Schedule of Benefits Summary

Group Name: Educators Health Alliance | Effective Date: September 01, 2021

Payment for Services	In-network Provider	Out-of-network Provider
Covered Services are reimbursed based on the Allowable Charge. Blue Cross and Blue Shield of Nebraska In-network Providers have agreed to accept the benefit payment as payment in full, not including Deductible, Coinsurance and/or Copayment amounts and any charges for non-covered services, which are the Covered Person's responsibility. That means In-network providers, under the terms of their contract with Blue Cross and Blue Shield, can't bill for amounts over the Contracted Amount. Out-of-network Providers can bill for amounts over the Out-of-network Allowance.		
In-network Provider: The provider network is shown on your I.D. card. For help in locating In-network Providers, visit www.nebraskablue.com.		
Deductible (the amount the Covered Person pays each Calendar Year for Covered Services before the Coinsurance is payable) • Individual • Family (Embedded*)	 $1,900 $3,800	 $3,800 $7,600
Coinsurance (the percentage amount the Covered Person must pay for most Covered Services after the Deductible has been met) • Covered Person Pays	 20%	 40%
Out-of-pocket Limit (does not include premium, penalty and amounts not covered by the plan) • Individual • Family (Embedded*)	 $5,500 $11,000	 $11,000 $22,000
Once the annual Out-of-pocket Limit is reached, most Covered Services are payable by the plan at 100% for the rest of the Calendar Year.		
In-network and Out-of-network Deductible and Out-of-pocket Limits cross accumulate. All other limits (days, visits, sessions, dollar amounts, etc.) do cross accumulate between In-network and Out-of-network, unless noted differently.		
Day, session or visit limits for certain services shown on this summary are not applicable to Mental Illness and/or Substance Dependence and Abuse.		
*Embedded – If you have single coverage, you only need to satisfy the individual Deductible and Out-of-pocket Limit amounts. If you have family coverage, no one family member contributes more than the individual amount. Family members may combine their covered expenses to satisfy the required family Deductible and Out-of-pocket amounts.		

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

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

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

Out-of-pocket Limit includes:

- Deductible
- Coinsurance
- Medical Copays
- Prescription Drug Copays

Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Physician Office • Primary Care Physician Office Visit • Specialist Physician Office Visit • Other Covered Services and supplies provided in the Physician's Office (with or without an office visit billed)	 $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
Primary Care Physician is a physician who has a majority of his or her practice in internal or general medicine, obstetrics/gynecology, general pediatrics or family practice. A **physician assistant** is covered in the same manner as a Primary Care Physician. ***Specialist Physician*** is a physician who is not a Primary Care Physician. ***Office Visit Benefits*** for Primary Care and Specialist Physician Office Visit include office visits (including the initial visit to diagnose pregnancy) and consultations. ***Other Covered Services not part of the Physician Office Benefit (Refer to the appropriate category for benefit information) include:*** Allergy Injections & Serum; Other Injections; Advanced Diagnostic Imaging (CT, MRI, MRA, MRS, PET & SPECT scans and other Nuclear Medicine); Pregnancy Services; Preventive Services; Radiation Therapy & Chemotherapy; Surgery & Anesthesia; Therapy & Manipulations; Durable Medical Equipment; Sleep Studies; Biofeedback; Psychological Evaluations, Assessments, and Testing.		
Telehealth Services	$10 Copay	Not Covered
Convenient Care/Retail Clinics (Quick Care)	Same as a Primary Care Physician	Deductible and Coinsurance
Urgent Care Facility Services (a single copay applies to each urgent care visit)	$55 Copay then Deductible and Coinsurance	Deductible and Coinsurance
Emergency Care Services (services received in a Hospital emergency room setting) • Facility • Professional Services (Copayment is waived if admitted to the hospital within 24 hours for the same diagnosis)	 $85 Copay then Deductible and Coinsurance Deductible and Coinsurance	 In-network level of benefits In-network level of benefits
Outpatient Hospital or Facility Services Services such as surgery, laboratory and radiology, cardiac and pulmonary rehabilitation, observation stays, and other services provided on an outpatient basis	Deductible and Coinsurance	Deductible and Coinsurance
Inpatient Hospital or Facility Services Charges for room and board, diagnostic testing, rehabilitation and other ancillary services provided on an inpatient basis	Deductible and Coinsurance	Deductible and Coinsurance
Orthopedic Specialty Inpatient Hospital or Facility Services	Deductible and Coinsurance	Deductible and Coinsurance
NOTE: Deductibles and Coinsurance may be waived if Covered Services are provided at a designated Preferred Center. See www.nebraskablue.com for a list of Covered Services and designated hospitals.		

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

Mental Illness and/or Substance Dependence and Abuse Covered Services	In-network Provider	Out-of-network Provider
Inpatient Services	Deductible and Coinsurance	Deductible and Coinsurance
Outpatient Services • Office Visit • Telehealth Services • All Other Outpatient Items & Services	Plan Pays 100% Plan Pays 100% Deductible and Coinsurance	Deductible and Coinsurance Not Covered Deductible and Coinsurance
Emergency Care Services (services received in a Hospital emergency room setting) • Facility • Professional Services	Deductible and Coinsurance Deductible and Coinsurance	In-network level of benefits In-network level of benefits

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

Other Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Hearing Aids (up to age 19 limited to $3,000 every 48 months)	Same as any other illness	Same as any other illness
Home Health Aide, Skilled Nursing and Respiratory Care • Home Health Aide (limited to 60 days per Calendar Year) • Skilled Nursing Care (limited to 8 hours per day) • Respiratory Care (limited to 60 days per Calendar Year)	 Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance	 Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance
Home Infusion Therapy	Deductible and Coinsurance	Deductible and Coinsurance
Hospice Services	Deductible and Coinsurance	Deductible and Coinsurance
Independent Laboratory • Diagnostic • Preventive	 Deductible and Coinsurance Same as Preventive Services In-network level of benefits	 In-network level of benefits Same as Preventive Services In-network level of benefits
Infertility • Services to diagnose • Treatment to promote fertility	 Same as any other illness Not Covered	 Same as any other illness Not Covered
Nicotine Addiction • Medical services and therapy • Nicotine addiction classes & alternative therapy, such as acupuncture	 Same as Substance Dependence and Abuse Not Covered	 Same as Substance Dependence and Abuse Not Covered
Obesity • Non-surgical treatment • Surgical Treatment	 Not Covered Not Covered	 Not Covered Not Covered
Oral Surgery and Dentistry Services such as impacted wisdom teeth, incision and drainage abscesses, excision of tumors and cysts and bone grafts to the jaw. Dental treatment when due to an accidental injury to naturally healthy teeth (treatment related to accidents must be provided within 12 months of the date of injury).	Deductible and Coinsurance	Deductible and Coinsurance
Organ and Tissue Transplantation	Deductible and Coinsurance	Deductible and Coinsurance
Ostomy Supplies	Deductible and Coinsurance	Deductible and Coinsurance

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

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

Prescription Drugs	In-network Provider	Out-of-network Provider
Retail – per 30-day supply		
• Generic drugs (including non-preferred contraceptives)	25% Coinsurance, $10 minimum Copay, $40 maximum Copay	25% Coinsurance, $10 minimum Copay, $40 maximum Copay + 25% Penalty
• Preferred Brand Name Drugs	25% Coinsurance, $50 minimum Copay, $100 maximum Copay	25% Coinsurance, $50 minimum Copay, $100 maximum Copay + 25% Penalty
• Non-preferred Brand Name Drugs	50% Coinsurance, $75 minimum Copay, $150 maximum Copay	50% Coinsurance, $75 minimum Copay, $150 maximum Copay + 25% Penalty
Mail order – per 180-day supply		
• Generic drugs (including non-preferred contraceptives)	25% Coinsurance, $50 minimum Copay, $200 maximum Copay	Not Covered
• Preferred Brand Name Drugs	25% Coinsurance, $250 minimum Copay, $500 maximum Copay	Not Covered
• Non-preferred Brand Name Drugs	50% Coinsurance, $375 minimum Copay, $750 maximum Copay	Not Covered
Diabetic Supplies		
• Generic	20% Coinsurance	20% Coinsurance + 25% Penalty
• Formulary Brand Name	20% Coinsurance	20% Coinsurance + 25% Penalty
• Non-formulary Brand Name	30% Coinsurance	30% Coinsurance + 25% Penalty
Specialty drugs	25% Coinsurance, $125 minimum Copay, $250 maximum Copay	50% Coinsurance, $250 minimum Copay, $500 maximum Copay
Contraceptives		
• Preferred		
- Generic	Plan Pays 100%	25% Penalty
- Brand Name	Plan Pays 100%	25% Penalty
• Non-preferred		
- Generic	Same as any other Generic Drugs	
- Brand Name	Same as any other Non-preferred Brand Name	
Diabetic Insulin		
• Preferred		
- Generic	Plan Pays 100%	25% Penalty
- Brand Name	Plan Pays 100%	25% Penalty
• Non-preferred		
- Generic	Same as any other Generic Drugs	
- Brand Name	Same as any other Non-preferred Brand Name	
Infertility FDA approved prescription drugs to promote fertility	Not Covered	Not Covered
Nicotine Addiction FDA approved prescription drugs and over-the-counter nicotine addiction drugs and deterrents	Plan Pays 100%	25% Penalty
Obesity FDA approved prescription drugs	Not Covered	Not Covered
This plan uses a prescription drug list (PDL). The PDL for this plan is 10, and the Pharmacy Network is C. You can find this prescription drug list and network listing on www.nebraskablue.com. Or you may contact Member Services at the phone number on the back of your I.D. card.		

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.