BlueCross BlueShield Nebraska

An Overview of Your

Health Care and Prescription Drug Benefits

Educators Health Alliance

A Health and Prescription Drug Plan Exclusively for

Educators Health Alliance

The EHA makes nine health and prescription drug plan options available to EHA members. See the Schedule of Benefits Summaries (SOBS) on the following pages for a brief overview of the benefits of each option.

OPTION 1

Schedule of Benefits Summary

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.

Payments for Services	In-Network Provider	Out-of-Network Provider
In-network Provider: The provider network is shown on your ID card. For help in locating In-network Providers, visit nebraskablue.com.		
Deductible (the amount the Covered Person pays each Calendar Year for Covered Services before the Coinsurance is payable)		
Individual	$600	$1,200
Family (Embedded*)	$1,200	$2,400
Coinsurance Benefits (% 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	$4,350	$8,700
Family	$8,700	$17,400

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.

In-network and Out-of-network Deductible and Out-of-pocket Limits are separate and do cross accumulate. All other limits (days, visits, sessions, dollar amounts, etc.) do cross accumulate between In-network and Out-of-network, unless noted differently.

*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
- 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 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)	$30 Copay $50 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 (by a designated provider)	$10 Copay	Not Covered
Convenient Care/Retail Clinics (Quick Care)	Same as a Primary Care Physician	Same as a Primary Care Physician
Urgent Care Facility Services	$50 Copay then Deductible and Coinsurance	Deductible and Coinsurance
Emergency Care Services (services received in a Hospital emergency room setting) • Facility • Professional Services (Copayment is waived if admitted to the hospital within 24 hours for the same diagnosis)	$75 Copay then Deductible and Coinsurance Deductible and Coinsurance	In-network level of benefits In-network level of benefits
Outpatient Hospital or Facility Services Services such as surgery, laboratory and radiology, cardiac and pulmonary rehabilitation, observation stays, and other services provided on an outpatient basis	Deductible and Coinsurance	Deductible and Coinsurance
Inpatient Hospital or Facility Services Charges for room and board, diagnostic testing, rehabilitation and other ancillary services provided on an inpatient basis	Deductible and Coinsurance	Deductible and Coinsurance
Preventive Services • Affordable Care Act (ACA) required preventive services (may be subject to limits that include, but are not limited to, age, gender, and frequency) • ACA required covered preventive services (outside of limits) • Other covered preventive services not required by ACA	Plan Pays 100% Deductible and Coinsurance Plan Pays 100%	Deductible and Coinsurance Deductible and Coinsurance 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 (by a designated provider) • All Other Outpatient Items & Services	Deductible and Coinsurance $10 Copay Deductible and Coinsurance	Deductible and Coinsurance Not Covered Deductible and Coinsurance
Emergency Care Services (services received in a Hospital emergency room setting)		
• Facility • Professional Services	Deductible and Coinsurance Deductible and Coinsurance	In-network level of benefits In-network level of benefits

Other Covered Services – Illness or Injury	In-Network Provider	Out-of-Network Provider
Acupuncture	Not Covered	Not Covered
Advanced Diagnostic Imaging (CT, MRI, MRA, MRS, PET & SPECT scans and other Nuclear Medicine)	Deductible and Coinsurance	Deductible and Coinsurance
Ambulance (to the nearest facility for appropriate care) • Ground Ambulance • Air Ambulance	Deductible and Coinsurance Deductible and Coinsurance	In-network level of benefits Deductible and Coinsurance (In-network level of benefits if due to an emergency)
Biofeedback	Deductible and Coinsurance	Deductible and Coinsurance
Bone Anchored Hearing Aids (BAHA) and Cochlear implants	Deductible and Coinsurance	Deductible and Coinsurance
Dermatological Services	Same as any other illness	Same as any other illness
Diabetic Services Services include education, self-management training, podiatric appliances and equipment.	Deductible and Coinsurance	Deductible and Coinsurance
Durable Medical Equipment and Supplies (including Prosthetics) (rental or purchase, whichever is least costly; rental shall not exceed the cost of purchasing)	Deductible and Coinsurance	Deductible and Coinsurance
Eye Glasses or Contact Lenses Only covered if required because of a change in prescription as a result of intraocular surgery or ocular injury (must be within 12 months of surgery or injury)	Deductible and Coinsurance	Deductible and Coinsurance
Hearing Aids	Not Covered	Not Covered
Home Health Aide and Skilled Nursing Home Health Aide (limited to 60 days per Calendar Year) Skilled Nursing Care (limited to 8 hours per day)	Deductible and Coinsurance	Deductible and Coinsurance
Home Infusion Therapy	Deductible and Coinsurance	Deductible and Coinsurance
Hospice Services	Deductible and Coinsurance	Deductible and Coinsurance
Independent Laboratory • Diagnostic • Preventive	Deductible and Coinsurance Same as Preventive Services In-network level of benefits	In-network level of benefits Same as Preventive Services In-network level of benefits
Infertility • Services to diagnose • Treatment to promote fertility	Same as any other illness Not Covered	Same as any other illness Not Covered

Other Covered Services – Illness or Injury	In-Network Provider	Out-of-Network Provider
Nicotine Addiction		
• Medical services and therapy	Same as Substance Dependence and Abuse	Same as Substance Dependence and Abuse
• Nicotine addiction classes & alternative therapy, such as acupuncture	Not Covered	Not Covered
Obesity		
• Non-surgical treatment	Not Covered	Not Covered
• Surgical Treatment	Not Covered	Not Covered
Oral Surgery and Dentistry Services such 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
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 NOTE: Newborns are covered at birth, subject to the plan's enrollment provisions.	Deductible and Coinsurance	Deductible and Coinsurance
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 (must follow within 90 days of discharge from acute hospitalization)	Deductible and Coinsurance	Deductible and Coinsurance
Rehabilitation Services		
• Cardiac rehabilitation(limited to 18 sessions per diagnosis during the preceding four months of certain cardiac diagnosis)	Deductible and Coinsurance	Deductible and Coinsurance
• Pulmonary Rehabilitation (Chronic lung disease is limited to 18 sessions per diagnosis, not to exceed 18 sessions per Calendar Year. Lung, heart-lung transplants and lung volume are limited to 18 sessions following referral and prior to surgery plus 18 sessions within six months of discharge from hospital following surgery.)	Deductible and Coinsurance	Deductible and Coinsurance
Renal Dialysis	Deductible and Coinsurance	Deductible and Coinsurance
Respiratory Care (limited to 60 days per Calendar Year)	Deductible and Coinsurance	Deductible and Coinsurance
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

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

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

OPTION 2

Schedule of Benefits Summary

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.

Payments for Services	In-Network Provider	Out-of-Network Provider
In-network Provider: The provider network is shown on your ID card. For help in locating In-network Providers, visit nebraskablue.com.		
Deductible (the amount the Covered Person pays each Calendar Year for Covered Services before the Coinsurance is payable)		
Individual	$750	$1,500
Family (Embedded*)	$1,500	$3,000
Coinsurance Benefits (% 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	$4,500	$9,000
Family (Embedded*)	$9,000	$18,000

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 are separate and do cross accumulate. All other limits (days, visits, sessions, dollar amounts, etc.) do cross accumulate between In-network and Out-of-network, unless noted differently.

*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
- 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 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)	$30 Copay $50 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 (by a designated provider)	$10 Copay	Not Covered
Convenient Care/Retail Clinics (Quick Care)	Same as a Primary Care Physician	Same as a Primary Care Physician
Urgent Care Facility Services	$50 Copay then Deductible and Coinsurance	Deductible and Coinsurance
Emergency Care Services (services received in a Hospital emergency room setting) • Facility • Professional Services (Copayment is waived if admitted to the hospital within 24 hours for the same diagnosis)	$75 Copay then Deductible and Coinsurance Deductible and Coinsurance	In-network level of benefits In-network level of benefits
Outpatient Hospital or Facility Services Services such as surgery, laboratory and radiology, cardiac and pulmonary rehabilitation, observation stays, and other services provided on an outpatient basis	Deductible and Coinsurance	Deductible and Coinsurance
Inpatient Hospital or Facility Services Charges for room and board, diagnostic testing, rehabilitation and other ancillary services provided on an inpatient basis	Deductible and Coinsurance	Deductible and Coinsurance
Preventive Services • Affordable Care Act (ACA) required preventive services (may be subject to limits that include, but are not limited to, age, gender, and frequency) • ACA required covered preventive services (outside of limits) • Other covered preventive services not required by ACA	Plan Pays 100% Deductible and Coinsurance Plan Pays 100%	Deductible and Coinsurance Deductible and Coinsurance 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 (by a designated provider) • All Other Outpatient Items & Services	Deductible and Coinsurance $10 Copay Deductible and Coinsurance	Deductible and Coinsurance Not Covered Deductible and Coinsurance
Emergency Care Services (services received in a Hospital emergency room setting)		
• Facility • Professional Services	Deductible and Coinsurance Deductible and Coinsurance	In-network level of benefits In-network level of benefits

Other Covered Services – Illness or Injury	In-Network Provider	Out-of-Network Provider
Acupuncture	Not Covered	Not Covered
Advanced Diagnostic Imaging (CT, MRI, MRA, MRS, PET & SPECT scans and other Nuclear Medicine)	Deductible and Coinsurance	Deductible and Coinsurance
Ambulance (to the nearest facility for appropriate care)		
• Ground Ambulance • Air Ambulance	Deductible and Coinsurance Deductible and Coinsurance	In-network level of benefits Deductible and Coinsurance (In-network level of benefits if due to an emergency)
Biofeedback	Deductible and Coinsurance	Deductible and Coinsurance
Bone Anchored Hearing Aids (BAHA) and Cochlear implants	Deductible and Coinsurance	Deductible and Coinsurance
Dermatological Services	Same as any other illness	Same as any other illness
Diabetic Services Services include education, self-management training, podiatric appliances and equipment.	Deductible and Coinsurance	Deductible and Coinsurance
Durable Medical Equipment and Supplies (including Prosthetics) (rental or purchase, whichever is least costly; rental shall not exceed the cost of purchasing)	Deductible and Coinsurance	Deductible and Coinsurance
Eye Glasses or Contact Lenses Only covered if required because of a change in prescription as a result of intraocular surgery or ocular injury (must be within 12 months of surgery or injury)	Deductible and Coinsurance	Deductible and Coinsurance
Hearing Aids	Not Covered	Not Covered
Home Health Aide and Skilled Nursing Home Health Aide (limited to 60 days per Calendar Year) Skilled Nursing Care (limited to 8 hours per day)	Deductible and Coinsurance	Deductible and Coinsurance
Home Infusion Therapy	Deductible and Coinsurance	Deductible and Coinsurance
Hospice Services	Deductible and Coinsurance	Deductible and Coinsurance
Independent Laboratory		
• Diagnostic • Preventive	Deductible and Coinsurance Same as Preventive Services In-network level of benefits	In-network level of benefits Same as Preventive Services In-network level of benefits
Infertility		
• Services to diagnose • Treatment to promote fertility	Same as any other illness Not Covered	Same as any other illness Not Covered

Other Covered Services – Illness or Injury	In-Network Provider	Out-of-Network Provider
Nicotine Addiction		
• Medical services and therapy	Same as Substance Dependence and Abuse	Same as Substance Dependence and Abuse
• Nicotine addiction classes & alternative therapy, such as acupuncture	Not Covered	Not Covered
Obesity		
• Non-surgical treatment	Not Covered	Not Covered
• Surgical Treatment	Not Covered	Not Covered
Oral Surgery and Dentistry Services such 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
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 NOTE: Newborns are covered at birth, subject to the plan's enrollment provisions.	Deductible and Coinsurance	Deductible and Coinsurance
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 (must follow within 90 days of discharge from acute hospitalization)	Deductible and Coinsurance	Deductible and Coinsurance
Rehabilitation Services		
• Cardiac rehabilitation(limited to 18 sessions per diagnosis during the preceding four months of certain cardiac diagnosis)	Deductible and Coinsurance	Deductible and Coinsurance
• Pulmonary Rehabilitation (Chronic lung disease is limited to 18 sessions per diagnosis, not to exceed 18 sessions per Calendar Year. Lung, heart-lung transplants and lung volume are limited to 18 sessions following referral and prior to surgery plus 18 sessions within six months of discharge from hospital following surgery.)	Deductible and Coinsurance	Deductible and Coinsurance
Renal Dialysis	Deductible and Coinsurance	Deductible and Coinsurance
Respiratory Care (limited to 60 days per Calendar Year)	Deductible and Coinsurance	Deductible and Coinsurance
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

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

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

OPTION 3

Schedule of Benefits Summary

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.

Payments for Services	In-Network Provider	Out-of-Network Provider
In-network Provider: The provider network is shown on your ID card. For help in locating In-network Providers, visit nebraskablue.com.		
Deductible (the amount the Covered Person pays each Calendar Year for Covered Services before the Coinsurance is payable)		
Individual	$900	$1,800
Family (Embedded*)	$1,800	$3,600
Coinsurance Benefits (% 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	$4,650	$9,300
Family	$9,300	$18,600

Once the annual Out-of-pocket Limit is reached, most Covered Services are payable by the plan at 100% for the rest of the Calendar Year.

In-network and Out-of-network Deductible and Out-of-pocket Limits are separate and do cross accumulate. All other limits (days, visits, sessions, dollar amounts, etc.) do cross accumulate between In-network and Out-of-network, unless noted differently.

*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
- 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 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)	$30 Copay $50 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 (by a designated provider)	$10 Copay	Not Covered
Convenient Care/Retail Clinics (Quick Care)	Same as a Primary Care Physician	Same as a Primary Care Physician
Urgent Care Facility Services	$50 Copay then Deductible and Coinsurance	Deductible and Coinsurance
Emergency Care Services (services received in a Hospital emergency room setting) • Facility • Professional Services (Copayment is waived if admitted to the hospital within 24 hours for the same diagnosis)	$75 Copay then Deductible and Coinsurance Deductible and Coinsurance	In-network level of benefits In-network level of benefits
Outpatient Hospital or Facility Services Services such as surgery, laboratory and radiology, cardiac and pulmonary rehabilitation, observation stays, and other services provided on an outpatient basis	Deductible and Coinsurance	Deductible and Coinsurance
Inpatient Hospital or Facility Services Charges for room and board, diagnostic testing, rehabilitation and other ancillary services provided on an inpatient basis	Deductible and Coinsurance	Deductible and Coinsurance
Preventive Services • Affordable Care Act (ACA) required preventive services (may be subject to limits that include, but are not limited to, age, gender, and frequency) • ACA required covered preventive services (outside of limits) • Other covered preventive services not required by ACA	Plan Pays 100% Deductible and Coinsurance Plan Pays 100%	Deductible and Coinsurance Deductible and Coinsurance 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	Deductible and Coinsurance	Deductible and Coinsurance
• Telehealth Services (by a designated provider)	$10 Copay	Not Covered
• All Other Outpatient Items & Services	Deductible and Coinsurance	Deductible and Coinsurance
Emergency Care Services (services received in a Hospital emergency room setting)		
• Facility	Deductible and Coinsurance	In-network level of benefits
• Professional Services	Deductible and Coinsurance	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	Deductible and Coinsurance	In-network level of benefits
• Air Ambulance	Deductible and Coinsurance	Deductible and Coinsurance (In-network level of benefits if due to an emergency)
Biofeedback	Deductible and Coinsurance	Deductible and Coinsurance
Bone Anchored Hearing Aids (BAHA) and Cochlear implants	Deductible and Coinsurance	Deductible and Coinsurance
Dermatological Services	Same as any other illness	Same as any other illness
Diabetic Services		
Services include education, self-management training, podiatric appliances and equipment.	Deductible and Coinsurance	Deductible and Coinsurance
Durable Medical Equipment and Supplies (including Prosthetics)		
(rental or purchase, whichever is least costly; rental shall not exceed the cost of purchasing)	Deductible and Coinsurance	Deductible and Coinsurance
Eye Glasses or Contact Lenses		
Only covered if required because of a change in prescription as a result of intraocular surgery or ocular injury (must be within 12 months of surgery or injury)	Deductible and Coinsurance	Deductible and Coinsurance
Hearing Aids	Not Covered	Not Covered
Home Health Aide and Skilled Nursing		
Home Health Aide (limited to 60 days per Calendar Year) Skilled Nursing Care (limited to 8 hours per day)	Deductible and Coinsurance	Deductible and Coinsurance
Home Infusion Therapy	Deductible and Coinsurance	Deductible and Coinsurance
Hospice Services	Deductible and Coinsurance	Deductible and Coinsurance
Independent Laboratory		
• Diagnostic	Deductible and Coinsurance	In-network level of benefits
• Preventive	Same as Preventive Services In-network level of benefits	Same as Preventive Services In-network level of benefits
Infertility		
• Services to diagnose	Same as any other illness	Same as any other illness
• Treatment to promote fertility	Not Covered	Not Covered

Other Covered Services – Illness or Injury	In-Network Provider	Out-of-Network Provider
Nicotine Addiction		
• Medical services and therapy	Same as Substance Dependence and Abuse	Same as Substance Dependence and Abuse
• Nicotine addiction classes & alternative therapy, such as acupuncture	Not Covered	Not Covered
Obesity		
• Non-surgical treatment	Not Covered	Not Covered
• Surgical Treatment	Not Covered	Not Covered
Oral Surgery and Dentistry Services such 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
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 NOTE: Newborns are covered at birth, subject to the plan's enrollment provisions.	Deductible and Coinsurance	Deductible and Coinsurance
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 (must follow within 90 days of discharge from acute hospitalization)	Deductible and Coinsurance	Deductible and Coinsurance
Rehabilitation Services		
• Cardiac rehabilitation(limited to 18 sessions per diagnosis during the preceding four months of certain cardiac diagnosis)	Deductible and Coinsurance	Deductible and Coinsurance
• Pulmonary Rehabilitation (Chronic lung disease is limited to 18 sessions per diagnosis, not to exceed 18 sessions per Calendar Year. Lung, heart-lung transplants and lung volume are limited to 18 sessions following referral and prior to surgery plus 18 sessions within six months of discharge from hospital following surgery.)	Deductible and Coinsurance	Deductible and Coinsurance
Renal Dialysis	Deductible and Coinsurance	Deductible and Coinsurance
Respiratory Care (limited to 60 days per Calendar Year)	Deductible and Coinsurance	Deductible and Coinsurance
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

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

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

OPTION 4

Schedule of Benefits Summary

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.

Payments for Services	In-Network Provider	Out-of-Network Provider
In-network Provider: The provider network is shown on your ID card. For help in locating In-network Providers, visit nebraskablue.com.		
Deductible (the amount the Covered Person pays each Calendar Year for Covered Services before the Coinsurance is payable)		
Individual	$1,000	$2,000
Family (Embedded*)	$2,000	$4,000
Coinsurance Benefits (% 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	$4,750	$9,500
Family (Embedded*)	$9,500	$19,000

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 are separate and do cross accumulate. All other limits (days, visits, sessions, dollar amounts, etc.) do cross accumulate between In-network and Out-of-network, unless noted differently.

*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
- 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 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)	$30 Copay $50 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 (by a designated provider)	$10 Copay	Not Covered
Convenient Care/Retail Clinics (Quick Care)	Same as a Primary Care Physician	Same as a Primary Care Physician
Urgent Care Facility Services	$50 Copay then Deductible and Coinsurance	Deductible and Coinsurance
Emergency Care Services (services received in a Hospital emergency room setting) • Facility • Professional Services (Copayment is waived if admitted to the hospital within 24 hours for the same diagnosis)	$75 Copay then Deductible and Coinsurance Deductible and Coinsurance	In-network level of benefits In-network level of benefits
Outpatient Hospital or Facility Services Services such as surgery, laboratory and radiology, cardiac and pulmonary rehabilitation, observation stays, and other services provided on an outpatient basis	Deductible and Coinsurance	Deductible and Coinsurance
Inpatient Hospital or Facility Services Charges for room and board, diagnostic testing, rehabilitation and other ancillary services provided on an inpatient basis	Deductible and Coinsurance	Deductible and Coinsurance
Preventive Services • Affordable Care Act (ACA) required preventive services (may be subject to limits that include, but are not limited to, age, gender, and frequency) • ACA required covered preventive services (outside of limits) • Other covered preventive services not required by ACA	Plan Pays 100% Deductible and Coinsurance Plan Pays 100%	Deductible and Coinsurance Deductible and Coinsurance 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 (by a designated provider) • All Other Outpatient Items & Services	Deductible and Coinsurance $10 Copay Deductible and Coinsurance	Deductible and Coinsurance Not Covered Deductible and Coinsurance
Emergency Care Services (services received in a Hospital emergency room setting)		
• Facility • Professional Services	Deductible and Coinsurance Deductible and Coinsurance	In-network level of benefits In-network level of benefits

Other Covered Services – Illness or Injury	In-Network Provider	Out-of-Network Provider
Acupuncture	Not Covered	Not Covered
Advanced Diagnostic Imaging (CT, MRI, MRA, MRS, PET & SPECT scans and other Nuclear Medicine)	Deductible and Coinsurance	Deductible and Coinsurance
Ambulance (to the nearest facility for appropriate care)		
• Ground Ambulance • Air Ambulance	Deductible and Coinsurance Deductible and Coinsurance	In-network level of benefits Deductible and Coinsurance (In-network level of benefits if due to an emergency)
Biofeedback	Deductible and Coinsurance	Deductible and Coinsurance
Bone Anchored Hearing Aids (BAHA) and Cochlear implants	Deductible and Coinsurance	Deductible and Coinsurance
Dermatological Services	Same as any other illness	Same as any other illness
Diabetic Services Services include education, self-management training, podiatric appliances and equipment.	Deductible and Coinsurance	Deductible and Coinsurance
Durable Medical Equipment and Supplies (including Prosthetics) (rental or purchase, whichever is least costly; rental shall not exceed the cost of purchasing)	Deductible and Coinsurance	Deductible and Coinsurance
Eye Glasses or Contact Lenses Only covered if required because of a change in prescription as a result of intraocular surgery or ocular injury (must be within 12 months of surgery or injury)	Deductible and Coinsurance	Deductible and Coinsurance
Hearing Aids	Not Covered	Not Covered
Home Health Aide and Skilled Nursing Home Health Aide (limited to 60 days per Calendar Year) Skilled Nursing Care (limited to 8 hours per day)	Deductible and Coinsurance	Deductible and Coinsurance
Home Infusion Therapy	Deductible and Coinsurance	Deductible and Coinsurance
Hospice Services	Deductible and Coinsurance	Deductible and Coinsurance
Independent Laboratory		
• Diagnostic • Preventive	Deductible and Coinsurance Same as Preventive Services In-network level of benefits	In-network level of benefits Same as Preventive Services In-network level of benefits
Infertility		
• Services to diagnose • Treatment to promote fertility	Same as any other illness Not Covered	Same as any other illness Not Covered

Other Covered Services – Illness or Injury	In-Network Provider	Out-of-Network Provider
Nicotine Addiction		
• Medical services and therapy	Same as Substance Dependence and Abuse	Same as Substance Dependence and Abuse
• Nicotine addiction classes & alternative therapy, such as acupuncture	Not Covered	Not Covered
Obesity		
• Non-surgical treatment	Not Covered	Not Covered
• Surgical Treatment	Not Covered	Not Covered
Oral Surgery and Dentistry Services such 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
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 NOTE: Newborns are covered at birth, subject to the plan's enrollment provisions.	Deductible and Coinsurance	Deductible and Coinsurance
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 (must follow within 90 days of discharge from acute hospitalization)	Deductible and Coinsurance	Deductible and Coinsurance
Rehabilitation Services		
• Cardiac rehabilitation(limited to 18 sessions per diagnosis during the preceding four months of certain cardiac diagnosis)	Deductible and Coinsurance	Deductible and Coinsurance
• Pulmonary Rehabilitation (Chronic lung disease is limited to 18 sessions per diagnosis, not to exceed 18 sessions per Calendar Year. Lung, heart-lung transplants and lung volume are limited to 18 sessions following referral and prior to surgery plus 18 sessions within six months of discharge from hospital following surgery.)	Deductible and Coinsurance	Deductible and Coinsurance
Renal Dialysis	Deductible and Coinsurance	Deductible and Coinsurance
Respiratory Care (limited to 60 days per Calendar Year)	Deductible and Coinsurance	Deductible and Coinsurance
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

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

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

OPTION 5

Schedule of Benefits Summary

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.

Payments for Services	In-Network Provider	Out-of-Network Provider
In-network Provider: The provider network is shown on your ID card. For help in locating In-network Providers, visit nebraskablue.com.		
Deductible (the amount the Covered Person pays each Calendar Year for Covered Services before the Coinsurance is payable)		
Individual	$1,1500	$2,300
Family (Embedded*)	$2,300	$4,600
Coinsurance Benefits (% 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	$4,900	$9,800
Family	$9,800	$19,600

Once the annual Out-of-pocket Limit is reached, most Covered Services are payable by the plan at 100% for the rest of the Calendar Year.

In-network and Out-of-network Deductible and Out-of-pocket Limits are separate and do cross accumulate. All other limits (days, visits, sessions, dollar amounts, etc.) do cross accumulate between In-network and Out-of-network, unless noted differently.

*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
- 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 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)	$30 Copay $50 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 (by a designated provider)	$10 Copay	Not Covered
Convenient Care/Retail Clinics (Quick Care)	Same as a Primary Care Physician	Same as a Primary Care Physician
Urgent Care Facility Services	$50 Copay then Deductible and Coinsurance	Deductible and Coinsurance
Emergency Care Services (services received in a Hospital emergency room setting) • Facility • Professional Services (Copayment is waived if admitted to the hospital within 24 hours for the same diagnosis)	$75 Copay then Deductible and Coinsurance Deductible and Coinsurance	In-network level of benefits In-network level of benefits
Outpatient Hospital or Facility Services Services such as surgery, laboratory and radiology, cardiac and pulmonary rehabilitation, observation stays, and other services provided on an outpatient basis	Deductible and Coinsurance	Deductible and Coinsurance
Inpatient Hospital or Facility Services Charges for room and board, diagnostic testing, rehabilitation and other ancillary services provided on an inpatient basis	Deductible and Coinsurance	Deductible and Coinsurance
Preventive Services • Affordable Care Act (ACA) required preventive services (may be subject to limits that include, but are not limited to, age, gender, and frequency) • ACA required covered preventive services (outside of limits) • Other covered preventive services not required by ACA	Plan Pays 100% Deductible and Coinsurance Plan Pays 100%	Deductible and Coinsurance Deductible and Coinsurance 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 (by a designated provider) • All Other Outpatient Items & Services	Deductible and Coinsurance $10 Copay Deductible and Coinsurance	Deductible and Coinsurance Not Covered Deductible and Coinsurance
Emergency Care Services (services received in a Hospital emergency room setting)		
• Facility • Professional Services	Deductible and Coinsurance Deductible and Coinsurance	In-network level of benefits In-network level of benefits

Other Covered Services – Illness or Injury	In-Network Provider	Out-of-Network Provider
Acupuncture	Not Covered	Not Covered
Advanced Diagnostic Imaging (CT, MRI, MRA, MRS, PET & SPECT scans and other Nuclear Medicine)	Deductible and Coinsurance	Deductible and Coinsurance
Ambulance (to the nearest facility for appropriate care) • Ground Ambulance • Air Ambulance	Deductible and Coinsurance Deductible and Coinsurance	In-network level of benefits Deductible and Coinsurance (In-network level of benefits if due to an emergency)
Biofeedback	Deductible and Coinsurance	Deductible and Coinsurance
Bone Anchored Hearing Aids (BAHA) and Cochlear implants	Deductible and Coinsurance	Deductible and Coinsurance
Dermatological Services	Same as any other illness	Same as any other illness
Diabetic Services Services include education, self-management training, podiatric appliances and equipment.	Deductible and Coinsurance	Deductible and Coinsurance
Durable Medical Equipment and Supplies (including Prosthetics) (rental or purchase, whichever is least costly; rental shall not exceed the cost of purchasing)	Deductible and Coinsurance	Deductible and Coinsurance
Eye Glasses or Contact Lenses Only covered if required because of a change in prescription as a result of intraocular surgery or ocular injury (must be within 12 months of surgery or injury)	Deductible and Coinsurance	Deductible and Coinsurance
Hearing Aids	Not Covered	Not Covered
Home Health Aide and Skilled Nursing Home Health Aide (limited to 60 days per Calendar Year) Skilled Nursing Care (limited to 8 hours per day)	Deductible and Coinsurance	Deductible and Coinsurance
Home Infusion Therapy	Deductible and Coinsurance	Deductible and Coinsurance
Hospice Services	Deductible and Coinsurance	Deductible and Coinsurance
Independent Laboratory • Diagnostic • Preventive	Deductible and Coinsurance Same as Preventive Services In-network level of benefits	In-network level of benefits Same as Preventive Services In-network level of benefits
Infertility • Services to diagnose • Treatment to promote fertility	Same as any other illness Not Covered	Same as any other illness Not Covered

Other Covered Services – Illness or Injury	In-Network Provider	Out-of-Network Provider
Nicotine Addiction		
• Medical services and therapy	Same as Substance Dependence and Abuse	Same as Substance Dependence and Abuse
• Nicotine addiction classes & alternative therapy, such as acupuncture	Not Covered	Not Covered
Obesity		
• Non-surgical treatment	Not Covered	Not Covered
• Surgical Treatment	Not Covered	Not Covered
Oral Surgery and Dentistry Services such 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
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 NOTE: Newborns are covered at birth, subject to the plan's enrollment provisions.	Deductible and Coinsurance	Deductible and Coinsurance
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 (must follow within 90 days of discharge from acute hospitalization)	Deductible and Coinsurance	Deductible and Coinsurance
Rehabilitation Services		
• Cardiac rehabilitation(limited to 18 sessions per diagnosis during the preceding four months of certain cardiac diagnosis)	Deductible and Coinsurance	Deductible and Coinsurance
• Pulmonary Rehabilitation (Chronic lung disease is limited to 18 sessions per diagnosis, not to exceed 18 sessions per Calendar Year. Lung, heart-lung transplants and lung volume are limited to 18 sessions following referral and prior to surgery plus 18 sessions within six months of discharge from hospital following surgery.)	Deductible and Coinsurance	Deductible and Coinsurance
Renal Dialysis	Deductible and Coinsurance	Deductible and Coinsurance
Respiratory Care (limited to 60 days per Calendar Year)	Deductible and Coinsurance	Deductible and Coinsurance
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

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

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

OPTION 6

Schedule of Benefits Summary

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.

Payments for Services	In-Network Provider	Out-of-Network Provider
In-network Provider: The provider network is shown on your ID card. For help in locating In-network Providers, visit nebraskablue.com.		
Deductible (the amount the Covered Person pays each Calendar Year for Covered Services before the Coinsurance is payable)		
Individual	$1,500	$3,000
Family (Embedded*)	$3,000	$6,000
Coinsurance Benefits (% 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	$5,250	$10,500
Family	$10,500	$21,000

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 are separate and do cross accumulate. All other limits (days, visits, sessions, dollar amounts, etc.) do cross accumulate between In-network and Out-of-network, unless noted differently.

*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
- 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 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)	$30 Copay $50 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 (by a designated provider)	$10 Copay	Not Covered
Convenient Care/Retail Clinics (Quick Care)	Same as a Primary Care Physician	Same as a Primary Care Physician
Urgent Care Facility Services	$50 Copay then Deductible and Coinsurance	Deductible and Coinsurance
Emergency Care Services (services received in a Hospital emergency room setting) • Facility • Professional Services (Copayment is waived if admitted to the hospital within 24 hours for the same diagnosis)	$75 Copay then Deductible and Coinsurance Deductible and Coinsurance	In-network level of benefits In-network level of benefits
Outpatient Hospital or Facility Services Services such as surgery, laboratory and radiology, cardiac and pulmonary rehabilitation, observation stays, and other services provided on an outpatient basis	Deductible and Coinsurance	Deductible and Coinsurance
Inpatient Hospital or Facility Services Charges for room and board, diagnostic testing, rehabilitation and other ancillary services provided on an inpatient basis	Deductible and Coinsurance	Deductible and Coinsurance
Preventive Services • Affordable Care Act (ACA) required preventive services (may be subject to limits that include, but are not limited to, age, gender, and frequency) • ACA required covered preventive services (outside of limits) • Other covered preventive services not required by ACA	Plan Pays 100% Deductible and Coinsurance Plan Pays 100%	Deductible and Coinsurance Deductible and Coinsurance 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 (by a designated provider) • All Other Outpatient Items & Services	Deductible and Coinsurance $10 Copay Deductible and Coinsurance	Deductible and Coinsurance Not Covered Deductible and Coinsurance
Emergency Care Services (services received in a Hospital emergency room setting)		
• Facility • Professional Services	Deductible and Coinsurance Deductible and Coinsurance	In-network level of benefits In-network level of benefits

Other Covered Services – Illness or Injury	In-Network Provider	Out-of-Network Provider
Acupuncture	Not Covered	Not Covered
Advanced Diagnostic Imaging (CT, MRI, MRA, MRS, PET & SPECT scans and other Nuclear Medicine)	Deductible and Coinsurance	Deductible and Coinsurance
Ambulance (to the nearest facility for appropriate care) • Ground Ambulance • Air Ambulance	Deductible and Coinsurance Deductible and Coinsurance	In-network level of benefits Deductible and Coinsurance (In-network level of benefits if due to an emergency)
Biofeedback	Deductible and Coinsurance	Deductible and Coinsurance
Bone Anchored Hearing Aids (BAHA) and Cochlear implants	Deductible and Coinsurance	Deductible and Coinsurance
Dermatological Services	Same as any other illness	Same as any other illness
Diabetic Services Services include education, self-management training, podiatric appliances and equipment.	Deductible and Coinsurance	Deductible and Coinsurance
Durable Medical Equipment and Supplies (including Prosthetics) (rental or purchase, whichever is least costly; rental shall not exceed the cost of purchasing)	Deductible and Coinsurance	Deductible and Coinsurance
Eye Glasses or Contact Lenses Only covered if required because of a change in prescription as a result of intraocular surgery or ocular injury (must be within 12 months of surgery or injury)	Deductible and Coinsurance	Deductible and Coinsurance
Hearing Aids	Not Covered	Not Covered
Home Health Aide and Skilled Nursing Home Health Aide (limited to 60 days per Calendar Year) Skilled Nursing Care (limited to 8 hours per day)	Deductible and Coinsurance	Deductible and Coinsurance
Home Infusion Therapy	Deductible and Coinsurance	Deductible and Coinsurance
Hospice Services	Deductible and Coinsurance	Deductible and Coinsurance
Independent Laboratory • Diagnostic • Preventive	Deductible and Coinsurance Same as Preventive Services In-network level of benefits	In-network level of benefits Same as Preventive Services In-network level of benefits
Infertility • Services to diagnose • Treatment to promote fertility	Same as any other illness Not Covered	Same as any other illness Not Covered

Other Covered Services – Illness or Injury	In-Network Provider	Out-of-Network Provider
Nicotine Addiction		
• Medical services and therapy	Same as Substance Dependence and Abuse	Same as Substance Dependence and Abuse
• Nicotine addiction classes & alternative therapy, such as acupuncture	Not Covered	Not Covered
Obesity		
• Non-surgical treatment	Not Covered	Not Covered
• Surgical Treatment	Not Covered	Not Covered
Oral Surgery and Dentistry Services such 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
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 NOTE: Newborns are covered at birth, subject to the plan's enrollment provisions.	Deductible and Coinsurance	Deductible and Coinsurance
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 (must follow within 90 days of discharge from acute hospitalization)	Deductible and Coinsurance	Deductible and Coinsurance
Rehabilitation Services		
• Cardiac rehabilitation(limited to 18 sessions per diagnosis during the preceding four months of certain cardiac diagnosis)	Deductible and Coinsurance	Deductible and Coinsurance
• Pulmonary Rehabilitation (Chronic lung disease is limited to 18 sessions per diagnosis, not to exceed 18 sessions per Calendar Year. Lung, heart-lung transplants and lung volume are limited to 18 sessions following referral and prior to surgery plus 18 sessions within six months of discharge from hospital following surgery.)	Deductible and Coinsurance	Deductible and Coinsurance
Renal Dialysis	Deductible and Coinsurance	Deductible and Coinsurance
Respiratory Care (limited to 60 days per Calendar Year)	Deductible and Coinsurance	Deductible and Coinsurance
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

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

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

OPTION 7

Schedule of Benefits Summary

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.

Payments for Services	In-Network Provider	Out-of-Network Provider
In-network Provider: The provider network is shown on your ID card. For help in locating In-network Providers, visit nebraskablue.com.		
Deductible (the amount the Covered Person pays each Calendar Year for Covered Services before the Coinsurance is payable)		
Individual	$2,000	$4,000
Family (Embedded*)	$4,000	$8,000
Coinsurance Benefits (% amount the Covered Person must pay for most Covered Services after the Deductible has been met)		
Covered Person Pays	30%	40%
Out-of-pocket Limit (does not include premium, penalty and amounts not covered by the plan)		
Individual	$6,850	$13,700
Family	$13,700	$27,400

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.

In-network and Out-of-network Deductible and Out-of-pocket Limits are separate and do cross accumulate. All other limits (days, visits, sessions, dollar amounts, etc.) do cross accumulate between In-network and Out-of-network, unless noted differently.

*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
- 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 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)	$45 Copay $65 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 (by a designated provider)	$15 Copay	Not Covered
Convenient Care/Retail Clinics (Quick Care)	Same as a Primary Care Physician	Same as a Primary Care Physician
Urgent Care Facility Services	$65 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)	$90 Copay then Deductible and Coinsurance Deductible and Coinsurance	In-network level of benefits In-network level of benefits
Outpatient Hospital or Facility Services Services such as surgery, laboratory and radiology, cardiac and pulmonary rehabilitation, observation stays, and other services provided on an outpatient basis	Deductible and Coinsurance	Deductible and Coinsurance
Inpatient Hospital or Facility Services Charges for room and board, diagnostic testing, rehabilitation and other ancillary services provided on an inpatient basis	Deductible and Coinsurance	Deductible and Coinsurance
Preventive Services • Affordable Care Act (ACA) required preventive services (may be subject to limits that include, but are not limited to, age, gender, and frequency) • ACA required covered preventive services (outside of limits) • Other covered preventive services not required by ACA	Plan Pays 100% Deductible and Coinsurance Plan Pays 100%	Deductible and Coinsurance Deductible and Coinsurance 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 (by a designated provider) • All Other Outpatient Items & Services	Deductible and Coinsurance $15 Copay Deductible and Coinsurance	Deductible and Coinsurance Not Covered Deductible and Coinsurance
Emergency Care Services (services received in a Hospital emergency room setting)		
• Facility • Professional Services	Deductible and Coinsurance Deductible and Coinsurance	In-network level of benefits In-network level of benefits

Other Covered Services – Illness or Injury	In-network Provider	Out-of-Network Provider
Acupuncture	Not Covered	Not Covered
Advanced Diagnostic Imaging (CT, MRI, MRA, MRS, PET & SPECT scans and other Nuclear Medicine)	Deductible and Coinsurance	Deductible and Coinsurance
Ambulance (to the nearest facility for appropriate care) • Ground Ambulance • Air Ambulance	Deductible and Coinsurance Deductible and Coinsurance	In-network level of benefits Deductible and Coinsurance (In-network level of benefits if due to an emergency)
Biofeedback	Deductible and Coinsurance	Deductible and Coinsurance
Bone Anchored Hearing Aids (BAHA) and Cochlear implants	Deductible and Coinsurance	Deductible and Coinsurance
Dermatological Services	Same as any other illness	Same as any other illness
Diabetic Services Services include education, self-management training, podiatric appliances and equipment.	Deductible and Coinsurance	Deductible and Coinsurance
Durable Medical Equipment and Supplies (including Prosthetics) (rental or purchase, whichever is least costly; rental shall not exceed the cost of purchasing)	Deductible and Coinsurance	Deductible and Coinsurance
Eye Glasses or Contact Lenses Only covered if required because of a change in prescription as a result of intraocular surgery or ocular injury (must be within 12 months of surgery or injury)	Deductible and Coinsurance	Deductible and Coinsurance
Hearing Aids	Not Covered	Not Covered
Home Health Aide and Skilled Nursing Home Health Aide (limited to 60 days per Calendar Year) Skilled Nursing Care (limited to 8 hours per day)	Deductible and Coinsurance	Deductible and Coinsurance
Home Infusion Therapy	Deductible and Coinsurance	Deductible and Coinsurance
Hospice Services	Deductible and Coinsurance	Deductible and Coinsurance
Independent Laboratory • Diagnostic • Preventive	Deductible and Coinsurance Same as Preventive Services In-network level of benefits	In-network level of benefits Same as Preventive Services In-network level of benefits
Infertility • Services to diagnose • Treatment to promote fertility	Same as any other illness Not Covered	Same as any other illness Not Covered

Other Covered Services – Illness or Injury	In-network Provider	Out-of-Network Provider
Nicotine Addiction		
• Medical services and therapy	Same as Substance Dependence and Abuse	Same as Substance Dependence and Abuse
• Nicotine addiction classes & alternative therapy, such as acupuncture	Not Covered	Not Covered
Obesity		
• Non-surgical treatment	Not Covered	Not Covered
• Surgical Treatment	Not Covered	Not Covered
Oral Surgery and Dentistry Services such 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
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 NOTE: Newborns are covered at birth, subject to the plan's enrollment provisions.	Deductible and Coinsurance	Deductible and Coinsurance
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 (must follow within 90 days of discharge from acute hospitalization)	Deductible and Coinsurance	Deductible and Coinsurance
Rehabilitation Services		
• Cardiac rehabilitation(limited to 18 sessions per diagnosis during the preceding four months of certain cardiac diagnosis)	Deductible and Coinsurance	Deductible and Coinsurance
• Pulmonary Rehabilitation (Chronic lung disease is limited to 18 sessions per diagnosis, not to exceed 18 sessions per Calendar Year. Lung, heart-lung transplants and lung volume are limited to 18 sessions following referral and prior to surgery plus 18 sessions within six months of discharge from hospital following surgery.)	Deductible and Coinsurance	Deductible and Coinsurance
Renal Dialysis	Deductible and Coinsurance	Deductible and Coinsurance
Respiratory Care (limited to 60 days per Calendar Year)	Deductible and Coinsurance	Deductible and Coinsurance
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

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

Prescription Drugs	In-network Provider	Out-of-Network Provider
Prescription Drug Deductible (the amount the Covered Person pays each Calendar Year for Covered Prescription Drugs before the Prescription Drug Copayments and/or Coinsurance are applicable)		
• Individual	Not Applicable	Not Applicable
• Family	Not Applicable	Not Applicable
Retail – per 30-day supply		
• Generic drugs (including non-preferred contraceptives)	30% Coinsurance, $7 minimum Copay, $30 maximum Copay	30% Coinsurance, $7 minimum Copay, $30 maximum Copay + 25% Penalty
• Preferred Brand Name Drugs	30% Coinsurance, $45 minimum Copay, $90 maximum Copay	30% Coinsurance, $45 minimum Copay, $90 maximum Copay + 25% Penalty
• Non-preferred Brand Name Drugs	50% Coinsurance, $70 minimum Copay, $110 maximum Copay	50% Coinsurance, $70 minimum Copay, $110 maximum Copay + 25% Penalty
Mail order – per 180-day supply		
• Generic drugs (including non-preferred contraceptives)	30% Coinsurance, $35 minimum Copay, $150 maximum Copay	Not Covered
• Preferred Brand Name Drugs	30% Coinsurance, $225 minimum Copay, $450 maximum Copay	Not Covered
• Non-preferred Brand Name Drugs	50% Coinsurance, $350 minimum Copay, $550 maximum Copay	Not Covered
Specialty drugs	25% Coinsurance, $60 minimum Copay, $120 maximum Copay	50% Coinsurance, $170 minimum Copay, $340 maximum Copay
Contraceptives		
• Preferred		
– Generic	Plan Pays 100%	25% Penalty
– Brand Name	Plan Pays 100%	25% Penalty
• Non-preferred		
– Generic	Same as any other Generic Drugs	
– Brand Name	Same as any other Non-preferred Brand Name	
Infertility		
FDA approved prescription drugs to promote fertility	Not Covered	Not Covered
Nicotine Addiction		
FDA approved prescription drugs and over-the-counter nicotine addiction drugs and deterrents	Plan Pays 100%	25% Penalty
Obesity		
FDA approved prescription drugs	Not Covered	Not Covered

OPTION 8

Schedule of Benefits Summary

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.

Payments for Services	In-Network Provider	Out-of-Network Provider
In-network Provider: The provider network is shown on your ID card. For help in locating In-network Providers, visit nebraskablue.com.		
Deductible (the amount the Covered Person pays each Calendar Year for Covered Services before the Coinsurance is payable)		
Individual	$3,500	$7,000
Family (Aggregate*)	$6,850	$13,700
Coinsurance Benefits (% amount the Covered Person must pay for most Covered Services after the Deductible has been met)		
Covered Person Pays	0%	20%
Out-of-pocket Limit (does not include premium, penalty and amounts not covered by the plan)		
Individual	$3,500	$12,000
Family	$6,850	$23,700

Once the annual Out-of-pocket Limit is reached, most Covered Services are payable by the plan at 100% for the rest of the Calendar Year.

In-network and Out-of-network Deductible and Out-of-pocket Limits are separate and do cross accumulate. All other limits (days, visits, sessions, dollar amounts, etc.) do cross accumulate between In-network and Out-of-network, unless noted differently.

*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) (copay(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 Provider	Out-of-Network Provider
Physician Office		
• Primary Care Physician Office Visit	Deductible	Deductible and Coinsurance
• Specialist Physician Office Visit	Deductible	Deductible and Coinsurance
• Other Covered Services and supplies provided in the Physician's Office (with or without an office visit billed)	Deductible	Deductible and Coinsurance
• Allergy Injections and Serum	Deductible	Deductible and Coinsurance
• Other Injections	Deductible	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.

Convenient Care/Retail Clinics (Quick Care)	Same as a Primary Care Physician	Same as a Primary Care Physician
Telehealth Services (by a designated provider)	Deductible	Not Covered
Urgent Care Facility Services	Deductible	Deductible and Coinsurance
Emergency Care Services (services received in a Hospital emergency room setting)		
• Facility	Deductible	In-network level of benefits
• Professional Services	Deductible	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	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	Deductible and Coinsurance
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	Deductible and Coinsurance
• Other covered preventive services not required by ACA	Plan Pays 100%	Deductible and Coinsurance
Immunizations		
• Pediatric (up to age 7)	Plan Pays 100%	Coinsurance
• Age 7 and older	Plan Pays 100%	Deductible and Coinsurance
• Related to an illness	Same as any other illness	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	Deductible and Coinsurance
Outpatient Services		
• Office Visit	Deductible	Deductible and Coinsurance
• Telehealth Services (by a designated provider)	Deductible	Not Covered
• All Other Outpatient Items & Services	Deductible	Deductible and Coinsurance
Emergency Care Services (services received in a Hospital emergency room setting)		
• Facility	Deductible	In-network level of benefits
• Professional Services	Deductible	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	Deductible and Coinsurance
Ambulance (to the nearest facility for appropriate care)		
• Ground Ambulance	Deductible	In-network level of benefits
• Air Ambulance	Deductible	Deductible and Coinsurance (In-network level of benefits if due to an emergency)
Biofeedback	Deductible	Deductible and Coinsurance
Biofeedback Bone Anchored Hearing Aids(BAHA) and Cochlear implants	Deductible	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	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	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	Deductible and Coinsurance
Hearing Aids	Not Covered	Not Covered
Home Health Aide and Skilled Nursing		
Home Health Aide (limited to 60 days per Calendar Year) Skilled Nursing Care (limited to 8 hours per day)	Deductible	Deductible and Coinsurance
Home Infusion Therapy	Deductible	Deductible and Coinsurance
Hospice Services	Deductible	Deductible and Coinsurance
Independent Laboratory		
• Diagnostic	Deductible	In-network level of benefits
• Preventive	Same as Preventive Services In-network level of benefits	Same as Preventive Services In-network level of benefits
Infertility		
• Services to diagnose	Same as any other illness	Same as any other illness
• Treatment to promote fertility	Not Covered	Not Covered

Other Covered Services – Illness or Injury	In-Network Provider	Out-of-Network Provider
Nicotine Addiction		
• Medical services and therapy	Same as Substance Dependence and Abuse	Same as Substance Dependence and Abuse
• Nicotine addiction classes & alternative therapy, such as acupuncture	Not Covered	Not Covered
Obesity		
• Non-surgical treatment	Not Covered	Not Covered
• Surgical Treatment	Not Covered	Not Covered
Oral Surgery and Dentistry Services such 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	Deductible and Coinsurance
Organ and Tissue Transplantation	Deductible	Deductible and Coinsurance
Ostomy Supplies	Deductible	Deductible and Coinsurance
Physician Professional Services Inpatient and Outpatient services, such as, surgery, surgical assistant, anesthesia, inpatient hospital visits and other non-surgical services	Deductible	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	Deductible and Coinsurance
• Newborn care NOTE: Newborns are covered at birth, subject to the plan's enrollment provisions.	Deductible	Deductible and Coinsurance
Radiation Therapy and Chemotherapy	Deductible	Deductible and Coinsurance
Radiology (x-ray) Services and other Diagnostic Test	Deductible	Deductible and Coinsurance
Rehabilitation Services – Inpatient Facility (must follow within 90 days of discharge from acute hospitalization)	Deductible	Deductible and Coinsurance
Rehabilitation Services		
• Cardiac rehabilitation(limited to 18 sessions per diagnosis during the preceding four months of certain cardiac diagnosis)	Deductible	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	Deductible and Coinsurance
Renal Dialysis	Deductible	Deductible and Coinsurance
Respiratory Care (limited to 60 days per Calendar Year)	Deductible	Deductible and Coinsurance
Sexual Dysfunction	Not Covered	Not Covered
Skilled Nursing Facility (limited to 60 days per Calendar Year)	Deductible	Deductible and Coinsurance
Sleep Studies	Deductible	Deductible and Coinsurance
Temporomandibular and Craniomandibular Joint Disorder	Deductible	Deductible and Coinsurance

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

Prescription Drugs	In-Network Provider	Out-of-Network Provider
Prescription Drug Deductible (the amount the Covered Person pays each Calendar Year for Covered Prescription Drugs before the Prescription Drug Copayments and/or Coinsurance are applicable)		
• Individual	Not Applicable	Not Applicable
• Family	Not Applicable	Not Applicable
Retail – per 30-day supply		
• Generic drugs (including non-preferred contraceptives)	Deductible	Deductible and Coinsurance + 25% Penalty
• Preferred Brand Name Drugs	Deductible	Deductible and Coinsurance + 25% Penalty
• Non-preferred Brand Name Drugs	Deductible	Deductible and Coinsurance + 25% Penalty
Mail order – per 180-day supply		
• Generic drugs (including non-preferred contraceptives)	Deductible	Not Covered
• Preferred Brand Name Drugs	Deductible	Not Covered
• Non-preferred Brand Name Drugs	Deductible	Not Covered
Specialty drugs	Same as Retail	Deductible and Coinsurance
Contraceptives		
• Preferred		
– Generic	Plan Pays 100%	25% Penalty
– Brand Name	Plan Pays 100%	25% Penalty
• Non-preferred		
– Generic	Same as any other Generic Drugs	
– Brand Name	Same as any other Non-preferred Brand Name	
Infertility		
FDA approved prescription drugs to promote fertility	Not Covered	Not Covered
Nicotine Addiction		
FDA approved prescription drugs and over-the-counter nicotine addiction drugs and deterrents	Plan Pays 100%	25% Penalty
Obesity		
FDA approved prescription drugs	Not Covered	Not Covered

OPTION 9

Schedule of Benefits Summary

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.

Payments for Services	In-Network Provider	Out-of-Network Provider
In-network Provider: The provider network is shown on your ID card. For help in locating In-network Providers, visit nebraskablue.com.		
Deductible (the amount the Covered Person pays each Calendar Year for Covered Services before the Coinsurance is payable)		
Individual	$4,000	$8,000
Family (Embedded*)	$8,000	$16,000
Coinsurance Benefits (% amount the Covered Person must pay for most Covered Services after the Deductible has been met)		
Covered Person Pays	30%	50%
Out-of-pocket Limit (does not include premium, penalty and amounts not covered by the plan)		
Individual	$6,350	$12,700
Family	$12,700	$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.

In-network and Out-of-network Deductible and Out-of-pocket Limits are separate and do cross accumulate. All other limits (days, visits, sessions, dollar amounts, etc.) do cross accumulate between In-network and Out-of-network, unless noted differently.

*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:

- 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 Provider	Out-of-Network Provider
Physician Office		
• Primary Care Physician Office Visit	Deductible and Coinsurance	Deductible and Coinsurance
• Specialist Physician Office Visit	Deductible and Coinsurance	Deductible and Coinsurance
• Other Covered Services and supplies provided in the Physician's Office (with or without an office visit billed)	Deductible and Coinsurance	Deductible and Coinsurance
• Allergy Injections and Serum	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.

Convenient Care/Retail Clinics (Quick Care)	Same as a Primary Care Physician	Same as a Primary Care Physician
Telehealth Services (by a designated provider)	Deductible and Coinsurance	Not Covered
Urgent Care Facility Services	Deductible and Coinsurance	Deductible and Coinsurance
Emergency Care Services (services received in a Hospital emergency room setting)		
• Facility	Deductible and Coinsurance	In-network level of benefits
• Professional Services	Deductible and Coinsurance	In-network level of benefits
Outpatient Hospital or Facility Services		
Services such as surgery, laboratory and radiology, cardiac and pulmonary rehabilitation, observation stays, and other services provided on an outpatient basis	Deductible and Coinsurance	Deductible and Coinsurance
Inpatient Hospital or Facility Services		
Charges for room and board, diagnostic testing, rehabilitation and other ancillary services provided on an inpatient basis	Deductible and Coinsurance	Deductible and Coinsurance
Preventive Services		
• 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)	Plan Pays 100%	Coinsurance
• Age 7 and older	Plan Pays 100%	Deductible and Coinsurance
• Related to an illness	Same as any other illness	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	Deductible and Coinsurance	Deductible and Coinsurance
• Telehealth Services (by a designated provider)	Deductible and Coinsurance	Not Covered
• All Other Outpatient Items & Services	Deductible and Coinsurance	Deductible and Coinsurance
Emergency Care Services (services received in a Hospital emergency room setting)		
• Facility	Deductible and Coinsurance	In-network level of benefits
• Professional Services	Deductible and Coinsurance	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	Deductible and Coinsurance	In-network level of benefits
• Air Ambulance	Deductible and Coinsurance	Deductible and Coinsurance (In-network level of benefits if due to an emergency)
Biofeedback	Deductible and Coinsurance	Deductible and Coinsurance
Bone Anchored Hearing Aids (BAHA) and Cochlear implants	Deductible and Coinsurance	Deductible and Coinsurance
Dermatological Services	Same as any other illness	Same as any other illness
Diabetic Services		
Services include education, self-management training, podiatric appliances and equipment.	Deductible and Coinsurance	Deductible and Coinsurance
Durable Medical Equipment and Supplies (including Prosthetics)		
(rental or purchase, whichever is least costly; rental shall not exceed the cost of purchasing)	Deductible and Coinsurance	Deductible and Coinsurance
Eye Glasses or Contact Lenses		
Only covered if required because of a change in prescription as a result of intraocular surgery or ocular injury (must be within 12 months of surgery or injury)	Deductible and Coinsurance	Deductible and Coinsurance
Hearing Aids	Not Covered	Not Covered
Home Health Aide and Skilled Nursing		
Home Health Aide (limited to 60 days per Calendar Year) Skilled Nursing Care (limited to 8 hours per day)	Deductible and Coinsurance	Deductible and Coinsurance
Home Infusion Therapy	Deductible and Coinsurance	Deductible and Coinsurance
Hospice Services	Deductible and Coinsurance	Deductible and Coinsurance
Independent Laboratory		
• Diagnostic	Deductible and Coinsurance	In-network level of benefits
• Preventive	Same as Preventive Services In-network level of benefits	Same as Preventive Services In-network level of benefits
Infertility		
• Services to diagnose	Same as any other illness	Same as any other illness
• Treatment to promote fertility	Not Covered	Not Covered

Other Covered Services – Illness or Injury	In-Network Provider	Out-of-Network Provider
Nicotine Addiction		
• Medical services and therapy	Same as Substance Dependence and Abuse	Same as Substance Dependence and Abuse
• Nicotine addiction classes & alternative therapy, such as acupuncture	Not Covered	Not Covered
Obesity		
• Non-surgical treatment	Not Covered	Not Covered
• Surgical Treatment	Not Covered	Not Covered
Oral Surgery and Dentistry Services such 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
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 NOTE: Newborns are covered at birth, subject to the plan's enrollment provisions.	Deductible and Coinsurance	Deductible and Coinsurance
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 (must follow within 90 days of discharge from acute hospitalization)	Deductible and Coinsurance	Deductible and Coinsurance
Rehabilitation Services		
• Cardiac rehabilitation(limited to 18 sessions per diagnosis during the preceding four months of certain cardiac diagnosis)	Deductible and Coinsurance	Deductible and Coinsurance
• Pulmonary Rehabilitation (Chronic lung disease is limited to 18 sessions per diagnosis, not to exceed 18 sessions per Calendar Year. Lung, heart-lung transplants and lung volume are limited to 18 sessions following referral and prior to surgery plus 18 sessions within six months of discharge from hospital following surgery.)	Deductible and Coinsurance	Deductible and Coinsurance
Renal Dialysis	Deductible and Coinsurance	Deductible and Coinsurance
Respiratory Care (limited to 60 days per Calendar Year)	Deductible and Coinsurance	Deductible and Coinsurance
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

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

Prescription Drugs	In-Network Provider	Out-of-Network Provider
Prescription Drug Deductible (the amount the Covered Person pays each Calendar Year for Covered Prescription Drugs before the Prescription Drug Copayments and/or Coinsurance are applicable)		
• Individual	Not Applicable	Not Applicable
• Family	Not Applicable	Not Applicable
Retail – per 30-day supply		
• Generic drugs (including non-preferred contraceptives)	Deductible and Coinsurance	Deductible and Coinsurance + 25% Penalty
• Preferred Brand Name Drugs	Deductible and Coinsurance	Deductible and Coinsurance + 25% Penalty
• Non-preferred Brand Name Drugs	Deductible and Coinsurance	Deductible and Coinsurance + 25% Penalty
Mail order – per 180-day supply		
• Generic drugs (including non-preferred contraceptives)	Deductible and Coinsurance	Not Covered
• Preferred Brand Name Drugs	Deductible and Coinsurance	Not Covered
• Non-preferred Brand Name Drugs	Deductible and Coinsurance	Not Covered
Specialty drugs	Same as Retail	Deductible and Coinsurance
Contraceptives		
• Preferred		
– Generic	Plan Pays 100%	25% Penalty
– Brand Name	Plan Pays 100%	25% Penalty
• Non-preferred		
– Generic	Same as any other Generic Drugs	
– Brand Name	Same as any other Non-preferred Brand Name	
Infertility		
FDA approved prescription drugs to promote fertility	Not Covered	Not Covered
Nicotine Addiction		
FDA approved prescription drugs and over-the-counter nicotine addiction drugs and deterrents	Plan Pays 100%	25% Penalty
Obesity		
FDA approved prescription drugs	Not Covered	Not Covered

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 PPO network is called NEtwork BLUE and it's made up of 95% of Nebraska's doctors and 100% 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 that 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 in excess of 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 additional time-saving convenience for you, we send our benefit payment directly to in-network providers.

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 and 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.

It's easy to locate in-network providers wherever you are.

Locate NEtwork BLUE Providers in Nebraska

By phone: **1-877-721-2583**
On the Web: **nebraskablue.com/find-a-doctor**

Locate BlueCard PPO Providers Nationwide

By phone: **1-800-810-BLUE (2583)**
On the Web: **bcbs.com**

Calendar Year Deductible

Please note: If your group changes September 1 to a new plan with a higher deductible, that new deductible will apply to all claims incurred between September 1 and December 31, and then must be satisfied again for the next calendar year starting January 1.

For example, if your group is currently on a $600 calendar year deductible and your group changes September 1 to the $750 deductible, and you have already met the full $600 deductible, any claims incurred between September 1 and December 31 will be applied toward the $750 deductible. In other words, you will need to meet the additional $150 to get to the $750 total, since the deductible is on a calendar year basis.

All options except HSA-eligible $3,500 and $4,000 deductible plan
If you're covered under a single membership, you must satisfy one individual deductible each calendar year. 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 9 (HSA-eligible $4,000 embedded 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.

Option 8 (HSA-eligible $3,500 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, employee/spouse or employee/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.

Coinsurance and Your Calendar Year Out-of-Pocket Limit

Options 1-6 and Option 9
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 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. No one family member contributes more than the individual out-of-pocket amount.

Option 8 (HSA-eligible $3,500 deductible)
After you meet your calendar year deductible, you are responsible for paying a certain percentage of covered charges (called "coinsurance") for out-of-network providers, 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 out-of-network aggregate family out-of-pocket 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.

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 (most paid at 100%)
- 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**.*

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

Office Visit Exam Copay

Not applicable to the HSA-eligible Plans (Options 8 and 9)
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 charts on pages 3-47 for your plan's copay amount.

Prescription Drug Coverage

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

Options 1 through 7
Your coverage is based on Blue Cross and Blue Shield of Nebraska's (BCBSNE) drug formulary. A formulary 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 the charts on pages 3-47 for further details. To review the drug formulary online, go to **nebraskablue.com/druglist** or call our Member Services Department at the number on the back of your BCBSNE member ID card.

Options 8 and 9
Your prescription drug benefits are subject to your plan's in-network deductible and coinsurance.

Using Your Prescription Drug Benefits
To use your prescription drug benefits, take your Blue Cross and Blue Shield of Nebraska 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 Prime Therapeutics Specialty Pharmacy. For more information, please refer to the Prime Therapeutics Specialty Pharmacy brochure.

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 apply toward the health plan's calendar year out-of-pocket limit.

Please note: The formulary is revised on a regular basis. **nebraskablue.com/druglist** provides you with the most up-to-date version.

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.)

Here's What's Covered Under Your Rx Nebraska Plan

- Drugs requiring a prescription, either by state or federal law, written by a qualified physician or dentist (except those items listed in the next section). Certain drugs may be subject to quantity maximums as determined by Blue Cross and Blue Shield of Nebraska.
- Injectables.
- Insulin and other diabetic supplies, including needles, syringes, test strips and lancets (also covered under health).
- Prescription vitamins (including pre-natal).
- Oral contraceptives (including transdermal patch).
- Human immunodeficiency virus (HIV) medications.
- Anti-rejection medications.
- Compound medications containing at least one prescription ingredient (restrictions may apply).
- Topical retinoids, through age 40.*

* After reaching age maximum, preauthorization required.

These Drugs Are Not Covered Under Your Rx Nebraska Plan

- Over-the-counter medications.
- Diet or appetite suppressants.
- Dietary supplements.
- Prescription drugs purchased in a foreign country (except while living abroad or in medical emergencies while traveling).
- Medications, services or drugs that are not cost effective compared to established alternatives.
- Experimental/investigational drugs.
- Fertility medications.
- Erectile dysfunction agents.
- Topical Minoxidil (Rogaine).
- Health or beauty aids; cosmetic alteration drugs, including Renova.

Note: This is a partial list of what is covered and not covered under your plan. For a complete list, please refer to the certificate of coverage or the master group contract.

Getting Your Prescription Filled

Take your prescription and your Blue Cross and Blue Shield of Nebraska member ID card to a participating Rx Nebraska pharmacy. You'll pay the pharmacist the applicable coinsurance amount (refer to your plan on pages 3-47.

Please note: 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.

Using Your Mail Service Pharmacy Benefit
If you use the PrimeMail® Mail Service Pharmacy 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 shown in the charts on pages 3-47 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 PrimeMail at 877-357-7463.

The Prescription Drug Preauthorization Program

As part of our efforts to address the serious issue of escalating costs and continue to provide you with access to quality and cost-effective pharmacy care, Blue Cross and Blue Shield of Nebraska requires that benefits for certain prescription drugs be preauthorized.

Gastroprotective NSAIDs
This program manages the use of costly gastroprotective NSAIDs used to treat inflammation and reduce pain. These drugs work the same as drugs such as naproxen and ibuprofen.

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

Proton Pump Inhibitors (PPIs)
PPIs are used to help reduce stomach acid and provide relief from the symptoms of heartburn, ulcers, and gastroesophageal reflux disease (GERD).

For benefits to be considered for the formulary brand medication Nexium Delayed Release suspension packets, members must first use a prescription generic formulary PPI. For benefits to be considered for a non-formulary PPI, members must first use three formulary PPIs. Benefits for generic formulary PPIs do not require preauthorization.

If You Go to a Nonparticipating Pharmacy

If you have your prescription filled at a nonparticipating pharmacy, you must pay the pharmacist the entire cost of the prescription, then file a claim with Blue Cross and Blue Shield of Nebraska (with the itemized statement attached). Reimbursement for prescriptions filled at a nonparticipating pharmacy will be based on the standard discounted cost of the drug at a participating pharmacy minus the applicable coinsurance amount and a 25% penalty. Rx Nebraska claim forms are available at **nebraskablue.com/claimforms** or by calling our Member Services Department at the number on the back of your BCBSNE member ID card.

Before Your Member ID Card Arrives

Between the time you enroll in the plan and the time you receive your Blue Cross and Blue Shield of Nebraska member ID card, you may find you need to get a prescription filled. Rx Nebraska benefits are available to you, but you'll need to pay the participating pharmacist the full amount, then file a claim (with the itemized statement attached). You will be reimbursed, minus your applicable coinsurance amount. Please indicate on the claim form that you haven't received your member ID card yet. Rx Nebraska claim forms are available at **nebraskablue.com/claimforms** or by calling our Member Services Department at **1-877-721-2583**.

Please note: It is important that once you receive your member ID card you have it with you when you have your prescription filled at a participating pharmacy. If you don't have your card with you, you will be required to pay the pharmacist the entire cost of the drug and file a claim. You will be reimbursed as if you had gone to a nonparticipating pharmacy (see the previous section, "If You Go to a Nonparticipating Pharmacy.")

If You Have Questions

If you have questions about your Rx Nebraska benefits, call our Member Services Department at **1-877-721-2583**. You can also visit **nebraskablue.com/rxtools**.

Certification

Blue Cross and Blue Shield of Nebraska 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, Blue Cross and Blue Shield of Nebraska 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 services, supplies or drugs must be certified:

- Organ and tissue transplants;
- Pulmonary rehabilitation;
- 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; and
- 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.

For certification of benefits, call 402-390-1870 or 1-800-247-1103.

COMMITTED TO PROMOTING QUALITY CARE AND PATIENT SAFETY

Inpatient Hospital & 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 on the back of your BCBSNE member ID card.

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.

Maternity & Newborn Coverage

Maternity coverage is available to subscribers and covered spouses and dependent daughters. If the employee is covered under a single membership, a newborn will be covered for a period of 31 days. Application for change to family coverage must be made within 31 days of birth to continue the baby's coverage.

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. All covered charges incurred by a newborn from birth will be subject to a separate, individual calendar year deductible.

To learn more about our free maternity management program, please call 1-877-348-4329 or visit **nebraskablue.com/maternitycare**.

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 TMJ and craniomandibular disorder.

Home Health Aide, Skilled Nursing Care and Hospice Benefits

The following covered services require benefit preauthorization. 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.

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; invitro 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.

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

Late 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.

Late enrollees may enroll only during the annual enrollment period designated for the EHA health plan.

You or your eligible dependents are not considered late enrollees if:

- you and/or your dependent were covered under other qualifying previous coverage at the time of your initial eligibility for this group coverage; and
- you and/or your dependent 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
- you and/or your eligible dependent request enrollment within 31 days after termination of qualifying previous coverage; or within 60 days of the loss of Medicaid or SCHIP coverage.

New Enrollees

A "new enrollee" is defined as a new employee who enrolls within 31 days of employment, and special enrollees who enroll in a timely manner.

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 Nebraska providers or an amount determined by the onsite Plan for out-of-network providers.

What is an HSA?

Options 8 and 9 are HSA-eligible health plans. 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 "high deductible health plan" is eligible to establish an HSA. To qualify as a high deductible health plan, 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. Withdrawals for other purposes are taxable and, for individuals who are not disabled or over age 65, subject to a 20% penalty.

Contributions may be made by the individual, his or her employer, or both.

Please note: HSA deductible and coinsurance maximums may be increased annually to conform with cost of living adjustments permitted by Section 223 of the Internal Revenue Code and subsequent amendments.

Keep Track of Your Health Care

Quick, Easy and When You Need It

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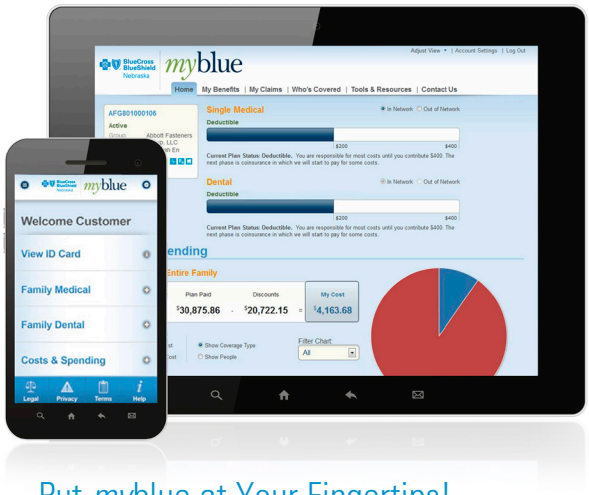
Get 24/7 secure access to everything you need to manage your Blue Cross and Blue Shield of Nebraska health plan.

- Find an in-network doctor
- Access your member ID card
- Look up claims
- Compare cost for treatments
- View important policy documents and forms



Put *my*blue at Your Fingertips!

There are two easy ways to sign up for free:

1. Download the ***my*blue Nebraska app** on your mobile device from the Apple App Store or Google Play
2. Go to **mynebraskablue.com**

   Then, select "Sign Up" and complete the four easy steps

You will need your member ID number found on the front of your BCBSNE member ID card.

If you have questions about *my*blue, just call the phone number on the back of your BCBSNE member ID card.

Learn what ***my*blue has to offer:**

Log in to *my*blue and find tools to help answer important health care questions. All of these tools are under the Tools & Resources tab:

Know Before You Go

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

Review Your Doctor

In the Find a Doctor or Hospital section, you can write a review of your health care experience and read reviews written by others.

MyPrime®

Blue Cross and Blue Shield of Nebraska contracts with Prime Therapeutics® to provide group pharmacy benefits. You may view information about your pharmacy benefits by going to My Pharmacy. You will be directed to MyPrime. This website is loaded with interactive tools to help you manage your prescription drugs.

With MyPrime, you can find:

- your prescription benefits
- your drug claim history
- prescription drug list (also known as a formulary)
- a pharmacy locator
- a drug cost calculator
- a comparison of brand name and generic drug costs

Prime Therapeutics LLC is an independent company that provides pharmacy benefit management services for Blue Cross and Blue Shield of Nebraska.

Save Time and Money with Telehealth

Blue Cross and Blue Shield of Nebraska believes in the importance of providing options to help you access affordable and immediate health care. That is why we are delighted to offer telehealth services to our members. Amwell can be used any time, day or night. It's perfect when your doctor's office is closed, you're too sick or busy to see someone in person, or even when you're 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. It's easy to use, affordable, private and secure.

Rather than having to schedule a doctor's appointment and travel to and from the doctor's office, telehealth lets you interact with a doctor at your convenience for common conditions, such as:

- sinus infection
- cold
- flu
- fever
- rash
- abdominal pain
- pinkeye
- ear infection
- migraine
- sore throat

Who Provides Telehealth Services?

Blue Cross and Blue Shield of Nebraska provides telehealth services through American Well®, also known as Amwell, the industry's leader in telehealth solutions. With Amwell, you can register for free, and the cost per visit is less than the cost of an in-person doctor office visit.

Amwell offers:

- A choice of trusted, U.S. board-certified doctors
- Access to a licensed physician via computer, tablet or phone
- Consultation and diagnosis for common conditions, including e-prescriptions to your pharmacy of choice (when appropriate and where allowed*)

Behavioral Health Services Also Available

Amwell's licensed therapists can provide treatment for any of the following conditions:

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

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

* Telehealth is available in most states, but some states do not allow telehealth consults or telehealth prescriptions. For more information, visit: info.americanwell.com/where-can-i-see-a-doctor-online. Psychiatry services are not available in all states. American Well is an independent company that provides telehealth services for Blue Cross and Blue Shield of Nebraska.

Identity Protection Services

Blue Cross and Blue Shield of Nebraska has teamed with AllClear ID to offer all eligible BCBSNE members access to AllClear Identity Repair and the option to enroll in AllClear Credit Monitoring.

How Identity Repair Works

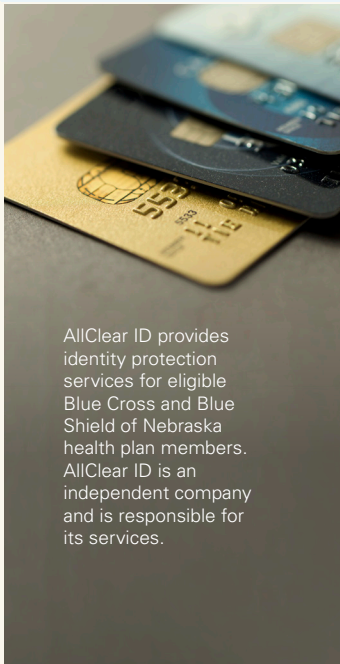
If you experience identity theft, a dedicated investigator from AllClear ID will act as your guide and advocate from start to finish by initiating the dispute process, and ensuring that your identity returns to its pre-fraud state.

Enhance Your Protection with Credit Monitoring

With AllClear Credit Monitoring, you can have additional layers of protection that specifically monitor new credit accounts opened in your name. If this happens, AllClear ID alerts you so you stay informed of your credit activity.

You and your eligible family members may enroll in AllClear Credit Monitoring – at no cost to you. (While AllClear Identity Repair is automatic protection, you must enroll in credit monitoring because you will need to provide AllClear ID with personal information such as your Social Security number.)

Ask your employer for the redemption code to renew or enroll.



AllClear ID provides identity protection services for eligible Blue Cross and Blue Shield of Nebraska health plan members. AllClear ID is an independent company and is responsible for its services.

Health and Wellness Resources

A healthier you. Little things can make a big difference.

The lifestyle decisions we make regarding nutrition, weight, exercise, smoking, seatbelt use, and more directly impact our health care costs. Blue Cross and Blue Shield of Nebraska offers resources to help you make positive lifestyle changes.

Blue365®
Because health is a big deal℠

Blue365 is a national program that gives Blue members exclusive access to discounts and savings. Members can explore special offerings from leading national companies in these categories:

- Financial Health
- Fitness
- Healthy Eating
- Lifestyle
- Personal Care
- Wellness

Visit **nebraskablue.com/blue365** to learn more.

BlueHealth Advantage®
Little Things. Big Difference.

Our wellness and lifestyle management program offers:

- Educational health and wellness information
- Lifestyle management guides
- Personal health assessment tools

To check out all the valuable health and wellness resources available to you, go to **bluehealthadvantagene.com**.

LIVE WELL NEBRASKA

Visit Live Well Nebraska to find the latest health information, health care tips and personal health journeys. The site on Omaha.com provides Nebraska with a comprehensive source of news and information for healthy living.

Visit **livewellnebraska.com** to learn more.

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BlueCross BlueShield Nebraska

Blue Cross and Blue Shield of Nebraska Contacts and Resources

Blue Cross and Blue Shield of Nebraska Member Services Department

Phone
1-877-721-2583

Website
nebraskablue.com/contact

To locate NEtwork BLUE providers in Nebraska

Phone
1-877-721-2583

Website
nebraskablue.com/find-a-doctor

To locate BlueCard PPO providers nationwide

Phone
Toll-free 1-800-810-BLUE (2583)

Website
bcbs.com

To locate participating Rx Nebraska pharmacies nationwide

Phone
1-877-800-0746

Website
nebraskablue.com/myprime

This brochure provides you with an overview of the Blue Cross and Blue Shield of Nebraska health care and prescription drug coverage offered to 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.

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