

Schedule of Benefits Summary

Group Name: Nebraska Health Care Association Employers Insurance Consortium

Effective Date: January 01, 2023

Payment for Services	In-network Provider	Out-of-network Provider
<p>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. In some situations, Out-of-network Providers can bill for amounts over the Out-of-network Allowance.</p>		
<p>In-network Provider: The provider network is shown on your I.D. card. For help in locating In-network Providers, visit www.NebraskaBlue.com.</p>		
<p>Deductible (the amount the Covered Person pays each Calendar Year for Covered Services before the Coinsurance is payable)</p> <ul style="list-style-type: none"> Individual Family (Embedded*) 	<p>\$2,000 \$4,000</p>	<p>\$4,000 \$8,000</p>
<p>Coinsurance (the percentage amount the Covered Person must pay for most Covered Services after the Deductible has been met)</p> <ul style="list-style-type: none"> Covered Person Pays 	<p>20%</p>	<p>40%</p>
<p>Out-of-pocket Limit (does not include premium, penalty and amounts not covered by the plan)</p> <ul style="list-style-type: none"> Individual Family (Embedded*) 	<p>\$4,000 \$8,000</p>	<p>\$8,000 \$16,000</p>
<p>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.</p>		
<p>In-network and Out-of-network Deductible and Out-of-pocket Limits are separate and do not cross accumulate. All other limits (days, visits, sessions, dollar amounts, etc.) do cross accumulate between In-network and Out-of-network, unless noted differently.</p>		
<p>Day, session or visit limits for certain services shown on this summary are not applicable to Mental Illness and/or Substance Dependence and Abuse.</p>		
<p>*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.</p>		

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

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

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

Out-of-pocket Limit includes:

- Deductible
- Coinsurance
- Medical Copays
- Prescription Drug Copays

Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Physician Office <ul style="list-style-type: none"> 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) 	\$25 Copay \$50 Copay Applicable office visit copay	Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance
<p>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.</p> <p>Specialist Physician is a physician who is not a Primary Care Physician.</p> <p>Office Visit Benefits for Primary Care and Specialist Physician Office Visit include office visits (including the initial visit to diagnose pregnancy) and consultations.</p> <p>Other Covered Services not part of the Physician Office Benefit (Refer to the appropriate category for benefit information) include: 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.</p>		
Telehealth Services	\$10 Copay	Not Covered
Convenient Care/Retail Clinics (Quick Care)	Same as a Primary Care Physician	Deductible and Coinsurance
Urgent Care Facility Services (a single copay applies to each urgent care visit)	\$75 Copay	Deductible and Coinsurance
Emergency Care Services (services received in a Hospital emergency room setting) <ul style="list-style-type: none"> Facility Professional Services (Copayment is waived if admitted to the hospital within 24 hours for the same diagnosis)	\$150 Copay then Coinsurance Coinsurance	In-network level of benefits In-network level of benefits
Outpatient Hospital or Facility Services Services such as surgery, laboratory and radiology, cardiac and pulmonary rehabilitation, observation stays, and other services provided on an outpatient basis	Deductible and Coinsurance	Deductible and Coinsurance
Inpatient Hospital or Facility Services Charges for room and board, diagnostic testing, rehabilitation and other ancillary services provided on an inpatient basis	Deductible and Coinsurance	Deductible and Coinsurance
Orthopedic Specialty Hospital or Facility Services	Deductible and Coinsurance	Deductible and Coinsurance
<p>NOTE: Deductibles and Coinsurance may be waived if Covered Services are provided at a designated Preferred Center. See www.NebraskaBlue.com for a list of Covered Services and designated hospitals.</p>		

Preventive Services	In-network Provider	Out-of-network Provider
Preventive Services <ul style="list-style-type: none"> 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, such as: <ul style="list-style-type: none"> Laboratory tests as specified by Us, including urinalysis and complete blood count; general health panel; metabolic panel; prostate cancer screening (PSA) and hearing exams All other laboratory tests; radiology, cardiac stress tests; EKG; pulmonary function and other screenings and services 	Plan Pays 100% Plan Pays 100% Plan Pays 100% Same as any other illness	Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance Same as any other illness
Immunizations <ul style="list-style-type: none"> 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
Colorectal Cancer Screenings (starting at age 45) <ul style="list-style-type: none"> Colonoscopy Screening <ul style="list-style-type: none"> Diagnostic or Preventive Screening (one every five years) Screenings outside the age or frequency limit Sigmoidoscopy/Proctoscopy Screening <ul style="list-style-type: none"> Preventive Screening (one every five years) Screenings outside the age or frequency limit Barium enema, Fecal occult blood tests, FIT DNA, CT of the Colon and other tests as determined under ACA Preventive Services <ul style="list-style-type: none"> Preventive Screenings Diagnostic Screenings 	Plan Pays 100% Same as any other illness Plan Pays 100% Same as any other illness Plan Pays 100% Same as any other illness	Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance
NOTE: Related Services will pay in the same manner as the Colorectal Cancer Screening when performed on the same date of service.		

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 <ul style="list-style-type: none"> Office Services Telehealth Services All Other Outpatient Items & Services 	Plan Pays 100% Plan Pays 100% Deductible and Coinsurance	Deductible and Coinsurance Not Covered Deductible and Coinsurance
Emergency Care Services (services received in a Hospital emergency room setting) <ul style="list-style-type: none"> Facility Professional Services (Copayment is waived if admitted to the hospital within 24 hours for the same diagnosis)	\$150 Copay then Coinsurance 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) <ul style="list-style-type: none"> • Ground Ambulance • Air Ambulance 	Deductible and Coinsurance Deductible and Coinsurance	In-network level of benefits In-network level of benefits
Autism Spectrum Disorder	Same as mental illness	Same as mental illness
Biofeedback	Deductible and Coinsurance	Deductible and Coinsurance
Bone Anchored Hearing Aids and Cochlear Implants	Deductible and Coinsurance	Deductible and Coinsurance
Dermatological Services	Same as any other illness	Same as any other illness
Diabetic Services Services include education, self-management training, podiatric appliances and equipment.	Deductible and Coinsurance	Deductible and Coinsurance
Drugs Administered in an Outpatient Setting (such as home, physician office and other outpatient settings) (NOTE: Benefits for specific prescription drugs and covered services administered in an outpatient setting, other than a hospital emergency room, are not payable under Medical. These drugs are only payable under the Prescription Drug plan. A list of these drugs and covered services is available on the website www.NebraskaBlue.com or by contacting the Member Services Department.)	Same as any other illness	Same as any other illness
Durable Medical Equipment and Supplies (including Prosthetics) (rental or purchase, whichever is least costly; rental shall not exceed the cost of purchasing)	Deductible and Coinsurance	Deductible and Coinsurance
Eye Glasses or Contact Lenses Only covered if required because of a change in prescription as a result of intraocular surgery or ocular injury (must be within 12 months of surgery or injury)	Deductible and Coinsurance	Deductible and Coinsurance

Other Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Hearing Aids (up to age 19 limited to \$3,000 every 48 months)	Same as any other illness	Same as any other illness
Home Health Aide, Skilled Nursing and Respiratory Care <ul style="list-style-type: none"> Home Health Aide (limited to 60 days per Calendar Year) Skilled Nursing Care (limited to 8 hours per day) Respiratory Care (limited to 60 days per Calendar Year) 	Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance	Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance
Home Infusion Therapy	Deductible and Coinsurance	Deductible and Coinsurance
Hospice Services	Deductible and Coinsurance	Deductible and Coinsurance
Independent Laboratory <ul style="list-style-type: none"> Diagnostic Preventive 	Plan Pays 100% Same as Preventive Services In-network level of benefits	In-network level of benefits Same as Preventive Services In-network level of benefits
Infertility <ul style="list-style-type: none"> Services to diagnose Treatment to promote fertility 	Same as any other illness Not Covered	Same as any other illness Not Covered
Nicotine Addiction <ul style="list-style-type: none"> Medical services and therapy Nicotine addiction classes & alternative therapy, such as acupuncture 	Same as Substance Dependence and Abuse Not Covered	Same as Substance Dependence and Abuse Not Covered
Obesity <ul style="list-style-type: none"> Non-surgical treatment Surgical Treatment 	Not Covered Not Covered	Not Covered Not Covered
Oral Surgery and Dentistry Services such as incision and drainage of abscesses and excision of tumors and cysts. Dental treatment when due to an accidental injury to naturally healthy teeth (treatment related to accidents must be provided within 12 months of the date of injury).	Deductible and Coinsurance	Deductible and Coinsurance
Organ and Tissue Transplantation	Deductible and Coinsurance	Deductible and Coinsurance
Ostomy Supplies	Deductible and Coinsurance	Deductible and Coinsurance

Other Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Physician Professional Services Inpatient and Outpatient services, such as, surgery, surgical assistant, anesthesia, inpatient hospital visits and other non-surgical services	Deductible and Coinsurance	Deductible and Coinsurance
Pregnancy, Maternity and Newborn Care <ul style="list-style-type: none"> • Pregnancy and maternity (Payment for prenatal and postnatal care is included in the payment for the delivery) • 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	Deductible and Coinsurance	Deductible and Coinsurance
Rehabilitation Services <ul style="list-style-type: none"> • Cardiac rehabilitation (limited to 18 sessions per diagnosis) • Pulmonary Rehabilitation (Chronic lung disease is limited to 18 sessions per diagnosis, not to exceed 18 sessions per Calendar Year. Lung, heart-lung transplants and lung volume are limited to 18 sessions following referral and prior to surgery plus 18 sessions within six months of discharge from hospital following surgery.) 	Deductible and Coinsurance	Deductible and Coinsurance
Renal Dialysis	Deductible and Coinsurance	Deductible and Coinsurance

Other Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Sexual Dysfunction	Not Covered	Not Covered
Skilled Nursing Facility (limited to 60 days per Calendar Year)	Deductible and Coinsurance	Deductible and Coinsurance
Sleep Studies	Deductible and Coinsurance	Deductible and Coinsurance
Temporomandibular and Craniomandibular Joint Disorder	Deductible and Coinsurance	Deductible and Coinsurance
Therapy & Manipulations <ul style="list-style-type: none"> • Physical, occupational or speech therapy services, chiropractic or osteopathic physiotherapy (combined limit to 60 sessions per Calendar Year for both rehabilitative and habilitative services) • Chiropractic or osteopathic manipulative treatments or adjustments (combined limit to 30 sessions per Calendar Year) 	Deductible and Coinsurance Deductible and Coinsurance	Deductible and Coinsurance Deductible and Coinsurance
Vision Exams <ul style="list-style-type: none"> • Diagnostic (to diagnose an illness) • Preventive (routine exam including refraction) 	See Physician Office Services Not Covered	See Physician Office Services Not Covered
Wigs	Not Covered	Not Covered
All Other Covered Services	Deductible and Coinsurance	Deductible and Coinsurance

Prescription Drugs	In-network Provider	Out-of-network Provider
<i>Retail – per 30-day supply</i> <ul style="list-style-type: none"> • Generic drugs (including non-preferred contraceptives) • Preferred Brand Name Drugs • Non-preferred Brand Name Drugs 	\$10 Copay \$30 Copay \$50 Copay	50% Coinsurance 50% Coinsurance 50% Coinsurance
NOTE: A 90-day supply is available at an Extended Supply Network subject to 3 copays		
<i>Home Delivery – per 90-day supply</i> <ul style="list-style-type: none"> • Generic drugs (including non-preferred contraceptives) • Preferred Brand Name Drugs • Non-preferred Brand Name Drugs 	\$30 Copay \$90 Copay \$150 Copay	Not Covered Not Covered Not Covered
<i>Specialty drugs</i> (specialty drugs must be purchased through a designated specialty pharmacy)	\$100 Copay	Not Covered
Contraceptives <ul style="list-style-type: none"> • Preferred <ul style="list-style-type: none"> - Generic - Brand Name • Non-preferred <ul style="list-style-type: none"> - Generic - Brand Name 	Plan Pays 100% Plan Pays 100% Same as any other Generic Drugs Same as any other Non-preferred Brand Name	50% Coinsurance 50% Coinsurance
Diabetic Insulin <ul style="list-style-type: none"> • Preferred <ul style="list-style-type: none"> - Generic - Brand Name • Non-preferred <ul style="list-style-type: none"> - Generic - Brand Name 	Plan Pays 100% Plan Pays 100% Same as any other Generic Drugs Same as any other Non-preferred Brand Name	50% Coinsurance 50% Coinsurance

This plan uses a prescription drug list (PDL). The PDL for this plan is 40, and the Pharmacy Network is C. You can find this prescription drug list and network listing on www.NebraskaBlue.com. Or you may contact Member Services at the phone number on the back of your I.D. card.

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