms and conditions of the contract will govern.

Covered Services – Illness or Injury	In Network	Out of Network
<b>Physician Office</b> <ul style="list-style-type: none"> <li>Primary care physician office visit</li> <li>Specialist physician office visit</li> <li>Other covered services and supplies provided in the physician’s office (with or without an office visit billed)</li> </ul>	Deductible and coinsurance Deductible and coinsurance Deductible and coinsurance	Deductible and coinsurance Deductible and coinsurance Deductible and coinsurance
<ul style="list-style-type: none"> <li>Allergy injections and serum</li> </ul>	Deductible and coinsurance	Deductible and coinsurance
<ul style="list-style-type: none"> <li>Other injections</li> </ul>	Deductible and coinsurance	Deductible and coinsurance
<p><b>Primary care physician</b> 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 <b>physician assistant</b> is covered in the same manner as a primary care physician.</p> <p><b>Specialist physician</b> is a physician who is not a primary care physician.</p> <p><b>Office visit benefits</b> for primary care and specialist physician office visit include office visits (including the initial visit to diagnose pregnancy) and consultations.</p> <p><b>Other covered services not part of the physician office benefit (Refer to the appropriate category for benefit information) include:</b> allergy injections and serum; other injections; advanced diagnostic imaging (CT, MRI, MRA, MRS, PET and SPECT scans and other nuclear medicine); pregnancy services; preventive services; radiation therapy and chemotherapy; surgery and anesthesia; therapy and manipulations; durable medical equipment; sleep studies; biofeedback; psychological evaluations, assessments and testing.</p>		
<b>Convenient Care/Retail Clinics (Quick Care)</b>	Same as a primary care physician	Same as a primary care physician
<b>Telehealth Services</b>	Deductible and coinsurance	Not covered
<b>Urgent Care Facility Services</b>	Deductible and coinsurance	Deductible and coinsurance
<b>Emergency Care Services</b> (services received in a hospital emergency room setting) <ul style="list-style-type: none"> <li>Facility</li> <li>Professional services</li> </ul>	Deductible and coinsurance Deductible and coinsurance	In-network level of benefits In-network level of benefits
<b>Outpatient Hospital or Facility Services</b> 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
<b>Inpatient Hospital or Facility Services</b> Charges for room and board, diagnostic testing, rehabilitation and other ancillary services provided on an inpatient basis	Deductible and coinsurance	Deductible and coinsurance
<b>Preventive Services</b> <ul style="list-style-type: none"> <li>Affordable Care Act (ACA) required preventive services (may be subject to limits that include, but are not limited to, age, gender, and frequency)</li> <li>ACA required covered preventive services (outside of limits)</li> <li>Other covered preventive services not required by ACA</li> </ul>	Plan pays 100% Deductible and coinsurance Plan pays 100%	Deductible and coinsurance Deductible and coinsurance Deductible and coinsurance
<b>Immunizations</b> <ul style="list-style-type: none"> <li>Pediatric (up to age 7)</li> <li>Age 7 and older</li> <li>Related to an illness</li> </ul>	Plan pays 100% Plan pays 100% Same as any other illness	Coinsurance Deductible and coinsurance Same as any other illness

<b>Mental Illness and/or Substance Dependence and Abuse Covered Services</b>	<b>In Network</b>	<b>Out of Network</b>
<b>Inpatient Services</b>	Deductible and coinsurance	Deductible and coinsurance
<b>Outpatient Services</b> <ul style="list-style-type: none"> <li>• Office visit</li> <li>• Telehealth services</li> <li>• All other outpatient items and services</li> </ul>	Deductible and coinsurance Deductible and coinsurance Deductible and coinsurance	Deductible and coinsurance Not covered Deductible and coinsurance
<b>Emergency Care Services</b> (services received in a hospital emergency room setting) <ul style="list-style-type: none"> <li>• Facility</li> <li>• Professional services</li> </ul>	Deductible and coinsurance Deductible and coinsurance	In-network level of benefits In-network level of benefits
<b>Other Covered Services – Illness or Injury</b>	<b>In Network</b>	<b>Out of Network</b>
<b>Acupuncture</b>	Not covered	Not covered
<b>Advanced Diagnostic Imaging</b> (CT, MRI, MRA, MRS, PET and SPECT scans and other nuclear medicine)	Deductible and coinsurance	Deductible and coinsurance
<b>Ambulance</b> (to the nearest facility for appropriate care) <ul style="list-style-type: none"> <li>• Ground ambulance</li> <li>• Air ambulance</li> </ul>	Deductible and coinsurance Deductible and coinsurance	In-network level of benefits Deductible and coinsurance (In-network level of benefits if due to an emergency)
<b>Biofeedback</b>	Deductible and coinsurance	Deductible and coinsurance
<b>Bone Anchored Hearing Aids (BAHA) and Cochlear Implants</b>	Deductible and coinsurance	Deductible and coinsurance
<b>Dermatological Services</b>	Same as any other illness	Same as any other illness
<b>Diabetic Services</b> Services include education, self-management training, podiatric appliances and equipment	Deductible and coinsurance	Deductible and coinsurance
<b>Durable Medical Equipment and Supplies (including prosthetics)</b> (Rental or purchase, whichever is least costly; rental shall not exceed the cost of purchasing)	Deductible and coinsurance	Deductible and coinsurance
<b>Eye Glasses or Contact Lenses</b> 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
<b>Hearing Aids</b> (up to age 19 limited to \$3,000 every 48 months)	Same as any other illness	Same as any other illness
<b>Home Health Aide and Skilled Nursing</b> 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
<b>Home Infusion Therapy</b>	Deductible and coinsurance	Deductible and coinsurance
<b>Hospice Services</b>	Deductible and coinsurance	Deductible and coinsurance
<b>Independent Laboratory</b> <ul style="list-style-type: none"> <li>• Diagnostic</li> <li>• Preventive</li> </ul>	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
<b>Infertility</b> <ul style="list-style-type: none"> <li>• Services to diagnose</li> <li>• Treatment to promote fertility</li> </ul>	Same as any other illness Not covered	Same as any other illness Not covered

Other Covered Services – Illness or Injury	In Network	Out of Network
<b>Nicotine Addiction</b> <ul style="list-style-type: none"> <li>Medical services and therapy</li> <li>Nicotine addiction classes and alternative therapy, such as acupuncture</li> </ul>	Same as substance dependence and abuse Not covered	Same as substance dependence and abuse Not covered
<b>Obesity</b> <ul style="list-style-type: none"> <li>Non-surgical treatment</li> <li>Surgical treatment</li> </ul>	Not covered Not covered	Not covered Not covered
<b>Oral Surgery and Dentistry</b> 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
<b>Organ and Tissue Transplantation</b>	Deductible and coinsurance	Deductible and coinsurance
<b>Ostomy Supplies</b>	Deductible and coinsurance	Deductible and coinsurance
<b>Physician Professional Services</b> Inpatient and outpatient services, such as, surgery, surgical assistant, anesthesia, inpatient hospital visits and other non-surgical services	Deductible and coinsurance	Deductible and coinsurance
<b>Pregnancy, Maternity and Newborn Care</b> <ul style="list-style-type: none"> <li>Pregnancy and maternity (Payment for prenatal and postnatal care is included in the payment for the delivery)</li> <li>Newborn care</li> </ul> NOTE: Newborns are covered at birth, subject to the plan's enrollment provisions.	Deductible and coinsurance	Deductible and coinsurance
	Deductible and coinsurance	Deductible and coinsurance
<b>Radiation Therapy and Chemotherapy</b>	Deductible and coinsurance	Deductible and coinsurance
<b>Radiology (X-ray) Services and Other Diagnostic Test</b>	Deductible and coinsurance	Deductible and coinsurance
<b>Rehabilitation Services – Inpatient Facility</b>	Deductible and coinsurance	Deductible and coinsurance
<b>Rehabilitation Services</b> <ul style="list-style-type: none"> <li>Cardiac rehabilitation (Limited to 18 sessions per diagnosis during the preceding four months of certain cardiac diagnosis)</li> <li>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.)</li> </ul>	Deductible and coinsurance	Deductible and coinsurance
	Deductible and coinsurance	Deductible and coinsurance
<b>Renal Dialysis</b>	Deductible and coinsurance	Deductible and coinsurance
<b>Respiratory Care</b> (limited to 60 days per calendar year)	Deductible and coinsurance	Deductible and coinsurance
<b>Sexual Dysfunction</b>	Not covered	Not covered
<b>Skilled Nursing Facility</b> (limited to 60 days per calendar year)	Deductible and coinsurance	Deductible and coinsurance
<b>Sleep Studies</b>	Deductible and coinsurance	Deductible and coinsurance
<b>Temporomandibular and Craniomandibular Joint Disorder</b>	Deductible and coinsurance	Deductible and coinsurance



Other Covered Services – Illness or Injury	In Network	Out of Network
<b>Therapy and Manipulations</b> <ul style="list-style-type: none"> <li>Physical, occupational or speech therapy services, chiropractic or osteopathic physiotherapy (combined limit to 60 sessions per calendar year)</li> <li>Chiropractic or osteopathic manipulative treatments or adjustments (combined limit to 30 sessions per calendar year)</li> </ul>	Deductible and coinsurance Deductible and coinsurance	Deductible and coinsurance Deductible and coinsurance
<b>Vision Exams</b> <ul style="list-style-type: none"> <li>Diagnostic (to diagnose an illness)</li> <li>Preventive (routine exam including refraction)</li> </ul>	See physician office services Not covered	See physician office services Not covered
<b>Wigs</b>	Not covered	Not covered
<b>All Other Covered Services</b>	Deductible and coinsurance	Deductible and coinsurance

Prescription Drugs	In Network	Out of Network
<b>Prescription Drug Deductible</b> (The amount the member pays each calendar year for covered prescription drugs before the prescription drug copayments and/or coinsurance are applicable) <ul style="list-style-type: none"> <li>Individual</li> <li>Family</li> </ul>	Not applicable Not applicable	Not applicable Not applicable
<b>Retail – Per 30-Day Supply</b> <ul style="list-style-type: none"> <li>Generic drugs/Insulin (including non-preferred contraceptives)</li> <li>Preferred brand-name drugs/Insulin</li> <li>Non-Preferred brand-name drugs/Insulin</li> </ul>	Deductible and coinsurance Deductible and coinsurance Deductible and coinsurance	Deductible and coinsurance + 25% penalty Deductible and coinsurance + 25% penalty Deductible and coinsurance + 25% penalty
<b>Mail Order – Per 180-Day Supply</b> <ul style="list-style-type: none"> <li>Generic drugs (including non-preferred contraceptives)</li> <li>Preferred brand-name drugs</li> <li>Non-preferred brand-name drugs</li> </ul>	Deductible and coinsurance Deductible and coinsurance Deductible and coinsurance	Not covered Not covered Not covered
<b>Diabetic Supplies</b>	Deductible and coinsurance	In-network deductible + 25% penalty
<b>Specialty Drugs</b>	Same as retail	Deductible and coinsurance
<b>Contraceptives</b> <ul style="list-style-type: none"> <li>Preferred <ul style="list-style-type: none"> <li>Generic</li> <li>Brand-name</li> </ul> </li> <li>Non-preferred <ul style="list-style-type: none"> <li>Generic</li> <li>Brand-name</li> </ul> </li> </ul>	Plan pays 100% Plan pays 100%	25% penalty 25% penalty
	Same as any other generic drugs Same as any other non-preferred brand-name	
<b>Infertility</b> FDA approved prescription drugs to promote fertility	Not covered	Not covered
<b>Nicotine Addiction</b> FDA approved prescription drugs and over-the-counter nicotine addiction drugs and deterrents	Plan pays 100%	25% penalty
<b>Obesity</b> FDA approved prescription drugs	Not covered	Not covered

# OPTION 4 Qualified High Deductible Health Plan (QHDHP), Non-creditable

## Schedule of Benefits Summary

Covered services are reimbursed based on the allowable charge. BCBSNE 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 member's responsibility. That means in-network providers, under the terms of their contract with BCBSNE, can't bill for amounts over the contracted amount. Out-of-network providers can bill for amounts over the out-of-network allowance.

Payments for Services	In Network	Out of Network
<b>In-network provider:</b> The provider network is shown on your ID card. For help in locating in-network providers, visit <a href="http://NebraskaBlue.com">NebraskaBlue.com</a> .		
<b>Deductible</b> (The amount the member pays each calendar year for covered services before the coinsurance is payable)		
Individual	\$4,000	\$8,000
Family (Embedded*)	\$8,000	\$16,000
<b>Coinsurance</b> (The percentage amount the covered person must pay for most covered services after the deductible has been met)		
Member pays	30%	50%
<b>Out-of-Pocket Limit</b> (Does not include premium, penalty and amounts not covered by the plan)		
Individual	\$6,300	\$12,600
Family (Embedded*)	\$12,600	\$25,200

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.

Credits toward the deductible and out-of-pocket limits will be applied to both in-network and out-of-network benefits. 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) apply to:

- This plan has no medical or prescription drug copays

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

The deductible must be met each calendar year before copays and coinsurance are applicable.

**Please note:** This Schedule of Benefits Summary is intended to provide you with a brief overview of your benefits. It is not a contract and should not be regarded as one. For more complete information about your plan, including benefits, exclusions and contract limitations, please refer to the master group contract. In the event there are discrepancies between this document and the contract, the terms and conditions of the contract will govern.

Covered Services – Illness or Injury	In Network	Out of Network
<b>Physician Office</b> <ul style="list-style-type: none"> <li>Primary care physician office visit</li> <li>Specialist physician office visit</li> <li>Other covered services and supplies provided in the physician's office (with or without an office visit billed)</li> </ul>	Deductible and coinsurance Deductible and coinsurance Deductible and coinsurance	Deductible and coinsurance Deductible and coinsurance Deductible and coinsurance
<ul style="list-style-type: none"> <li>Allergy injections and serum</li> </ul>	Deductible and coinsurance	Deductible and coinsurance
<ul style="list-style-type: none"> <li>Other injections</li> </ul>	Deductible and coinsurance	Deductible and coinsurance
<p><b>Primary care physician</b> 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 <b>physician assistant</b> is covered in the same manner as a primary care physician.</p> <p><b>Specialist physician</b> is a physician who is not a primary care physician.</p> <p><b>Office visit benefits</b> for primary care and specialist physician office visit include office visits (including the initial visit to diagnose pregnancy) and consultations.</p> <p><b>Other covered services not part of the physician office benefit (Refer to the appropriate category for benefit information) include:</b> allergy injections and serum; other injections; advanced diagnostic imaging (CT, MRI, MRA, MRS, PET and SPECT scans and other nuclear medicine); pregnancy services; preventive services; radiation therapy and chemotherapy; surgery and anesthesia; therapy and manipulations; durable medical equipment; sleep studies; biofeedback; psychological evaluations, assessments and testing.</p>		
<b>Convenient Care/Retail Clinics (Quick Care)</b>	Same as a primary care physician	Same as a primary care physician
<b>Telehealth Services</b>	Deductible and coinsurance	Not covered
<b>Urgent Care Facility Services</b>	Deductible and coinsurance	Deductible and coinsurance
<b>Emergency Care Services</b> (services received in a hospital emergency room setting) <ul style="list-style-type: none"> <li>Facility</li> <li>Professional services</li> </ul>	Deductible and coinsurance Deductible and coinsurance	In-network level of benefits In-network level of benefits
<b>Outpatient Hospital or Facility Services</b> 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
<b>Inpatient Hospital or Facility Services</b> Charges for room and board, diagnostic testing, rehabilitation and other ancillary services provided on an inpatient basis	Deductible and coinsurance	Deductible and coinsurance
<b>Preventive Services</b> <ul style="list-style-type: none"> <li>Affordable Care Act (ACA) required preventive services (may be subject to limits that include, but are not limited to, age, gender, and frequency)</li> <li>ACA required covered preventive services (outside of limits)</li> <li>Other covered preventive services not required by ACA</li> </ul>	Plan pays 100% Deductible and coinsurance Plan pays 100%	Deductible and coinsurance Deductible and coinsurance Deductible and coinsurance
<b>Immunizations</b> <ul style="list-style-type: none"> <li>Pediatric (up to age 7)</li> <li>Age 7 and older</li> <li>Related to an illness</li> </ul>	Plan pays 100% Plan pays 100% Same as any other illness	Coinsurance Deductible and coinsurance Same as any other illness

<b>Mental Illness and/or Substance Dependence and Abuse Covered Services</b>	<b>In Network</b>	<b>Out of Network</b>
<b>Inpatient Services</b>	Deductible and coinsurance	Deductible and coinsurance
<b>Outpatient Services</b> <ul style="list-style-type: none"> <li>• Office visit</li> <li>• Telehealth services</li> <li>• All other outpatient items and services</li> </ul>	Deductible and coinsurance Deductible and coinsurance Deductible and coinsurance	Deductible and coinsurance Not covered Deductible and coinsurance
<b>Emergency Care Services</b> (services received in a hospital emergency room setting) <ul style="list-style-type: none"> <li>• Facility</li> <li>• Professional services</li> </ul>	Deductible and coinsurance Deductible and coinsurance	In-network level of benefits In-network level of benefits
<b>Other Covered Services – Illness or Injury</b>	<b>In Network</b>	<b>Out of Network</b>
<b>Acupuncture</b>	Not covered	Not covered
<b>Advanced Diagnostic Imaging</b> (CT, MRI, MRA, MRS, PET and SPECT scans and other nuclear medicine)	Deductible and coinsurance	Deductible and coinsurance
<b>Ambulance</b> (to the nearest facility for appropriate care) <ul style="list-style-type: none"> <li>• Ground ambulance</li> <li>• Air ambulance</li> </ul>	Deductible and coinsurance Deductible and coinsurance	In-network level of benefits Deductible and coinsurance (In-network level of benefits if due to an emergency)
<b>Biofeedback</b>	Deductible and coinsurance	Deductible and coinsurance
<b>Bone Anchored Hearing Aids (BAHA) and Cochlear Implants</b>	Deductible and coinsurance	Deductible and coinsurance
<b>Dermatological Services</b>	Same as any other illness	Same as any other illness
<b>Diabetic Services</b> Services include education, self-management training, podiatric appliances and equipment	Deductible and coinsurance	Deductible and coinsurance
<b>Durable Medical Equipment and Supplies (including prosthetics)</b> (Rental or purchase, whichever is least costly; rental shall not exceed the cost of purchasing)	Deductible and coinsurance	Deductible and coinsurance
<b>Eye Glasses or Contact Lenses</b> 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
<b>Hearing Aids</b> (up to age 19 limited to \$3,000 every 48 months)	Same as any other illness	Same as any other illness
<b>Home Health Aide and Skilled Nursing</b> 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
<b>Home Infusion Therapy</b>	Deductible and coinsurance	Deductible and coinsurance
<b>Hospice Services</b>	Deductible and coinsurance	Deductible and coinsurance
<b>Independent Laboratory</b> <ul style="list-style-type: none"> <li>• Diagnostic</li> <li>• Preventive</li> </ul>	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
<b>Infertility</b> <ul style="list-style-type: none"> <li>• Services to diagnose</li> <li>• Treatment to promote fertility</li> </ul>	Same as any other illness Not covered	Same as any other illness Not covered

Other Covered Services – Illness or Injury	In Network	Out of Network
<b>Nicotine Addiction</b> <ul style="list-style-type: none"> <li>Medical services and therapy</li> <li>Nicotine addiction classes and alternative therapy, such as acupuncture</li> </ul>	Same as substance dependence and abuse Not covered	Same as substance dependence and abuse Not covered
<b>Obesity</b> <ul style="list-style-type: none"> <li>Non-surgical treatment</li> <li>Surgical treatment</li> </ul>	Not covered Not covered	Not covered Not covered
<b>Oral Surgery and Dentistry</b> 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
<b>Organ and Tissue Transplantation</b>	Deductible and coinsurance	Deductible and coinsurance
<b>Ostomy Supplies</b>	Deductible and coinsurance	Deductible and coinsurance
<b>Physician Professional Services</b> Inpatient and outpatient services, such as, surgery, surgical assistant, anesthesia, inpatient hospital visits and other non-surgical services	Deductible and coinsurance	Deductible and coinsurance
<b>Pregnancy, Maternity and Newborn Care</b> <ul style="list-style-type: none"> <li>Pregnancy and maternity (Payment for prenatal and postnatal care is included in the payment for the delivery)</li> <li>Newborn care</li> </ul> NOTE: Newborns are covered at birth, subject to the plan's enrollment provisions.	Deductible and coinsurance  Deductible and coinsurance	Deductible and coinsurance  Deductible and coinsurance
<b>Radiation Therapy and Chemotherapy</b>	Deductible and coinsurance	Deductible and coinsurance
<b>Radiology (X-ray) Services and Other Diagnostic Test</b>	Deductible and coinsurance	Deductible and coinsurance
<b>Rehabilitation Services – Inpatient Facility</b>	Deductible and coinsurance	Deductible and coinsurance
<b>Rehabilitation Services</b> <ul style="list-style-type: none"> <li>Cardiac rehabilitation (Limited to 18 sessions per diagnosis during the preceding four months of certain cardiac diagnosis)</li> <li>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.)</li> </ul>	Deductible and coinsurance  Deductible and coinsurance	Deductible and coinsurance  Deductible and coinsurance
<b>Renal Dialysis</b>	Deductible and coinsurance	Deductible and coinsurance
<b>Respiratory Care</b> (limited to 60 days per calendar year)	Deductible and coinsurance	Deductible and coinsurance
<b>Sexual Dysfunction</b>	Not covered	Not covered
<b>Skilled Nursing Facility</b> (limited to 60 days per calendar year)	Deductible and coinsurance	Deductible and coinsurance
<b>Sleep Studies</b>	Deductible and coinsurance	Deductible and coinsurance
<b>Temporomandibular and Craniomandibular Joint Disorder</b>	Deductible and coinsurance	Deductible and coinsurance

Other Covered Services – Illness or Injury	In Network	Out of Network
<b>Therapy and Manipulations</b> <ul style="list-style-type: none"> <li>Physical, occupational or speech therapy services, chiropractic or osteopathic physiotherapy (combined limit to 60 sessions per calendar year)</li> <li>Chiropractic or osteopathic manipulative treatments or adjustments (combined limit to 30 sessions per calendar year)</li> </ul>	Deductible and coinsurance	Deductible and coinsurance
<b>Vision Exams</b> <ul style="list-style-type: none"> <li>Diagnostic (to diagnose an illness)</li> <li>Preventive (routine exam including refraction)</li> </ul>	See physician office services Not covered	See physician office services Not covered
<b>Wigs</b>	Not covered	Not covered
<b>All Other Covered Services</b>	Deductible and coinsurance	Deductible and coinsurance

Prescription Drugs	In Network	Out of Network
<b>Prescription Drug Deductible</b> (The amount the member pays each calendar year for covered prescription drugs before the prescription drug copayments and/or coinsurance are applicable) <ul style="list-style-type: none"> <li>Individual</li> <li>Family</li> </ul>	Not applicable Not applicable	Not applicable Not applicable
<b>Retail – Per 30-Day Supply</b> <ul style="list-style-type: none"> <li>Generic drugs/Insulin (including non-preferred contraceptives)</li> <li>Preferred brand-name drugs/Insulin</li> <li>Non-Preferred brand-name drugs/Insulin</li> </ul>	Deductible and coinsurance Deductible and coinsurance Deductible and coinsurance	Deductible and coinsurance + 25% penalty Deductible and coinsurance + 25% penalty Deductible and coinsurance + 25% penalty
<b>Mail order – Per 180-Day Supply</b> <ul style="list-style-type: none"> <li>Generic drugs (including non-preferred contraceptives)</li> <li>Preferred brand-name drugs</li> <li>Non-preferred brand-name drugs</li> </ul>	Deductible and coinsurance Deductible and coinsurance Deductible and coinsurance	Not covered Not covered Not covered
<b>Diabetic Supplies</b>	Deductible and coinsurance	In-network deductible + 25% penalty
<b>Specialty Drugs</b>	Same as retail	Deductible and coinsurance
<b>Contraceptives</b> <ul style="list-style-type: none"> <li>Preferred <ul style="list-style-type: none"> <li>Generic</li> <li>Brand-name</li> </ul> </li> <li>Non-preferred <ul style="list-style-type: none"> <li>Generic</li> <li>Brand-name</li> </ul> </li> </ul>	Plan pays 100% Plan pays 100%	25% penalty 25% penalty
<b>Infertility</b> FDA approved prescription drugs to promote fertility	Not covered	Not covered
<b>Nicotine Addiction</b> FDA approved prescription drugs and over-the-counter nicotine addiction drugs and deterrents	Plan pays 100%	25% penalty
<b>Obesity</b> FDA approved prescription drugs	Not covered	Not covered



# EHA PLAN INFORMATION

A health care plan exclusively for Educators Health Alliance members

## What is a PPO?

A PPO, or preferred provider organization, is a special arrangement between an insurer and a network of hospitals, doctors and other types of providers to pay for health care services. As a result of these special arrangements, you save money, because in most cases, you pay less in deductible and coinsurance when you use PPO network providers. If you go outside the network for medical care, you'll pay more money out of pocket.

## Your PPO Network in Nebraska

In Nebraska, your BCBSNE PPO network is called NEtwork BLUE and it's made up of 95% of Nebraska's doctors and 99% of the state's non-governmental acute care hospitals.\* That makes obtaining in-network care easy and convenient.

NEtwork BLUE providers have agreed to accept our benefit payment for covered services as payment in full, except for any deductible, copays and coinsurance amounts and charges for noncovered services, which are your responsibility. That means NEtwork BLUE providers, under the terms of their contract with us, can't bill you for amounts over our benefit allowance. Out-of-network providers can bill you for amounts exceeding the payable amount under the contract.

NEtwork BLUE providers also file your claims for you, meaning you have less paperwork to worry about. And as an added time-saving convenience for you, we send our benefit payment directly to in-network providers.

\*Source: BCBSNE statistics, March 23, 2020.

## The BlueCard® Program: Your National PPO Network

You have access to a national Blue Cross and Blue Shield PPO network called the BlueCard program.

To access your benefits wherever you are, all you have to do is use hospitals and doctors in the local Blue Cross Blue Shield Plan's BlueCard PPO provider network. When you do, you also enjoy the discount and claim filing agreements Blue Cross and Blue Shield Plans across the country have negotiated with the BlueCard doctors and hospitals in their area.

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📍 **Locate providers nationwide:**

Phone: **877-721-2583**

Website: **NebraskaBlue.com/Find-A-Doctor**  
.....

## Calendar-year Deductible

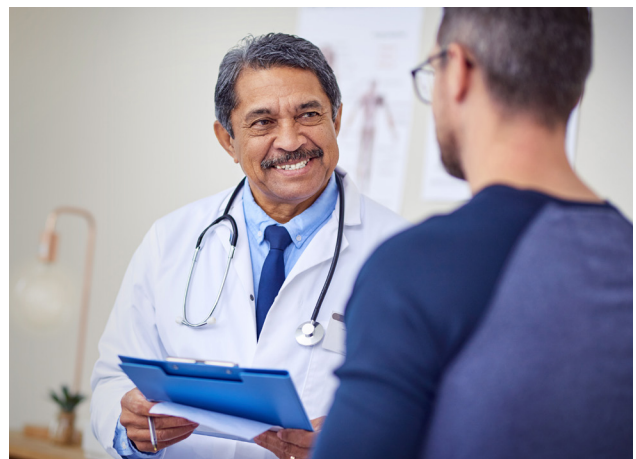
### Options 1 and 2

If you're covered under a single membership, you must satisfy one individual deductible each calendar year. The family deductible is equal to two times the individual deductible. Family members may combine their covered expenses to satisfy the required deductible amount. No one family member pays more than the individual deductible amount.

If you don't meet your deductible in a given year, covered charges incurred during October, November and December of that year may be carried over and applied toward the following year's deductible.

### Option 3 (QHDHP \$3,600 deductible)

If you're covered under a single membership, you must satisfy one individual deductible each calendar year. This plan requires satisfaction of an aggregate family deductible. Aggregate deductible means that if you have family, retiree/spouse or retiree/children coverage, the entire family deductible must be met prior to any benefits becoming available. Family members may combine their covered expenses to satisfy the required family deductible.



### Option 4 (QHDHP \$4,000 deductible)

If you're covered under a single membership, you must satisfy one individual deductible each calendar year. The family deductible is equal to two times the individual deductible. Family members may combine their covered expenses to satisfy the required deductible amount. No one family member pays more than the individual deductible amount.



## Coinsurance and Your Calendar-year Out-of-pocket Limit

### Options 1, 2 and 4

The out-of-pocket limit is the maximum amount of cost-sharing each covered person 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. Once you reach your out-of-pocket limit, you pay nothing for most covered services for the rest of the calendar year.

Under family membership, family members may combine their covered expenses to satisfy the required family out-of-pocket limit. No one family member contributes more than the individual out-of-pocket limit.

### Option 3 (QHDHP \$3,600 deductible)

After you meet your calendar year deductible, you are responsible for paying a certain percentage of covered charges (called "coinsurance") until you reach your out-of-pocket limit. Once you reach your out-of-pocket limit, you pay nothing for most covered services for the rest of the calendar year.

Under this plan's family membership, the entire aggregate family limit must be met before benefits for covered services are paid at 100% of the allowable charge. Family members may combine their covered expenses to satisfy the required out-of-pocket limit.

## Office Visit Exam Copay

### Options 1 and 2 Only

When you go to an in-network doctor, you pay a copay for a diagnostic (non-routine) office visit exam (does not apply to mental illness/substance abuse office visits). X-ray and lab charges and any tests or services the doctor may order will be subject to Deductible and coinsurance. Refer to the charts at the beginning of this booklet for your plan's copay amount.

## Benefits for Preventive Services

Preventive services benefits are available under all EHA health plan options. When a network provider is used, benefits are paid at 100% of the allowable charge (Deductible and coinsurance are waived).\*

Benefits are available for (but not limited to) the following covered services:

- Office visits, well-woman visits, and periodic exams to determine physical development
- Radiology/X-ray/pathology/lab
- Mammograms and Pap smears
- Immunizations (including pediatric\*\*)
- Colorectal cancer screenings and related services
- Cardiac stress tests
- Hearing exams
- Contraceptive methods, as well as contraceptive prescriptions for women (most paid at 100%)
- Breast pumps and supplies, as well as counseling for breastfeeding
- Developmental/autism screening for infants, children, and adolescents

\*Preventive benefits may be subject to age, gender and frequency limits. Preventive services benefits outside these limits, as well as services received out-of-network, are subject to the plan's applicable Deductible and coinsurance, unless otherwise stated. For a list of the preventive services mandated under the Patient Protection and Affordable Care Act (PPACA), along with their corresponding age, gender and frequency limits, please visit [NebraskaBlue.com/PreventiveCare](http://NebraskaBlue.com/PreventiveCare).

\*\*Deductible (if applicable) is waived for out-of-network pediatric immunizations.

## Prescription Drug Coverage

### Options 1 and 2

Your coverage is based on BCBSNE's prescription drug list, which is a list of generic and brand-name prescription medications. Your prescription drug benefits are divided into four tiers: generic drugs, formulary brand drugs that are in the formulary, non-formulary brand-name drugs that are not in the formulary, and specialty drugs. The coinsurance amount you pay for up to a 30-day supply of a covered prescription drug depends on what tier your medication is in.

Refer to pages 7 and 12 for further details.

To review the drug formulary online, go to [NebraskaBlue.com/DrugList](https://www.nebraskablue.com/DrugList) or call our Member Services Department at the number on the back of your BCBSNE member ID card.

### Option 3 and 4 (QHDHPs)

With options 3 and 4, your prescription drug benefits are subject to your plan's in-network deductible and coinsurance.

When you use a participating Rx Nebraska pharmacy, you'll automatically receive a special pre-negotiated discount on most of your prescription drugs. (The actual discount you receive depends on the pharmacy and the type of drug you purchase.)

### Using Your Prescription Drug Benefits

To use your prescription drug benefits, take your BCBSNE member ID card and your prescription to an Rx Nebraska participating pharmacy and pay the applicable coinsurance amount.

**Please note:** To be considered in-network, specialty drugs must be purchased through a designated specialty pharmacy. One of BCBSNE's designated specialty pharmacies is AllianceRx Walgreens Prime. For more information, visit [NebraskaBlue.com/Pharmacy](https://www.NebraskaBlue.com/Pharmacy).

Whenever appropriate, generic drugs will be used to fill your prescriptions. If you prefer a brand-name drug, you will be responsible for the difference in cost plus the applicable coinsurance amount.

If you have to file a claim (for example, if you have the prescription filled at a non-participating pharmacy, or if you don't present your card at a participating pharmacy), you will be reimbursed for the cost of the drug less the applicable coinsurance amount and a 25% penalty. Prescription drug coinsurance amounts do not apply toward the health plan's deductible, but do apply toward the calendar year out-of-pocket maximum.

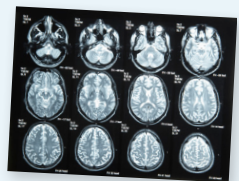
### Using Your Home Delivery Pharmacy Benefit

If you use the AllianceRx Walgreens Prime home delivery program, you may order up to a 180-day supply of a covered medication at one time (if allowed by your prescription). The minimum and maximum coinsurance amounts apply per 30-day supply, with a maximum of five times the amount per 180-day supply.

**Please note:** If you are ordering a 180-day supply, make sure the prescription is written for a 180-day supply, not including refills. For questions regarding available medications, please call AllianceRx Walgreens Prime at 877-357-7463.



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



## Certification

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.

To initiate the certification process, BCBSNE must be contacted by you, your family member, the physician, the hospital or someone acting on behalf of you or your family member.

The following must be certified:

- Organ and tissue transplants
- Subsequent purchases of home medical equipment
- Specified medications and/or quantities of medications
- Skilled nursing care in the home
- Skilled nursing facility care
- Hospice care
- All inpatient hospital admissions
- Inpatient mental illness and/or substance abuse
- Inpatient physical rehabilitation
- Long term acute care
- Services subject to surgical preauthorization programs

If certification requirements are not met, the following penalties may apply:

- Payable benefits may be reduced, and/or
- Benefits for all services may be denied.

**Please note:** Certification does not guarantee payment. All other group plan provisions apply, including copayments, deductibles, coinsurance, eligibility and exclusions.

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**For certification of benefits, call 402-390-1870  
 or 800-247-1103.**  
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## Inpatient Hospital and Long Term Acute Care Benefits

Benefits are available for (but not limited to) the following covered services:

- Semiprivate room; cardiac and intensive care units; treatment rooms and equipment
- Anesthesia
- Respiratory care
- FDA-approved drugs, intravenous solutions and vaccines administered in the hospital
- Chemotherapy
- Radiology, pathology and radiation therapy
- Physical, occupational and speech therapy
- Inpatient physical rehabilitation, subject to benefit precertification and certain requirements
- Physician-ordered skilled nursing facility services, up to 60 days per calendar year; subject to medical necessity criteria

## Outpatient Hospital Benefits

Benefits for the services listed under “Inpatient Hospital and Long-term Acute Care Benefits” are also available (subject to certain limitations) when they are received in a hospital outpatient department, emergency room or freestanding ambulatory surgical facility. In addition, benefits for outpatient cardiac and pulmonary rehabilitation are available, subject to preauthorization requirements and medical criteria.



## Physician Benefits

Benefits are available for (but not limited to) the following covered services:

- Surgery and surgical assistance (for specified procedures).
- Anesthesia.
- Radiation therapy and chemotherapy.
- Radiology and pathology, including tissue exams and interpretation of Pap smears.
- Routine screening mammograms.
- Allergy tests and extracts.
- Physician home, office, inpatient and outpatient visits for diagnosis/treatment of an illness or injury.

**Please note:** Some physician services such as total knee replacement, total hip replacement, and back surgery require pre-authorization. For questions regarding specific procedures, please contact BCBSNE's Member Services department at the number shown on the back of your BCBSNE member ID card.

## Maternity and Newborn Coverage

Maternity coverage is available to subscribers, covered spouses and dependent daughters. All newborns are covered for 31 days from the date of birth, including those born to dependent daughters or sons. In order for newborns to be added to the policy, application must be made within 31 days of the birth of the child, regardless of the employee's current coverage tier.

If the newborn is born to a dependent daughter or son, the employee must provide proof of legal guardianship for the newborn in order for the newborn's coverage to be continued under the employee's plan. For more information, please contact your employer or BCBSNE's Member Services department.

Benefits for covered newborn care include hospital room and board, screening tests (including newborn hearing), physician services and other medically necessary treatment. Obstetrical benefits include prenatal and postnatal care.

## Oral Surgery Benefits

Benefits are available for (but not limited to) the following covered services:

- Removal of tumors and cysts.
- Bone grafts to the jaw.
- Osteotomies.
- Treatment of natural teeth due to an accident which occurs within 12 months of an injury not related to eating, biting or chewing.
- Medically necessary services for the treatment of temporomandibular joint (TMJ) and craniomandibular disorder.

## Home Health Aide, Skilled Nursing Care and Hospice Benefits

The following covered services require benefit pre-authorization. Limitations and exclusions apply.

**Home health aide:** When related to active medical treatment, benefits include personal services (e.g. bathing, feeding and performing necessary household duties). Benefits are subject to a 60-day per calendar year limit.

**Skilled nursing care:** Benefits are available for medically necessary physician-ordered care by a registered or licensed practical nurse, up to eight hours per day.

**Hospice care:** Benefits include Medicare-certified home health aide services for a terminally ill patient, including nursing services, respite care, medical social worker visits, crisis care and bereavement counseling. Limited benefits for inpatient hospice care are also available.

## Organ and Tissue Transplant Benefits

Benefits are available for covered services associated with medically necessary organ and tissue transplants, including (but not limited to) liver, heart, lung, heart-lung, kidney, pancreas, pancreas-kidney and cornea. Limited benefits are also available for allogeneic/autologous bone marrow transplants for the specific conditions listed in the contract.

## Other Covered Services

- Ambulance services.
- Outpatient occupational therapy, physical therapy, speech therapy, cognitive training and chiropractic/osteopathic physiotherapy, up to a combined maximum of 60 sessions per calendar year.
- Chiropractic and osteopathic manipulative treatments, up to 30 sessions per calendar year.
- Inpatient and outpatient treatment of mental illness and/or substance abuse.\*
- Rental/initial purchase (whichever costs less) of medically necessary home medical equipment ordered by a doctor. Limited benefits are available for the repair, maintenance and adjustment of purchased covered medical equipment.
- Diabetes outpatient self-management training and patient management; podiatric appliances.
- Services in accordance with the Women's Health and Cancer Rights Act, which requires that a group health plan providing medical and surgical benefits for mastectomies also provide benefits for breast reconstruction, prostheses and treatment of physical complications.

\* Inpatient is defined as a patient 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.

Outpatient is defined as 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.

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**A more complete list of limitations and exclusions can be found in the Master Group Contract or by referring to the Certificate of Coverage and Schedule of Benefits Summary.**

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## Noncovered Services

This brochure contains only a partial listing of the limitations and exclusions that apply to your health care coverage. A more complete list may be found in the master group contract or by referring to the certificate of coverage and schedule of benefits.

No benefits are available for the following:

- Audiological exams (except newborn); hearing aids and their fitting.
- Abortions (except to save the life of the mother).
- Blood, plasma, or services by or for blood donors.
- Eye exams, refractions, eyeglasses, contact lenses, eye exercises or visual training.
- Artificial insemination; in vitro fertilization; fertility treatment, and related testing.
- Massage therapy.
- Treatment for weight reduction/obesity, including surgical procedures.
- Nutrition care, supplies, supplements or other nutritional substances, including Neocate, Vivonex and other over-the-counter infant formulas and supplements.
- Radial keratotomy or any other procedures/alterations of the refractive character of the cornea to correct myopia, hyperopia and/or astigmatism.
- Services we consider to be investigative, not medically necessary, experimental, cosmetic or obsolete.
- Services, drugs, medical supplies, devices or equipment that are not cost effective compared to established alternatives or that are provided for the convenience or personal use of the patient.
- Services provided before the coverage effective date or after termination.
- Services for illness or injury sustained while performing military service.
- Services for injury/illness arising out of or in the course of employment.
- Charges for services which are not within the provider's scope of practice.
- Charges in excess of our contracted amount.
- Charges made separately for services, supplies and materials we consider to be included within the total charge payable.

## Types of Enrollment

**Single Membership:** Covers the employee only.

**Employee and Spouse:** Covers the employee and his/her spouse.

**Employee and Child(ren):** Covers the employee and eligible dependent children, but does not provide coverage for a spouse.

**Family Membership:** Covers the employee, spouse, and eligible dependent children.

The employee's dependent children (excluding foster children) are covered to age 26. Reaching age 26 will not end the covered child's coverage as long as the child is and remains both incapable of self-sustaining employment by reason of mental or physical handicap and dependent upon the subscriber for support and maintenance.

## Allowable Charge

Payment is based on the allowable charge for a covered service. Generally, the allowable charge for services by in-network providers will be the contracted amount. The allowable charge for services by out-of-network providers will be based on the contracted amount for BCBSNE providers or an amount determined by the local Blue plan for out-of-network providers.

## Late and Special Enrollment

A "late enrollee" is defined as an employee or dependent for whom coverage is not requested within 31 days of his or her initial eligibility or during a special enrollment period. No late enrollees are accepted into the Direct Bill Program. Depending on your eligibility, other enrollment restrictions may apply. For further information, please contact our Member Services Department.

Your eligible dependents are not considered late enrollees if they:

- were covered under other qualifying previous coverage at the time of your initial eligibility for this group coverage; and
- lost coverage under the qualifying previous coverage as a result of: termination of employment; termination of eligibility; involuntary termination of the qualifying previous coverage; death of a spouse; divorce of a spouse; and
- requested enrollment within 31 days after termination of qualifying previous coverage; or within 60 days of the loss of Medicaid or SCHIP coverage

## What is a QHDHP?

Direct Bill Options 3 and 4 are QHDHPs that are eligible for a Health Savings Account (HSA). An HSA is a special tax-exempt account established through a qualified financial institution to pay for medical expenses.

In general, any individual who is covered under a qualified high deductible health plan (QHDHP) is eligible to establish an HSA. To qualify as a QHDHP, the plan must satisfy certain requirements with respect to deductibles and out-of-pocket expenses.

Funds in an HSA may be used to pay qualified medical expenses not reimbursed by insurance. Examples include deductibles and coinsurance, eye exams, glasses, contacts, dental services, prescription drugs, and qualified long-term care insurance premiums.

HSA withdrawals for other purposes are taxable and, for individuals who are not disabled or over age 65, subject to a 20% penalty.

Note: QHDHP deductible and out of pockets may be increased annually to conform with cost-of-living adjustments permitted by Section 223 of the Internal Revenue Code and subsequent amendments.







# DENTAL

## Schedule of Benefits Summary

Covered services are reimbursed based on the allowable charge. BCBSNE in-network providers have agreed to accept the benefit payment as payment in full, not including deductible, coinsurance and/or copay amounts and any charges for non-covered services, which are the member’s responsibility. That means that in-network providers, under the terms of their contract with BCBSNE, can’t bill for amounts over the contracted amount. Out-of-network providers can bill for amounts over the out-of-network allowance.

Payments for Services	In Network	Out of Network
<b>Deductible</b> (the amount the member pays each calendar year for combined covered services before the coinsurance is payable)		
Individual	\$25	\$50
Family	\$50	\$100
Calendar year deductible applies to the following coverage benefits	B & C services	B & C services
<b>Coinsurance</b> (The percentage amount the member must pay for most covered services after the deductible has been met)		
Coverage A (preventive and diagnostic)	0%	50%
Coverage B (maintenance, simple restorative, oral surgery, periodontics and endodontics)	25%	50%
Coverage C (complex restorative)	50%	50%
Coverage D (orthodontic dentistry)	Not covered	Not covered

Please note: This Schedule of Benefits Summary is intended to provide you with a brief overview of your benefits. It is not a contract and should not be regarded as one. For more complete information about your plan, including benefits, exclusions and contract limitations, please refer to the master group contract. In the event there are discrepancies between this document and the contract, the terms and conditions of the contract will govern.

<b>Coverage For Dental Services</b>	
<b>Coverage A – Preventive and Diagnostic</b>	
<ul style="list-style-type: none"> <li>• Comprehensive and/or periodic oral exams<sup>1</sup></li> <li>• Prophylaxis (cleaning, scaling and polishing)<sup>1</sup></li> <li>• Sealants (permanent first or second molar teeth) <i>(Covered Persons up to age 16) once every four calendar years</i></li> <li>• Pulp vitality tests</li> <li>• Fluoride varnishes<sup>1</sup></li> <li>• Topical fluoride <i>(Covered Persons up to age 16)<sup>1</sup></i></li> </ul>	<ul style="list-style-type: none"> <li>• Space maintainers, including re-cementation (prematurely lost primary teeth) <i>(Covered Persons up to age 16)</i></li> <li>• X-rays (bitewing, intraoral, occlusal, periapical, extraoral) <ul style="list-style-type: none"> <li>- supplement bitewings, including vertical bitewings <i>one set of four every calendar year</i></li> <li>- intraoral, occlusal, periapical and extraoral</li> <li>- panorex or full mouth series <i>one every three calendar years</i></li> </ul> </li> </ul>
<b>Coverage B – Maintenance, Simple Restorative, Oral Surgery, Periodontic, Endodontics</b>	
<ul style="list-style-type: none"> <li>• Oral surgery consisting of: <ul style="list-style-type: none"> <li>- simple extractions, including root removal 1<sup>st</sup> and 2<sup>nd</sup> bicuspid (orthodontic extractions are Not covered)</li> <li>- impacted extractions</li> <li>- transseptal fiberotomy/supra crestal fiberotomy</li> <li>- bone replacement graft</li> <li>- appliance removal not by dentist who placed device</li> <li>- oroantral fistula closure</li> <li>- primary closure of a sinus perforation</li> <li>- alveoplasty</li> <li>- frenectomy/frenuloplasty</li> <li>- removal of torus</li> <li>- root removal</li> <li>- tooth replantation</li> <li>- excision of hyperplastic tissue</li> </ul> </li> <li>• Periodontic services (Non-surgical) <ul style="list-style-type: none"> <li>- periodontic cleanings <i>four per calendar year</i></li> <li>- scaling and root planing <i>four every two calendar years</i></li> <li>- periodontal evaluations<sup>1</sup></li> <li>- provisional or permanent periodontal splinting</li> <li>- treatment of acute infection and oral lesions</li> <li>- full mouth debridement <i>one every three calendar years</i></li> </ul> </li> <li>• Periodontic Services (Surgical) <ul style="list-style-type: none"> <li>- gingivectomy<sup>3</sup></li> <li>- gingival flap procedures<sup>3</sup></li> <li>- osseous surgery, including flap entry and closure<sup>3</sup></li> <li>- osseous graft<sup>3</sup></li> <li>- guided tissue regeneration including biologic materials</li> <li>- pedicle tissue graft procedures<sup>3</sup></li> <li>- free soft tissue grafts<sup>3</sup></li> <li>- connective tissue graft and double pedicle graft<sup>3</sup></li> <li>- bone graft<sup>3</sup></li> <li>- biologic materials to aid in soft and osseous tissue regeneration<sup>3</sup></li> <li>- distal or proximal wedge procedures<sup>3</sup></li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Periodontic Services (Surgical) <i>continued</i> <ul style="list-style-type: none"> <li>- soft tissue allografts<sup>3</sup></li> <li>- crown exposure</li> <li>- crown lengthening<sup>4</sup></li> </ul> </li> <li>• General anesthesia (medically necessary)</li> <li>• Limited oral evaluation</li> <li>• Restorations <i>one per tooth every two calendar years</i></li> <li>• Pin retention</li> <li>• Palliative treatment</li> <li>• Dry socket treatment</li> <li>• Repair and re-cement of dentures, bridges, crowns, inlays/onlays and cast restorations</li> <li>• Emergency oral examinations</li> <li>• Consultation with dental consultant (medically necessary) Pre-formed crowns<sup>2</sup></li> <li>• Temporary crown (within 72 hours of accident)</li> <li>• Endodontic services (Non-surgical) <ul style="list-style-type: none"> <li>- pulp cap</li> <li>- vital pulpotomy<sup>4</sup></li> <li>- pulpal therapy<sup>4</sup></li> <li>- pulpal debridement<sup>4</sup></li> <li>- root canal therapy (treatment plan, x-rays, clinical procedures and follow up care)</li> <li>- retreatment of previous root canal therapy covered <i>after six months when performed by a different provider</i></li> <li>- apexification</li> </ul> </li> <li>• Endodontic Services (Surgical) <ul style="list-style-type: none"> <li>- apicoectomy<sup>4</sup></li> <li>- retrograde filling<sup>4</sup></li> <li>- bone graft<sup>4</sup></li> <li>- biologic materials to aid in soft/osseous tissue regeneration in connection with periradicular surgery<sup>4</sup></li> <li>- guided tissue regeneration<sup>4</sup></li> <li>- periradicular surgery<sup>4</sup></li> <li>- root amputation<sup>4</sup></li> <li>- hemisection<sup>4</sup></li> </ul> </li> </ul>
<b>Coverage C – Complex Restorative Dentistry</b>	
<ul style="list-style-type: none"> <li>• Pontics<sup>2</sup></li> <li>• Retainer (cast metal for resin bonded fixed prosthesis) <i>one every five calendar years</i></li> <li>• Inlays/onlays (used as abutments for fixed bridgework)<sup>2</sup></li> <li>• Inlays/onlay restorations<sup>2</sup></li> <li>• Sedative filling</li> <li>• Crowns<sup>2</sup></li> </ul>	<ul style="list-style-type: none"> <li>• Permanent bridge installation <i>one every five calendar years</i></li> <li>• Dentures – full and partial <i>one every five calendar years</i></li> <li>• Denture adjustments <i>after six months from the date of installation</i></li> <li>• Denture relining <i>one every three calendar years</i></li> <li>• Post and core</li> <li>• Core buildup</li> </ul>
<b>Coverage D – Orthodontic Dentistry (Not covered)</b>	
<ul style="list-style-type: none"> <li>• Surgical access, exposure or immobilization (unerupted teeth)</li> <li>• Placement of device to facilitate eruption (impacted teeth)</li> <li>• Diagnostic casts <i>one every two calendar years</i></li> <li>• Orthodontic appliances (initial and subsequent installations)</li> </ul>	<ul style="list-style-type: none"> <li>• Cephalometric x-rays</li> <li>• Extractions</li> <li>• Casts and models</li> </ul>

1 two every calendar year 2 one per tooth every five calendar years 3 four every five calendar years 4 once per tooth while covered under the Plan

## Noncovered Dental Services

The following is a partial listing of the exclusions and limitations that apply to EHA Direct Bill dental coverage; a complete list is in the master contract:

- Services not identified as covered under Coverages A, B and C in the contract.
- Dental services related to congenital malformations or primarily for cosmetic purposes.
- Services for orthodontic dentistry and treatment of the temporomandibular jaw joint.
- Supplies, education or training for dietary or nutrition counseling, personal oral hygiene or dental plaque control.
- Services received before the effective date of coverage or after termination of coverage.
- Services determined to be not medically necessary, investigative, or obsolete.
- Charges in excess of our contracted amount.
- Services covered under Workers' Compensation or Employers' Liability Law.
- Services provided by a person who is not a dentist, or by a dental hygienist not under the dentist's direct supervision.
- Charges made separately for services, supplies and materials considered to be included within the total charge payable.

## How Using In-network Dentists Benefits You

Our dental network in Nebraska is part of a larger provider network of multiple Blue Cross and Blue Shield Plans that, when combined, offers one of the largest national PPO dental networks. It provides you and your covered family members with lower out-of-pocket costs and broad access to participating dentists.

If you or your covered family members live or travel outside of Nebraska, you will be able to obtain covered services at the in-network level of benefits through the combined PPO dental network.

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### How to Locate Dentists

Phone: **877-721-2583**

Website: **NebraskaBlue.com/Find-A-Doctor**

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## Online Member Account

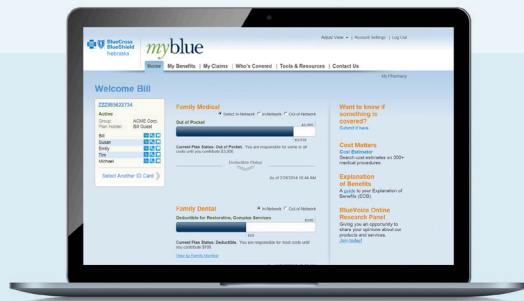
### myNebraskaBlue.com

BCBSNE members can locate helpful information at a time that's always convenient via **myNebraskaBlue.com**.

#### With myNebraskaBlue, members can:

- View current claims and claims history
- See deductible and out-of-pocket costs
- Find in-network doctors and hospitals
- Estimate costs before a visit or procedure
- Access pharmacy and prescription benefits information
- Select how they'd like to receive Explanation of Benefits documents – paper or electronic

Members may log in to **myNebraskaBlue.com** and find tools to help answer important health care questions. All of these tools are under the Tools & Resources tab:



### SIGN UP FOR FREE

Go to **myNebraskaBlue.com**. Then, select "Sign Up" and complete the easy steps.

Members will need their member ID number found on the front of their BCBSNE ID card.

To learn more, visit **myNebraskaBlue.com**. You may visit the site as a guest by selecting "Guest" on the myNebraskaBlue home page.

### Find an In-network Doctor

Members can search for providers by name, specialty or location and find in-network, quality doctors and hospitals to meet their needs.

### Estimate Costs

In the What's it Cost section, members can estimate medical costs before they receive care. Here members can find cost information for many common health care services and compare costs of doctors and hospitals.

### Pharmacy Benefits

BCBSNE contracts with Prime Therapeutics to provide pharmacy benefits and resources, including a MyPrime account with interactive tools to help manage their prescriptions. Members can access MyPrime® through the Pharmacy Benefits section of Tools and Resources.

#### With MyPrime®, members can find:

- Prescription benefits
- Prescription history
- Coverage information for their medicines
- A pharmacy locator
- Prescription cost information
- A comparison of brand-name and generic drug costs
- Information about the AllianceRx Walgreens Prime Home Delivery and Specialty pharmacies



# Save Time and Money with Telehealth

BCBSNE believes in the importance of providing options to help you access affordable and immediate health care. That is why we offer telehealth services to our members through Amwell. Telehealth can be used any time, day or night. It's perfect when your doctor's office is closed, you're too sick to see someone in person or when traveling.

And, the cost per visit is less than the cost of your in-person doctor office visit. (For high-deductible health plans, the cost per visit is subject to your plan's deductible/coinsurance amount.)

### How does telehealth work?

Telehealth is an innovative patient consultation service that lets you connect with a U.S. board certified, licensed and credentialed doctor quickly and easily using your computer, tablet or phone.

Telehealth lets you interact with a doctor at your convenience for common conditions, such as:

- Sinus infection
- Cold
- Flu
- Fever
- Rash
- Abdominal pain
- Pink eye
- Ear infection
- Migraine
- Sore throat

### Behavioral health services also available

With telehealth behavioral health services, Amwell's licensed therapists can provide treatment for the following conditions:

- Anxiety
- Depression
- Attention deficit hyper-activity disorder (ADHD)
- Bereavement
- Panic attacks
- Obsessive-compulsive disorder (OCD)
- Trauma/post-traumatic stress disorder (PTSD)
- Stress
- And more

Therapists are available by appointment from 7 a.m. to 11 p.m. local time, seven days per week.



## Emphasis on Wellness

The lifestyle decisions employees make regarding nutrition, weight, exercise, smoking, seatbelt use and more can directly impact health care costs. BCBSNE offers resources to help your employees make positive lifestyle changes.



Our wellness and lifestyle program offers:

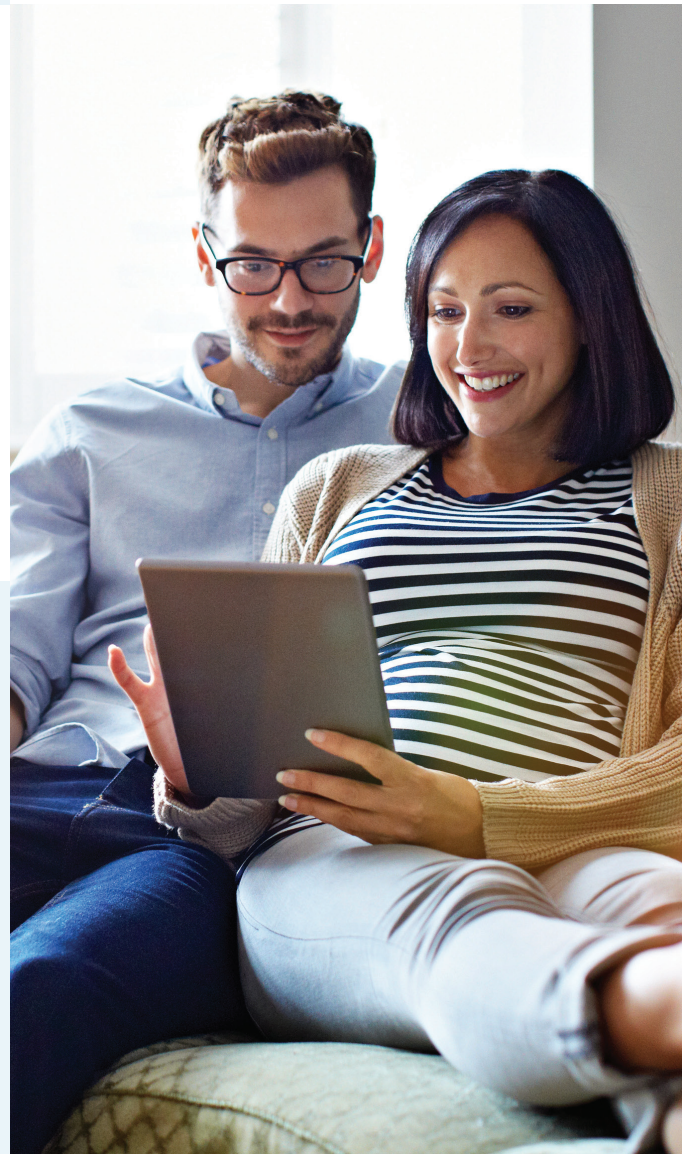
- Educational information
- Personal health assessment tools
- Monthly health challenges

To check out all the valuable health and wellness resources, visit [NebraskaBlue.com/Wellness](https://www.nebraskablue.com/Wellness).

## Pregnancy Care Program

The Pregnancy Care program provides members with education, encouragement and support throughout their pregnancy. With this program, members have access to a pregnancy tracking app, developed by Wellframe, that guides them through this exciting time and offers assistance in maintaining a healthy pregnancy. With the app, members may chat with a nurse, receive appointment reminders and track medications.

To learn more, visit [NebraskaBlue.com/PregnancyCare](https://www.nebraskablue.com/PregnancyCare).



Blue365 is a national program that offers members health and wellness discounts and savings. Members can explore special offerings from leading national companies in these categories:

- Apparel and footwear
- Fitness
- Hearing and vision
- Home and family
- Nutrition
- Personal care
- Travel

Visit [NebraskaBlue.com/Blue365](https://www.nebraskablue.com/Blue365) to learn more.





## RESOURCES

BCBSNE Member Services department

Phone: **877-721-2583**

Website: **[NebraskaBlue.com/Contact](https://www.NebraskaBlue.com/Contact)**

Locate pharmacies nationwide

Phone: **877-800-0746**

Website: **[NebraskaBlue.com/MyPrime](https://www.NebraskaBlue.com/MyPrime)**

Locate providers nationwide:

Phone: **877-721-2583**

Website: **[NebraskaBlue.com/Find-A-Doctor](https://www.NebraskaBlue.com/Find-A-Doctor)**

Access additional plan information

Website: **[EHAPlan.org](https://www.EHAPlan.org)**

This brochure provides you with an overview of the Blue Cross and Blue Shield of Nebraska health and dental coverage offered to Direct Bill members of Educators Health Alliance (EHA). This is not a contract. It is intended as a general overview only. It does not contain all the details of this coverage. For more complete information about your plan, including benefits, exclusions and contract limitations, please refer to the certificate of coverage or the master group contract. In the event there are discrepancies between this document and the contract, the terms and conditions of the contract will govern.