BlueCross BlueShield Nebraska

INDIVIDUAL PRODUCTS

Agent Administration Guide

Jan. 1, 2025

PURPOSE

This guide is intended to assist you in selling Blue Cross and Blue Shield of Nebraska's (BCBSNE) individual insurance products. By outlining our offerings, eligibility rules and business processes, we are providing you with the important information you need to represent BCBSNE to your clients as you help them navigate today's complex marketplace.

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BROKER RESOURCES

Broker Business Portal (BBP)
Brokers.NebraskaBlue.com

All enrollment links are housed in the BBP, including:

- Armor Health renewals
- Nebraska HeartlandBlue
- DentalEssentials
- Medicare Advantage and Supplement
- MedicareBlueSMRx (PDP)
- GeoBlue
- LifeSecure

If you don't have a login, email Broker_Appointment@NebraskaBlue.com

Agent Service Questions
Phone: 888-232-0942
Fax: 402-392-4150
Email: GroupLeader@NebraskaBlue.com

Submit Prerequested Enrollment Documents
Phone: 877-222-2374
Email:
IndContractInstallation@NebraskaBlue.com

Medical Records
Email: MUW@NebraskaBlue.com

Broker Materials
NebraskaBlue.com/Brokers
Access product-specific materials by clicking the links on the right-hand side of the page.
Username: bcbsne
Password: nebraska

Download or Order Marketing Materials
NebraskaBlue.com/MarketingOrder

Armor Health

Underwriting Data Hub Support
Email: Support@UWDataHub.com

Tumbleweed login support
Phone: 888-233-8351
Email: Support.Center@NebraskaBlue.com

Nebraska HeartlandBlue

Broker Business Portal/Enrollment Technical Support or Post-Enrollment Questions (claims, ID cards, etc.)
Phone: 888-232-0942
Fax: 402-392-4150
Email: GroupLeader@NebraskaBlue.com

Pre-Enrollment and Special Enrollment Period Questions
Email: GroupLeader@NebraskaBlue.com

Medicare Advantage

Medicare Advantage DRX Technical Questions
Email: DRXAdmin@bcbsm.com

Provider/Pharmacy Inquiry (If not listed in the directory)
Email: MedAdv@NebraskaBlue.com

Enrollment Status
Phone: 888-860-4335

Medicare Supplement

Medicare Supplement DRX Password Reset
Phone: 888-232-0942
Email: GroupLeader@NebraskaBlue.com

MedicareBlue℠ Rx (PDP)

Pre-enrollment Questions
866-464-3919

Post-enrollment Customer Service
866-849-2498
YourMedicareSolutions.com

MEMBER RESOURCES

Armor Health

Underwriting Data Hub Support
Email: Support@UWDataHub.com

Tumbleweed login support
Phone: 888-233-8351
Email: Support.Center@NebraskaBlue.com

Nebraska HeartlandBlue

Broker Business Portal/Enrollment Technical Support or Post-Enrollment Questions (claims, ID cards, etc.)
Phone: 888-232-0942
Fax: 402-392-4150
Email: GroupLeader@NebraskaBlue.com

Pre-Enrollment and Special Enrollment Period Questions
Email: GroupLeader@NebraskaBlue.com

Medicare Advantage

Medicare Advantage DRX Technical Questions
Email: DRXAdmin@bcbsm.com

Provider/Pharmacy Inquiry (If not listed in the directory)
Email: MedAdv@NebraskaBlue.com

Enrollment Status
Phone: 888-860-4335

Medicare Supplement

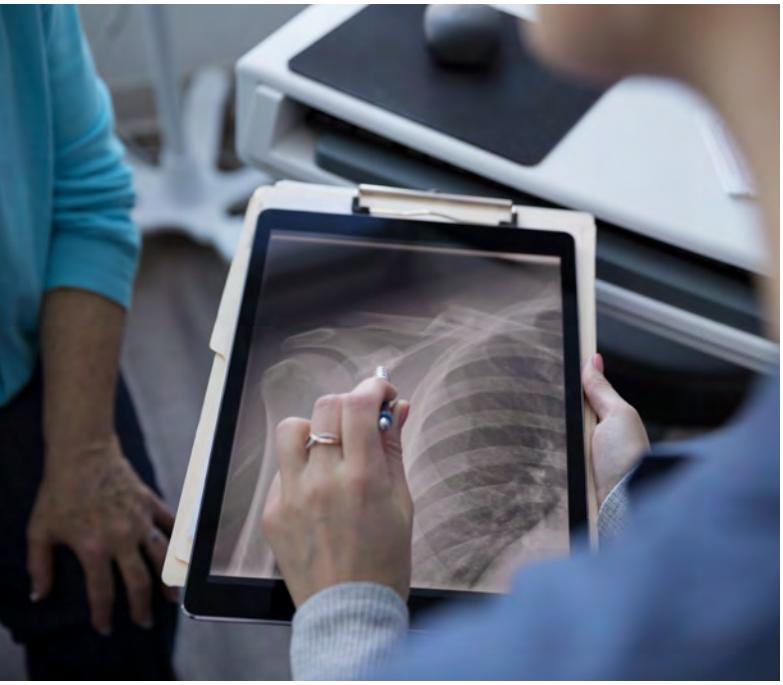
Medicare Supplement DRX Password Reset
Phone: 888-232-0942
Email: GroupLeader@NebraskaBlue.com

MedicareBlue℠ Rx (PDP)

Pre-enrollment Questions
866-434-2037

Post-enrollment Customer Service
888-832-0075
YourMedicareSolutions.com

Armor Health



ABOUT THE PLAN

Armor Health is a Short Term Limited Duration (STLD) enhanced tri-term plan, offering more coverage than traditional short-term plans.

Effective Jan. 1, 2024, Armor Health transitioned from a 12-month to a 36-month STLD plan, consisting of three consecutive terms: 364 days, 365 days and 365 days. Existing members' contracts renew monthly upon premium payment.

PROVIDER NETWORK

Armor Health policies use the NEtwork BLUE statewide network. This includes nationwide access to in-network providers through the BlueCard® program.

ELIGIBILITY

As of Sept. 1, 2024, BCBSNE stopped selling 36-month contracts due to regulatory changes. Current subscribers can make membership changes and add dependents, but new subscriptions are no longer available. Members over 65 or eligible for Medicare are not eligible. Coverage ends the month before a member turns 65. Only Nebraska residents are eligible. Coverage terminates if a member moves out of state, with 30 days' written notice. **Important note:** Medical underwriting and eligibility guidelines apply every 12 months.

GENERAL INFORMATION

Renewals and additions to existing policies are subject to medical underwriting. Armor Health is a tri-term policy; members enroll for three consecutive terms:

Term 1: 364 days (ends at 11:59 p.m.)
Term 2: 365 days
Term 3: 365 days

Armor Health policies are not guaranteed to be renewable. Members may term their coverage at any time during the coverage period. If a member elects to term coverage, they will not be considered eligible for an ACA Special Enrollment Period.

Members will be underwritten annually to determine their premium rate and eligibility for coverage based on claim history, age, sex and tobacco use. Members who become ineligible for coverage based on underwriting will qualify for a Special Enrollment Period to enroll in an off-exchange Nebraska HeartlandBlue ACA plan outside the annual Open Enrollment Period (OEP) which runs Nov. 1 - Jan. 15.

Members over the age of 65 and/or eligible for Medicare are not eligible for coverage under Armor Health. If a subscriber turns age 65 while covered, their coverage will end the last day of the month prior to the month in which they turn 65.

Armor Health is available to Nebraska residents only. If a member moves out of state while covered under Armor Health, coverage will terminate. BCBSNE will provide the member with 30 days written notice of the termination.

AGENT OF RECORD (AOR)

Renewal

An AOR change can be requested for any of the following circumstances for an Armor Health renewal:

1. A member would like to change the agent they are working with to a different agent
2. An agent has changed agencies and would like to move the policy to their new agency
3. An agency would like to change the agent who is working on the policy within the agency
4. A renewal offer is not showing on the BBP under an agent's writing number

For an AOR change to be processed, follow these steps:

1. The AOR form must be filled out completely, including:
   - All applicant information
   - All broker information
   - Member's signature
   - Agent's signature
   - Current date
2. The AOR form must be signed and received within 45 days and at least five days prior to the re-enrollment effective date to Broker_Appointment@NebraskaBlue.com

The commission effective date will be the same effective date as the re-enrollment offer.

Once the form has been submitted, the AOR change will be processed within 2-3 business days. After the change has been completed, an email will be sent to the individual who submitted the request to confirm the change has been processed.

Please note that if a renewal offer has already been processed by another agent and agency, the AOR change will not be processed. If an AOR request is received after the given timeline, the AOR change will not be processed.

For additional information about the AOR process, including appointments and book of business transfers, or to access the AOR forms, visit **NebraskaBlue.com/AOR**. All other AOR questions should be directed to Broker_Appointment@NebraskaBlue.com.

EFFECTIVE DATE CHANGES

Adding a dependent, you must request an effective date, and it must be the first of the month. The effective date cannot be a date prior to submission or a date more than 60 days in the future from submission. Any deductible, coinsurance, preexisting waiting period or limits met under the prior plan will not be credited to the new plan.

Dependent Additions

1. The requested effective date must be within 60 days of the original dependent addition request submission date, on or after the date the request is submitted, and be the first day of the requested month.
2. An effective date requested prior to the current date will not be honored.
3. The request must be received by BCBSNE prior to the 11th day following:
   a. The initially selected effective date or
   b. The subscriber's receipt date of the Schedule of Benefits (SOB). BCBSNE will honor the change of the effective date up to 11 days from the receipt of the SOB if past the original effective date.
4. The subscriber should reconfirm any payment preferences after the new effective date is in place.
5. A new Schedule of Benefits (SOB) will be mailed to the subscriber with the new effective date and premium.

The application for adding a dependent will need to be accepted on the BBP and a copy of the Effective Date Change Request form, signed by the subscriber, must be sent to IndContractInstallation@NebraskaBlue.com. A handwritten request, signed and dated by the subscriber, will also be accepted; however, if any necessary information is missing, we may not be able to process the request.

DEPENDENT COVERAGE AND MEMBER ADDITIONS

Current Armor Health members can add a dependent (spouse or dependent children) to their 36-month policy for the remainder of the contract period, pending eligibility and underwriting guidelines. To add an eligible dependent after the original coverage effective date, members must complete a separate paper application, which is subject to medical underwriting for the dependent only. A twelve-month preexisting condition waiting period applies to added dependents, and applicants can be denied coverage.

Dependents must be added to the existing policy and are subject to its contract term duration. Changing the policy is not permitted. Applications can be found at **NebraskaBlue.com/Brokers/Forms**.

Application Checklist

Applications for dependent additions will be done electronically.

- Complete a paper application (including the requested effective date) for the dependent and email it to MUW@NebraskaBlue.com.
- If an application is not filled out completely, it will not be processed. An email will be sent to the broker alerting them that the application needs to be completed with all required information and resubmitted.
- Applicants must detail health conditions or previous treatments and medications within the last five years for each new dependent/member identified on the application.

* A termination for nonpayment is not considered a cancellation request. For information on reinstatements, please see page 9.

- BCBSNE will complete underwriting and communicate denial or acceptance as well as rates via email to the broker.
- You will have 30 days to respond to the offer, or the application will be voided.

Eligible Children up to Age 26

An eligible dependent is defined as:

- The subscriber's biological or adopted children
- A grandchild who lives with the subscriber in a regular child-parent relationship where the grandchild receives no support or maintenance from the parent and where the subscriber is a court-appointed guardian of the grandchild
- A stepchild (i.e., the child of the subscriber's current spouse)
- A child, other than a grandchild or stepchild, for whom the subscriber is a court-appointed guardian (this does not include a foster child)

When a dependent turns 26, their coverage under the parent or guardian's policy will end at the close of the calendar year. Dependents losing coverage due to this age limit can enroll in an Off-Exchange Nebraska HeartlandBlue plan through a SEP outside of OEP.

Court-Ordered Health Coverage

In the case of court-ordered health coverage by the policyholder for stepchildren or other dependents who are not the natural-born or adopted children of the member, a copy of the court order should be provided. Additionally, a signed dependency statement establishing the relationship between the adult and child may be required in some cases. This documentation may be sent to IndContractInstallation@NebraskaBlue.com.

Newborns and Adopted Children

Coverage will begin at birth for an eligible child born after the policy's effective date. Coverage for a newly adopted child of the subscriber shall begin the date of the placement for adoption or the date of entry of an order granting custody to the adoptive parents for purposes of adoption, whichever is earlier. The first 31 days of coverage will be provided free of charge. Eligible newborns or newly adopted children may be added to a policy by submitting a paper application within 31 days of birth or placement. The newborn or adopted child will be subject to medical underwriting to determine the premium rate, cannot be denied coverage and will **not** have a 12-month waiting period for preexisting conditions. Premiums for the child will begin the first of the month following acceptance of their Armor Health offer.

If an application to permanently add the dependent is not received before the 32nd day of coverage, the child's coverage will end. Applications or adoption documentation received on or after the 32nd day will be treated as a standard dependent addition.

The dependent will be subject to medical underwriting, may be denied and if approved, a 12-month waiting period for preexisting conditions will be applied as of their effective date as a permanently added dependent.

Legal Guardianships

Guardianships are handled on a case-by-case basis and are subject to management review. For questions regarding guardianships, please reach out to Group Leader and Broker Services by calling 888-232-0942.

Other Caregiver Situations

- Foster children, grandchildren, aged parents, brothers and sisters, etc., are not eligible even if they are claimed for income tax purposes
- In questionable cases, including legal guardianship, a signed dependency statement, a copy of the court order or a copy of the income tax return may be requested
- If a child is institutionalized because of a disability, and if the cost of their maintenance is provided by public welfare, the child does not qualify as a dependent under the health insurance policy

Extension of Coverage Under LB551

LB551 allows dependents to continue coverage from age 26 until the end of the calendar year. The dependent must be covered under the policy at the time they turn 26 to be eligible for an extension. The Extension of Coverage Request for Extended Eligibility to Age 30 must be completed. There is no medical underwriting. The form can be found at **NebraskaBlue.com/Brokers/Forms**.

RENEWAL RATES

Existing members will have a passive renewal, but eligibility is not guaranteed. Members are underwritten annually to determine the renewal rate. The cost of coverage is based on factors such as gender, age, geographic area, health and medication history and tobacco usage on an annual basis. All applicants will be individually underwritten and rated based on claims from the past 12 months.

PREEXISTING CONDITIONS

A preexisting condition is defined as a physical/mental condition, regardless of the cause for which diagnosis, care or treatment was recommended or received within the 12-month period prior to the coverage effective date. No benefits will be paid for a preexisting condition or congenital abnormality until coverage under the contract has been in effect for 365 consecutive days.

Maternity care is not a covered benefit under Armor Health, except for the initial diagnosis of pregnancy or complication of pregnancy that occurs prior to the end of pregnancy, is distinct from the pregnancy, but it cause or adversely affected by the pregnancy (c-section and postpartum are not considered complications of pregnancy.).

CANCELLATIONS/TERMINATIONS

Cancellation requests must be received in writing with the subscriber's signature. The subscriber is the individual who is named on the identification card. For a child-only policy, the parent or guardian identified in our records may provide a signature. We will not cancel coverage if the notice is signed by anyone other than the subscriber, parent or legal guardian.

For subscriber-requested cancellations, the policy will terminate on the last day of the month in which the notice is received or on the date noted on the cancellation request, as long as it is the last day of a future month.

We will accommodate end-of-the-month cancellations if the request is signed by the last day of the month and received within three business days. A request for the cancellation of automatic payments is a separate request from the policy cancellation request. To cancel automatic payments, members are asked to visit **myNebraskaBlue.com** to change future payments.

If the member also has dental coverage with us, they should specify whether the cancellation request applies to both Armor Health and dental coverage, or if they wish to keep one active. If the request does not explicitly state which contract to terminate, both the health and dental coverage will end.

Retroactive Terminations

We will allow retro-termination dates, before the date of notification, only in the event of a member's death. Proof of the date may be required.

Terminations Due to Death and Refund Rules[1]

In the event of the death of a subscriber, the policy will terminate on the last day of the month. The remaining members on the policy would be eligible for a SEP to enroll on an off-exchange Nebraska HeartlandBlue plan outside of OEP.

Upon receipt of a request for a pro-rata refund by a legal representative, BCBSNE will refund the unearned premium prorated to the month of the insured's death if the request has been made within one year after the insured's death, according to Neb. Rev. Stat. 44-310. If the premium refund request is made to BCBSNE beyond a year from the date of death and the member is currently active, we will refund no more than one year's premium. If BCBSNE is notified of the death and the member was already termed beyond a year from the date of the request, we are under no obligation to refund past premiums.

Reinstatement

The member may request their coverage be reviewed for reinstatement. They must submit payment online, over the phone (IVR), or mail in a cashiers check or money order for all past due, current and the next month's coverage with the reinstatement form. Checks are not accepted for reinstatement review. Reinstatement forms can be obtained **by calling the Member Services number listed on their ID card. If you have questions, please reach out to Group Leader or Broker Services at 888-232-0942.**

Reformation or Rescission of Membership

The medical questionnaire should be completed in its entirety, and include any health conditions or previous treatment and medications in the last five years for each individual on the application to prevent reformation or rescission.

If the applicant or someone acting on their behalf commits an act of fraud or makes an intentional misrepresentation of material fact involving the application for this contract or benefits payable under this contract, we may make a premium adjustment or rescind the coverage.

[1] Once the new STLD laws are in eff, we will not be able to continue a policy even due to death (unless final law specifies otherwise).

COMMUNICATIONS

You and your client will receive communications from us through email/BBP as necessary, including when:

- Any case-specific questions or information is needed to process the application
- Medical records are requested and/or have not been received
- An offer is pending in the BBP
- An application has been reviewed through medical underwriting

MEDICAL UNDERWRITING

Medical underwriting may review claim history of up to five years for previous BCBSNE members. For applicants who are not previous BCBSNE members, Underwriting will review the information on the health application as well as medical records (if applicable). For family memberships, each member is individually medically underwritten.

Medical underwriting is required under the following circumstances:

- Newborns of the subscriber or eligible dependent of a subscriber for continued coverage after the first 31 days
- Adopted child(ren) of a subscriber for continued coverage after the first 31 days
- Eligible dependents added to a single or family membership unit

Note: For more information regarding rate reconsiderations, please refer to the BBP.

OTHER POLICY PROVISIONS

Benefit Accumulators

Benefit accumulators track the dollar amounts applied toward a member's deductible and coinsurance maximum and day limits for non-essential benefits. These amounts/limits can be found within the contract and/or Schedule of Benefits Summary. Benefit accumulators incurred while enrolled in Armor Health will not follow the member in the event of a change/transfer request to or from another plan or upon renewal of Armor Health at the end of the 12-month benefit year.

Lifetime Accumulators

Lifetime accumulators track the dollar amounts paid by BCBSNE. Armor Health has a $1,000,000 lifetime maximum limit. Lifetime accumulators apply to every Armor Health contract with or without lapse, per person. Those reaching the dollar amount will terminate coverage on the date the claim that meets the lifetime maximum is processed.

Coordination of Benefits (COB)

Members with more than one health or dental plan for themselves, spouse and dependents must complete a Coordination of Benefits (COB) form. COB allows BCBSNE to work with other health and dental carriers to reduce out-of-pocket expenses for medical, dental and pharmacy claims. Individuals eligible for Medicare are ineligible for Armor Health. The COB questionnaire can be found on **NebraskaBlue.com/Forms**.

Area Member Moves

Armor Health is area rated. If a member moves within their existing geographic area, there will not be a change in the rate. If a member moves between rating areas, the billing will be updated to reflect the premium for the new area. Billing changes will be effective the first of the month following a 30-day notice. Moves out of state will render the contract ineligible and terminate at the end of the month in which the address change occurred.

PAYMENT OPTIONS

Members may choose to set up the monthly premium to be automatically withdrawn from their bank account via their **myNebraskaBlue.com** account or to choose bill direct on a monthly billing cycle. If a member wishes to set up banking information, they may select:

Automatic Payments

Members may set up automatic payments for the 20th of each month to pay in full for the following month. This date is not flexible; however, if the premium amount changes, members do not need to update their payment information.

Recurring payments

Recurring payments allow the member to schedule any date for the withdrawal and any amount so long as the full premium due is paid by the end of the month.

Because premium amounts may change, current members who have recurring payments set up will need to update their payment information.

Members may also make one-time web payments or pay via phone.

Direct Bill

If the member does not elect online payment options, they may mail a check with the billing remittance slip to

MAILING ADDRESS

Blue Cross and Blue Shield of Nebraska
PO Box 2638
Omaha, NE 68103-2638

All check payments, including bank bill payments, must include the remittance slip or could risk being returned as unable to process.

Late Payments and Insufficient Funds

A grace period for late premium payment is outlined in the policy contracts. If the premium is not received within 10 days of the due date listed on the invoice, the member will begin to receive notices of past-due premium.

If there are insufficient funds in the member's bank account on the regularly scheduled withdrawal date, a second withdrawal attempt may be made one to two days later. If there are still insufficient funds, the member will be notified of the returned payment, they have until the end of their contract grace period to make the payment or their policy may terminate for nonpayment, and they will have to go through the reinstatement process, if eligible. **Members should contact their payment institution to dispute or get details on any insufficient funds or denied payments.**

Third-Party Payment Policy

Payments made by a third-party payer for premiums or cost-share amounts on behalf of covered persons will not be accepted unless otherwise agreed to by BCBSNE, or as otherwise required by law. To be considered for a third-party payer option, the payer and member need to complete additional financial forms. These can be found at **NebraskaBlue.com/Brokers/Forms**

A third-party payer is defined as any person or entity not covered by this contract remitting payment(s) for premiums or applicable cost-share amounts on behalf of the subscriber.

Nebraska HeartlandBlue

ABOUT THE PLAN

BCBSNE is proud to offer Affordable Care Act (ACA) plans. ACA plans are grouped into different categories, often referred to as "metallic levels." These categories indicate how costs (coinsurance) are split between the member and the insurance plan. Nebraska HeartlandBlue plans are available in Bronze, Silver, Gold, as well as Standard. These plans are available both on- and off-exchange to all Nebraskans who are not eligible for Medicare.

On-exchange plans are eligible for Advanced Premium Tax Credits (APTC) and Silver plans are eligible for both APTC and Cost-Sharing Reduction. Standard plan options are available as required by CMS.

Nebraska HeartlandBlue plans offer the 10 essential health benefits and follow QHP cost-sharing limits. These essential health benefits include:

1. Outpatient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Pediatric services, including dental and vision
10. Preventive and wellness services and chronic disease management

PROVIDER NETWORK

Nebraska HeartlandBlue plans offer a variety of ACA coverage options for Nebraskans. These options include both Exclusive Provider Organization (EPO) options as well as Preferred Provider Organization (PPO) options.

With EPO plans, services are covered when you use doctors, hospitals and other health care providers in your network. Services received from providers outside the network (or outside the state of Nebraska) are not covered except for an emergency (with appropriate coding per the Consolidated Appropriation Act), or for services received at an urgent care facility. Individuals can self-refer to a specialist and are not required to select a primary care physician. Members should visit **NebraskaBlue.com/DoctorFinder** or call the number on the back of their member ID card to locate an in-network provider. View a listing of which networks are available in each county by visiting **NebraskaBlue.com/HeartlandBlue**.

Like EPO plans, PPO plans offer the best benefits when you receive services from doctors, hospitals and other health care providers within your network. What's more, PPO plans do cover services for providers that are outside of your health plan's network, but this coverage won't have the benefits associated with in-network providers such as lower cost sharing and lower contracted amounts. PPO plans also offer in-network providers nationwide through our BlueCard® network.

For members traveling outside the state of Nebraska, telehealth services are available. Members may utilize any in-network provider that offers telehealth services.

Nebraska HeartlandBlue plans offer telehealth services through Amwell®.

Premier Select BlueChoice HB

Premier Select BlueChoice HB network features Nebraska Methodist Hospital System and Nebraska Medicine. Key hospitals and health care providers in the Premier Select BlueChoice network include:

- Nebraska Methodist Hospital System
- Nebraska Medicine
- Children's Nebraska
- Boys Town National Research Hospital
- Bryan Health

All other Nebraska Providers are out of network.

To find doctors and hospitals in Premier Select BlueChoice HB, visit **NebraskaBlue.com/PremierSelectBlueChoiceHB**

Blueprint Health HB

Blueprint Health HB network features CHI Health. Key hospitals and health care providers in the Blueprint Health HB network include:

- CHI Health System
- Children's Nebraska
- Boys Town National Research Hospital
- Nebraska Spine Hospital

All other Nebraska providers are out of network.

To find doctors and hospitals in Blueprint Health HB, visit **NebraskaBlue.com/BlueprintHealthHB**.

NEtwork BLUE HB

NEtwork BLUE HB is our statewide network, made up of 98% of Nebraska's doctors and 99% of non-governmental acute care hospitals.[1]

*According to BCBSNE statistics, June 6, 2024.

To find doctors and hospitals in NEtwork BLUE HB, visit **NebraskaBlue.com/NEtworkBlueHB**

Amwell is an independent company that provides telehealth services for Blue Cross and Blue Shield of Nebraska.

Telehealth Services

Nebraska HeartlandBlue offers telehealth services through Amwell, the industry's leading telehealth solution. In addition to Amwell, members can visit with their in-network provider virtually if the provider offers telehealth capabilities. With telehealth services, members can access a nationwide network of U.S. board-certified physicians, available for live visits over the computer, tablet or phone, in less than 10 minutes. Amwell visits are often less than an emergency room, urgent care or even in-office doctor visits.

Telehealth Behavioral Health Services

With telehealth behavioral health services, Amwell's licensed therapists are available by appointment from 7 a.m. to 11 p.m. local time, seven days per week to provide treatment for the following conditions:

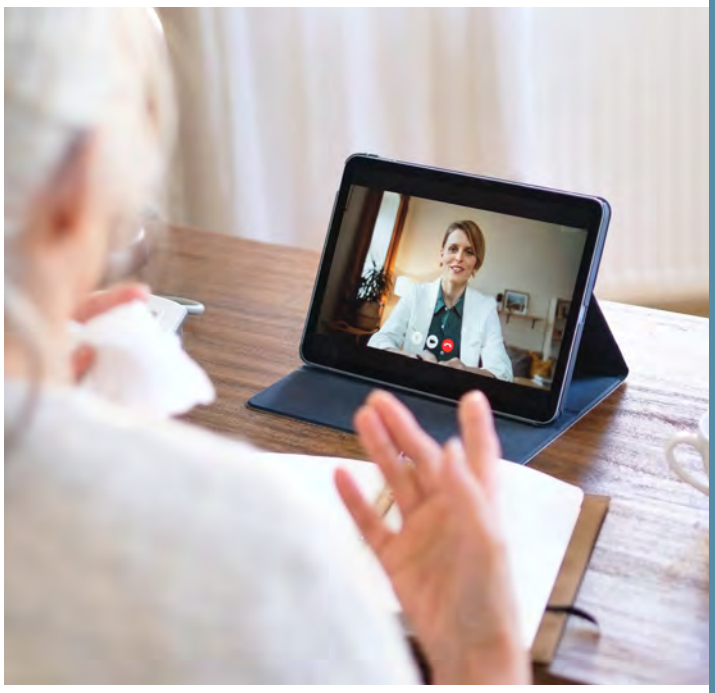
- Anxiety
- Depression
- Attention deficit hyperactivity disorder (ADHD)
- Obsessive-compulsive disorder (OCD)
- Trauma/post-traumatic stress disorder (PTSD)
- Bereavement
- Panic attacks
- Stress

AGENT OF RECORD (AOR)

An AOR change may occur automatically when a member re-enrolls into a plan or makes a change during an SEP event. For off-exchange enrollments, refer to the Armor AOR. For on-exchange enrollments, all AOR changes must be processed through an updated application through the Marketplace along with an updated broker consent form.

ELIGIBILITY

Application for coverage is limited to initial or annual enrollment through OEP or a SEP. Upon acceptance by BCBSNE of an application and payment of applicable premiums, coverage shall commence following the applied effective date.



New Health Applicant and Current Member

Members must be, and remain, a resident of the State of Nebraska and pay the premium by the due date. Individuals must complete an application truthfully and elect an enrollment type (single, family, or child-only). All dependents for whom coverage is requested must meet the definition of an eligible dependent.

Types of Enrollments Available

Single Membership: Covers a primary applicant.

Family Membership: Covers primary applicant and eligible dependent(s). This may include your spouse and/or eligible dependent children to age 26.

Child-Only: Covers an individual child 18 or younger.

Child-only coverage is available for children through the age of 19 as a single policy; child-only enrollment is only available during open enrollment or as a special enrollment period following effective date rules.

SPECIAL ENROLLMENT PERIOD

The below SEP guidelines apply for off-exchange enrollments. For details regarding on-exchange SEP enrollments refer to **Healthcare.gov** for eligibility and effective dates. If a member has not previously enrolled for coverage, they may be able to enroll during SEP. To view a full outline of SEP events, visit **NebraskaBlue.com/SEP**.

Uploading Off-Exchange-Required Documentation

Once the application has been submitted, brokers can submit required documentation by visiting **NebraskaBlue.com/ACAPayment** and select Upload Documents, enter the required subscriber's details and drag or drop the required documents into our system electronically.

*Please wait 24-48 hours before uploading documents to ensure the application is processed. The off-exchange policy will only be issued once all required documentation has been received.

FREE-LOOK PROVISIONS

If, after examination of a contract, members are not satisfied for any reason it may be returned to BCBSNE or its agent within 10 days of its delivery. If returned, any premium paid will be refunded, the contract will be retroactively voided and all parties will be in the same position as if no contract had been issued. This provision does not allow for changing an effective date.

DEPENDENT COVERAGE AND MEMBER ADDITIONS

Coverage is available for dependents including spouses and children up to age 26 per our eligibility guidelines (see Special Enrollment Section for ACA). In the case of court-ordered health coverage by the policyholder for stepchildren and/or other dependents who are not the natural-born or adopted children of the member, a copy of the court order should be provided.

Disabled Dependents and Extension of Dependent Coverage

Upon reaching age 26, a covered child will still be considered eligible for coverage through the end of the year. If he or she is physically or mentally disabled and is dependent on the member for support and maintenance. A premium increase from a dependents rate to the amount equivalent to a single member premium will apply upon approval.

If a child is institutionalized because of a disability, and if the cost of his/her maintenance is provided by public welfare, the child does not qualify as a dependent under the health insurance plan.

Adopted Children

Coverage for an adopted child will be effective on the date the child is placed with the parent for adoption or the date a court order grants custody, whichever is earlier. Adopted children must be enrolled within 60 days of the placement/custody order. If the child is adopted at birth, they may qualify for free 31 days of coverage to an existing policy. Only newborn adopted children are free for the first 31 days when added as of their date of birth.

Legal Guardianship

Subscriber is a court-appointed guardian of the grandchild or a child, other than a grandchild or stepchild (this does not include a foster child).

Grandchildren

Your grandchild(ren) is considered an eligible dependent if they live with you (the subscriber) in a regular parent-child relationship, and you provide financial support. The grandchild cannot receive any support or maintenance from the parent, and you must be a court-appointed guardian. If the parent of the grandchild is a covered dependent at the time of birth, the member may add the grandchild for the first 31 days. Thereafter, the grandchild must meet the above-referenced eligibility definition and provide documentation showing legal guardianship to continue the coverage.

Other Caregiver Situations

Foster children, aged parents, brothers and sisters, etc., are not eligible even though they may be claimed for income tax purposes.

In questionable cases, a signed dependency statement, a copy of the court order paperwork or a copy of the income tax return may be requested.

Newborn Children

Coverage for a newborn child begins at birth and is free for the first 31 days. To add coverage during this SEP, members can visit **myNebraskaBlue.com** or contact the Marketplace. The request must be made within 60 days of the birth.

To continue coverage after the first 31 days, a change request to family membership must be made within 31 days of the birth, and the additional premium must be paid. On-exchange members can make changes through **myNebraskaBlue.com** by clicking on "Report a Change," through their broker or by contacting the Marketplace. For off-exchange members, brokers can email GroupLeader@NebraskaBlue.com to request the permanent addition of the newborn. Off-exchange members need to return the letter and dependent details by uploading them on **myNebraskaBlue.com**.

Court-Ordered Health Coverage

For a dependent child, whose parents are divorced or separated or not living together, whether or not they have ever been married, a court decree will determine responsibility for the child's health care coverage and order of benefits.

Extension of Coverage Under LB551

Nebraska law allows a dependent who is no longer a full-time student, or who becomes older than the specified age at which coverage ends pursuant to the plan, to continue coverage through the end of the month in which the dependent: (a) marries; (b) is no longer a resident of the state, unless the child is under 19 years of age or is enrolled on a full-time basis in any college, university or trade school; (c) receives coverage under another health benefit plan or self-funded employee benefit plan; or (d) turns 30 years of age. The subscriber will be billed an additional premium for such coverage equivalent to that of a single adult.

This form must be completed and returned to BCBSNE prior to the end of the coverage year.

On-exchange members must make their changes through **myNebraskaBlue.com**, their broker or by contacting the Marketplace.

There is no medical underwriting. The Extension of Coverage Request form can be found at **NebraskaBlue.com/Brokers/Forms**.

At the end of the contract benefit period, the dependent will no longer qualify for coverage under LB551. To continue coverage, they will need to apply as a new applicant.

PREMIUM RATES

Premium rates will be reviewed during the renewal period and adjusted each year. BCBSNE policies are rated by age, geographical area and tobacco use.

PRE-EXISTING CONDITIONS

All Marketplace plans must cover treatment for pre-existing medical conditions.

- No insurance plan can reject, charge more or refuse to pay for essential health benefits for any condition present before your coverage started.
- Once enrolled, the plan can't deny coverage or raise rates based only on health.
- Medicaid and the Children's Health Insurance Program (CHIP) also can't refuse to cover you or charge you more because of your preexisting condition.

CANCELLATIONS/TERMINATIONS

On-exchange members must terminate their policy by contacting the Marketplace. On-exchange members can access the Marketplace by logging into their **myNebraskaBlue.com** account and clicking on "Report a Change." Off-exchange members can submit a request by logging into their **myNebraskaBlue.com** account and sending a message via contact us. They can also call the member services number on their ID card to request termination. Brokers can obtain a signed request from the subscriber to term coverage, completed forms can be sent to **GroupLeader@NebraskaBlue.com** for processing.

For a child-only policy, the parent or guardian identified in our records will have access to the member portal. Requested cancellations will terminate at the end of the month in which the cancellation was received.

Retroactive Terminations

BCBSNE will follow CMS guidelines regarding the retroactive termination process. For on-exchange plans please contact **Healthcare.gov** to process a retroactive termination.

For off-exchange plans —

We will allow termination dates prior to the date of notification only in the following situations:

- Divorce (proof of the date may be required), or death (proof of the date may be required), or
- You are a current policy subscriber and receive late notification of Medicaid eligibility (proof may be required).

Maximum refunds for a retroactive termination will not exceed 12 months in premium.

Reinstatement

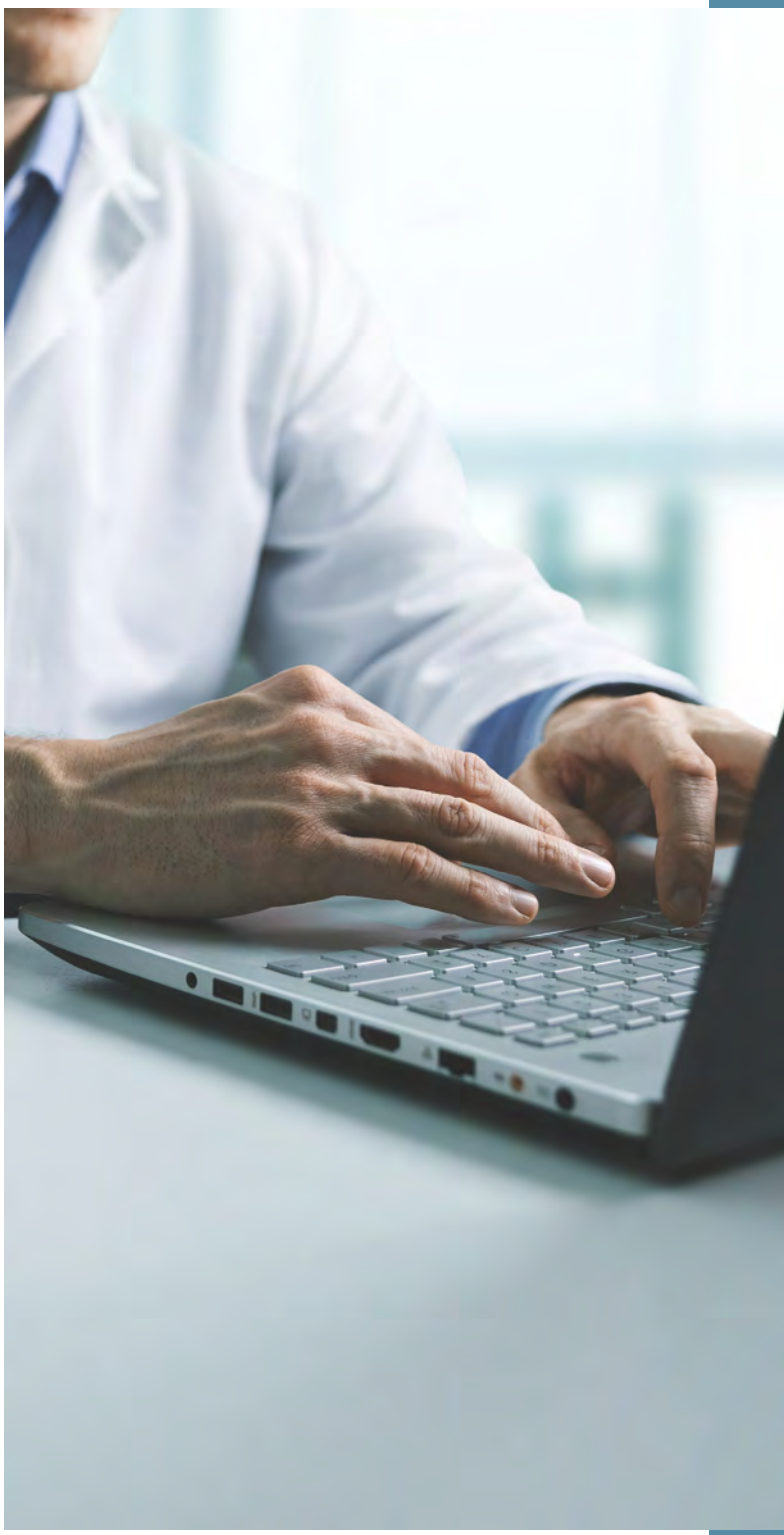
The member may request their coverage be reviewed by submitting a reinstatement form. They must submit payment or mail in a cashiers check or money order for all past due, current and the next month's coverage with the reinstatement form. Checks are not accepted for reinstatement review. Reinstatement forms can be obtained **by calling the Member Services number listed on their ID card. If you have questions, please reach out to Group Leader or Broker Services at 888-232-0942.**

Reformation or Recission of Membership

If a member or someone acting on behalf of the member commits an act of fraud or makes an intentional misrepresentation of material fact involving the application for coverage, or benefits payable under this coverage, we may make a premium adjustment or rescind the coverage.

The right of reformation applies to someone who is issued a contract at non-tobacco user rates when it is determined that the approval of such rate was based upon a material misrepresentation of the applicant's tobacco use. Documentation of tobacco use discovered in submitted claims may also be considered documented tobacco use and premiums may be adjusted accordingly.

BCBSNE limits its right of reformation or rescission to the first two years of coverage except for non-disclosed tobacco use or in cases where tobacco use starts or resumes.



COMMUNICATIONS

When applying, members may choose to receive written or email correspondence. If choosing email, they will receive correspondence such as billing statements, notices, tax forms, explanations of benefits (EOB) and marketing communications via email. If a spouse or other dependent would like to receive electronic communications, they may do so in the **myNebraskaBlue.com** account.

MEDICAL UNDERWRITING

Medical underwriting is the process used by insurance companies to review your demographic information and medical history to determine eligibility for coverage and premium amount. ACA plans cannot be medically underwritten.

APPLICATION PROCESS FOR NON-TOBACCO

Premiums may be adjusted as of Jan. 1 of each year or during an SEP event.

COMMON ACA TERMS

Domestic Partner

BCBSNE plans allow all legal spouses – same-sex and common law marriage from another state – but this excludes domestic partners.

Standardized Plans

The Department of Health and Human Services has required standardized plan designs be offered by all qualified health plan insurers in every product network type, metal level and throughout every service area a non-standardized plan option is offered. Standardized plans are plan options that offer the same deductibles, copayments and cost-sharing across all carriers.

Out-of-Pocket Limit

The total amount of cost-sharing a member is required to pay toward the cost of health care, this includes the deductible, coinsurance and any copays on the plan. After the annual out-of-pocket limit is reached, the policy pays covered services at 100% for the rest of the calendar year. The out-of-pocket limit does not include premium amounts, amounts over the allowable charge, charges for noncovered services or penalties for failure to comply with certification requirements or as imposed under the Rx Nebraska Prescription Drug Program.

Deductible

The fixed dollar amount members pay for covered health services each plan/policy year before the health plan begins to pay.

Embedded Deductible

If a member has an embedded deductible and out-of-pocket maximum their family members may combine their covered expenses to satisfy the required family deductible or out-of-pocket maximum; however, no one family member contributes more than their individual deductible or out-of-pocket maximum amount to satisfy the family deductible or out-of-pocket maximum.

Coinsurance

The percentage of the bill the member pays for covered services after their deductible has been met.

Copay

A fixed amount members pay when they get a covered health service. For example, a doctor's office visit.

Benefit Accumulators

If the member has an SEP occurrence mid-year their benefit accumulators may change if moving to a different plan. Please reach out to our broker services team for guidance prior to making a change for the member.

Lifetime Maximum

The maximum dollar amount the policy will pay for covered services during a covered person's lifetime. ACA plans do not have a lifetime maximum.

Coordination of Benefits (COB)

Members with more than one health or dental coverage for themselves, spouse and dependents require a Coordination of Benefits (COB). COB allows BCBSNE to work with other health and dental carriers to reduce out-of-pocket expenses for medical, dental and pharmacy claims. Individuals already enrolled in Medicare are ineligible for Nebraska HeartlandBlue but if they are enrolled in Nebraska HeartlandBlue prior to becoming eligible for Medicare, they can keep the Nebraska HeartlandBlue policy and enroll in Medicare at the same time but will not qualify for APTC or CSR.

Area Member Moves

Members moving to a new area would need to make the request via broker or online to change address. A network change may also be required. Any new rate would be applicable based on the effective date of the billing period for the next month and would be communicated via the process when making this change.

Mid-Year Transfers

Mid-year transfers are triggered by an SEP event. See SEP guidance on **Healthcare.gov**.

PAYMENT OPTIONS

Members may choose to have monthly premiums automatically withdrawn from a bank account or billed direct on a monthly billing cycle. Updates can be made to payment options along with partial and advance payments through the member's myNebraskaBlue online account.

A grace period for late premium payment is outlined in the policy contract.

If insufficient funds occur on the regularly scheduled withdrawal date, a second withdrawal attempt may be made one to two days later. If payment via check is returned we may attempt to process a second time via check processes. If this check is returned again we may attempt two additional times via ACH process. If the second attempt encounters insufficient funds, then coverage may terminate and members will have to go through the reinstatement process. Electronic payments may be canceled if multiple payments are returned in a row. Subscribers will receive communication regarding payment status and processing.

Direct Bill

Members can elect to remit a check, money order or one-time online payment. When remitting a check or money order, please ensure payment is received prior to the invoice due date to avoid any impacts to coverage. Please ensure that the remittance coupon from the invoice is also included in the envelope to ensure accurate posting of the payment.

BLUE CROSS AND BLUE SHIELD OF NEBRASKA
P.O. Box 505628
St. Louis, MO 63150-5628

FOR COURIER DELIVERY ONLY

Bank of America Lockbox Services BLUE CROSS AND BLUE SHIELD OF NEBRASKA and LBX # 505628
800 Market Street, 4th Floor
St. Louis, MO 63101

Late Payments and Insufficient Funds

Payments received after the due date could result in the policy being suspended or terminated. If a payment were made and returned for any reason from the member's financial institution this could also impact coverage. **Members should contact their payment institution to dispute or get details on any insufficient funds or denied payments.**

Partial Payments and Advance Payments

Updates can be made to payment options along with partial and advance payments through the member's myNebraskaBlue online account.

Third-Party Payment Policy

Payments made by a third-party payer for premiums or cost-share amounts on behalf of covered persons will not be accepted, unless otherwise stated on the subscriber's enrollment application or by agreement with BCBSNE, or as otherwise required by law. Third party payer is defined as any person or entity not covered by this contract remitting payment(s) for premiums or applicable cost-share amounts on behalf of the subscriber.

Dental Essentials

ABOUT THE PLAN

BCBSNE offers three DentalEssentials options. Policies may be purchased as stand-alone, or in combination with other coverage for both individuals and families.

PROVIDER NETWORK

DentalEssentials uses a dental network (the same as group dental products) that provides access to providers across the state and nationally. The provider directory is available online.

AGENT OF RECORD (AOR)/PLAN CHANGES

BCBSNE accepts an AOR change on DentalEssentials policies with a policy change. For example, if the member moves from Option 2 to the Enhanced option, then the AOR change will be accepted. AOR changes will not be accepted without a plan change. Plan changes can only be made during renewal and adding dental to an existing medical policy will not change the AOR.

To receive an AOR change:

At the time of application or renewal, AOR will automatically be transferred to the agent submitting the application.

FAX: 402-548-4685
EMAIL: Broker_Appointment@NebraskaBlue.com

Applicable commissions will be paid to the new agent per current commission guidelines based upon the original effective date of the policy, as outlined in the agency agreement.

For additional information about the AOR process including appointments and book of business transfers or to access the AOR forms, visit **NebraskaBlue.com/AOR**. All other AOR questions should be directed to Broker_Appointment@NebraskaBlue.com.

ELIGIBILITY

To be eligible for DentalEssentials, the applicant must be:

- A Nebraska resident
- Age 19 or over
- Not currently eligible for group dental coverage through BCBSNE

ENROLLMENT

Consumers can enroll in dental coverage either as a stand-alone plan or combined with health coverage. To enroll, visit **NebraskaBlue.com/GetDental** and submit an online application. The coverage effective date will be the first of the month following approval of the application.

When applying for health and dental coverage at the same time, the primary insured has to be the same on both health and dental coverage in order to receive one billing. When applying for a Medicare Supplement plan and dental coverage at the same time, both plans will be enrolled together and the member will receive one bill for both plans.

Armor Health, Nebraska HeartlandBlue and Medicare Supplement members members will have the opportunity to enroll in dental at their renewal period (if eligible). The dental effective date will coincide with the renewal date. Purchasing dental during the health renewal will waive the six-month waiting period for B services.

Free-Look Provisions

The new member has 10 business days from the contract mail date to contact us to cancel coverage and receive a full refund. This provision does not allow for changing an effective date.

PREMIUM RATES

Premiums may be based on age and plan option selected as of the annual renewal date each year.

CANCELLATIONS/TERMINATIONS

Cancellation requests must be received in writing with the subscriber's signature. The subscriber is the individual who is named on the identification card. We will not cancel coverage if the notice is not signed by the subscriber.

The contract will terminate at the end of the period for which premiums have been paid or an earlier date if specified in the cancellation request. All terminations will end at the end of the month in which the notice was received.

We will accommodate end-of-the-month terminations if the request is signed by the last day of the month and received within three business days. A request for the cancellation of automatic payments is a separate request from the policy cancellation request. To cancel automatic payments, members are asked to visit **myNebraskaBlue.com** to change future payments.

If a member has health and dental coverage with us, they should specify whether the termination request applies to both coverages or if they wish to keep one active. If the cancellation request does not explicitly state which contract to terminate, both the health and dental coverage will be termed.

A spouse or dependent may request to be termed at the end of the month with a signed, written request.

Retroactive Terminations

We will allow retro-termination dates, before their date of notification, only in the event of a member's death. Proof of the date may be required.

Terminations Due to Death and Refund Rules

Subscriber terminations due to death may be the date of death or the last day of the month. The remaining family members on the policy may be able to continue coverage. Please reach out to Group Leader and Broker Services at 888-232-0942 to determine how to cancel coverage and transition the remaining family members.

Upon receipt of a request for a pro-rata refund by a legal representative, BCBSNE will refund the unearned premium prorated to the month of the insured's death if the request has been made within one year after the insured's death, according to Neb. Rev. Stat. 44-310. If the premium refund request is made to BCBSNE beyond a year from the date of death and the member is currently active, we will refund no more than one year's premium. If BCBSNE is notified of the death and the member was already termed beyond a year from the date of the request, we are under no obligation to refund past premium.

Reinstatement

The member may request their coverage be reviewed for reinstatement. They must submit payment online, over the phone (IVR), or mail in a cashiers check or money order for all past due, current and the next month's coverage with the reinstatement form. Checks are not accepted for reinstatement review. Reinstatement forms can be obtained **by calling the Member Services number listed on their ID card. If you have questions, please reach out to Group Leader or Broker Services at 888-232-0942.**

Reformation or Rescission of Membership

If the applicant or someone acting on their behalf commits an act of fraud or makes an intentional misrepresentation of material fact involving the application for this contract or benefits payable under this contract, we may make a premium adjustment or rescind the coverage.

OTHER POLICY PROVISIONS

Waiting Periods

- Benefits for Coverage B services are subject to a six-month waiting period from the effective date of coverage.
    - New and renewing BCBSNE Medicare Supplement, Armor Health or Nebraska HeartlandBlue members who are applying for dental at the same time as their health coverage, will have their Coverage B waiting period waived.

      Note: This does not apply if an existing BCBSNE member transfers from one medical or dental plan to another. Adding or changing DentalEssentials coverage can be done at renewal (effective on the renewal date).
- Benefits for Coverage C services are subject to a 12-month waiting period from the effective date of coverage.

Policy Changes

DentalEssentials is not underwritten; moves between the coverage options are allowed at renewal by submitting a DentalEssentials application on **NebraskaBlue.com/GetDental**.

Policy changes are effective the first of the month following the approval of the change.

If the member is requesting to move to a plan with a higher calendar year maximum or additional benefits, the waiting period for C services will start over.

PAYMENT OPTIONS

Members may choose to set up the monthly premium to be automatically withdrawn from their bank account via their **myNebraskaBlue.com** account or to choose bill direct on a monthly billing cycle. If a member wishes to set up banking information, they may select:

Automatic Payments

Members may set up automatic payments for the 20th of each month to pay in full for the following month. This date is not flexible; however, if the premium amount changes, members do not need to update their payment information.

Recurring payments

Recurring payments allow the member to schedule any date for the withdrawal and any amount so long as the full premium due is paid by the end of the month. The member is responsible for updating this payment method if the premium amount changes.

Members may also make one-time web payments or pay via phone.

Direct Bill

If the member does not elect online payment options, they may mail a check with the billing remittance slip to

MAILING ADDRESS

Blue Cross and Blue Shield of Nebraska
PO Box 2638
Omaha, NE 68103-2638

Or overnight your payment to (for carriers other than USPS):

First National Bank of Omaha
Attn: Blue Cross and Blue Shield of Nebraska, Inc. and LBX # 2638
1620 Dodge St
Omaha, NE 68197-2204

All check payments, including bank bill payments, must include the remittance slip or could risk being returned as unable to process.

Late Payments and Insufficient Funds

A grace period for late premium payment is outlined in the plan contracts. If the premium is not received within 10 days of the due date listed on the invoice, the member will begin to receive notices of past-due premiums.

If there are insufficient funds in the member's bank account on the regularly scheduled withdrawal date, a second withdrawal attempt may be made one to two days later. If there are still insufficient funds, the member will be notified of the returned payment. They have until the end of their contract grace period to make the payment, or their policy may terminate for nonpayment and they will have to go through the reinstatement process, if eligible.

Third-Party Payment Policy

Payments made by a third-party payer for premiums or cost-share amounts on behalf of covered persons will not be accepted unless otherwise agreed to by BCBSNE, or as otherwise required by law. To be considered for a third-party payer option, the payer and member will need to complete additional financial forms. These can be found at **NebraskaBlue.com/Brokers/Forms.**

A third-party payer is defined as any person or entity not covered by this contract remitting payment(s) for premiums or applicable cost-share amounts on behalf of the subscriber.

Medicare Supplement

ABOUT THE PLAN

BCBSNE offers seven standardized Medicare Supplement plans. Each plan offers your clients different levels of coverage to meet their needs and budgets.

PROVIDER NETWORK

Medicare Supplement policies pay secondary to most Medicare-approved claims.

AGENT REQUIREMENTS

Agents are required to follow all guidelines regarding the marketing and sale of Medicare Supplement policies. Our Medicare Supplement plan application and accompanying forms include documentation to show that the required information was provided to or obtained from the applicant in adherence to these requirements.

AGENT OF RECORD (AOR)

An AOR change will occur automatically when a member's plan change (i.e., applying for discount or changing from one plan to another that would require medical underwriting) is approved and processed. Resubmitting an application for a member into the same plan they are already enrolled in will not change the AOR. **AOR change forms will no longer be accepted for Medicare Supplement policies.**

Mandated AOR Changes

As of Oct. 1, 2021, if an agent meets any of the following criteria, it will be the General Agent (GA)/Agency's responsibility to formally transfer the AOR to another appointed agent within the GA/Agency:

1. License expires with the Nebraska Department of Insurance
2. License is terminated by the Nebraska Department of Insurance
3. Discontinues certification for CMS, PDP and/or MAPD lines of business
4. Agent passes away, retires or is terminated

As of Oct. 1, 2021, when any of the above criteria are met, the GA/Agency will need to follow the below processes to re-assign the AOR individual lines of business that are currently assigned to the agent:

1. GA/Agency shall notify the member, via a letter communication, the identity of the newly assigned AOR.
2. GA/Agency shall notify BCBSNE within 30 days via email to Broker_Appointment@NebraskaBlue.com by sending in a copy of the member notification letter along with an excel spreadsheet with the below-required information:
   - Member name
   - Subscription ID
   - Date of Birth
   - Current AOR name
   - Current AOR writing number
   - New AOR name
   - New AOR writing number
3. If the GA/Agency does not notify BCBSNE via email within 30 days of the expiration or termination date of an agent's license, appointment or certification, the accounts will automatically be transferred to a BCBSNE house account. All commissions will cease to be paid to the GA/Agency/Agent effective first of the month following the agent's license expiration date.

ELIGIBILITY

To be eligible for Medicare Supplement, applicants must be enrolled under both Part A and Part B of Medicare and be 65 years of age. Effective Jan. 1, 2025, Part A is available for individuals who are Medicare eligible due to disability and under the age of 65 excluding end-stage renal disease.

All applications must be complete and truthful. The applicant will have to pass medical underwriting requirements, unless the application is submitted during the six-month period beginning with the month in which they are both 65 years of age or older and enrolled for benefits under Medicare Part B or are otherwise eligible for a guaranteed issue contract. Eligibility for a guaranteed issue contract is determined pursuant to the rules and regulations for Medicare Supplement plans. *If false or incomplete information is submitted, coverage may be rescinded, and the member would be ineligible for benefits. The contract will be considered void, and premiums, reduced by any benefits that might have been paid, will be refunded.*

Please note: By law, we cannot sell Medicare Supplement coverage if it duplicates other coverage the customer may have. It is the member's responsibility to terminate existing coverage to prevent duplication. We will not backdate or provide refunds. Medicare Supplement applications, which indicate the existence of other Medicare Supplement or Medicare Advantage coverage, will require a "Notice to application regarding replacement of Medicare Supplement insurance or Medicare Advantage" form signed by the customer with the intent to replace coverage, which is part of the Medicare Supplement application.

As of Jan. 1, 2020, Medicare Supplement plans sold to people new to Medicare won't be allowed to cover the Part B deductible. Because of this, Plans C and F are no longer available to people who are new to Medicare on or after Jan. 1, 2020.

- If a member already has either of these two plans or are covered by one of these plans prior to Jan. 1, 2020, they may keep their plan. If eligible for Medicare before Jan. 1, 2020, but not yet enrolled, they are eligible to apply for one of these plans.
- People new to Medicare are defined as those who turn 65 on or after Jan. 1, 2020, and those who first become eligible for Medicare benefits due to age, disability or ESRD on or after Jan. 1, 2020.

ENROLLMENT

To assist you in providing excellent service to your clients, BCBSNE has an online quote and enrollment tool for Medicare Supplement called DRX. If you need to request access to DRX please contact Broker_Appointment@NebraskaBlue.com for assistance.

Medicare Supplement Contact Information

Medicare Supplement DRX Password Reset

Phone 888-232-0942
Email GroupLeader@NebraskaBlue.com

Agent Service Questions

Phone 888-232-0942
Fax 402-392-4150

Submit Prerequested Enrollment Documents

Phone 877-222-2374
Email IndContractInstallation@NebraskaBlue.com

Medical Records:

Email MUW@NebraskaBlue.com

EFFECTIVE DATE CHANGES

New Medicare Supplement Applicant

1. Requested effective date must be within 90 days of the original application submission date, on or after the date the request is submitted and the first day of the requested month.
2. An effective date requested prior to the current date will not be honored.
3. Request must be received by BCBSNE prior to the 11th day following:
   a. The initially selected effective date or
   b. The member's receipt date of the Schedule of Benefits (SOB). BCBSNE will honor the change of the effective date up to 11 days from the receipt of the SOB if past the original effective date.
4. Member should reconfirm any payment preferences after new effective date is in place.

A copy of the Effective Date Change Request form, signed by the member, will need to be sent to IndContractInstallation@NebraskaBlue.com. A handwritten request, signed and dated by the member will also be accepted; however, if any necessary information is missing, we may not be able to process the request.

MEDICARE SUPPLEMENT AND MEDICAID

Current law prohibits the sale of Medicare Supplement policies to Medicaid beneficiaries except in these situations:

1. The Medicaid plan pays the premiums for the policy, and/or
2. The only medical assistance to which the individual is entitled under Medicaid is Medicare cost sharing in Part B. Medicare beneficiaries who have a Medicare Supplement policy may ask to have their Medicare Supplement policy suspended for a period of not more than 24 months when they enroll in Medicaid. Then, if Medicaid no longer covers them, they may get the same Medicare Supplement policy reinstated if it is within those 24 months. Otherwise, under federal law, the loss of Medicaid does not qualify for a special enrollment period with a Medicare Supplement.

FREE-LOOK PROVISION

The new member has 10 business days from the contract mail date to contact us to cancel coverage and receive a full refund. This provision does not allow for changing an effective date.

AUTO DECLINE GUIDANCE AND MEDICAL UNDERWRITING

Underwriting evaluation is based on some of the following factors:

- Height and weight
- Dates of treatment
- Diagnosis and prognosis
- Use of prescription drugs
- Stage of treatment
- Follow-up requirements
- Chronic or acute nature of the disease
- Claim history (if applicable)

MEDICAL UNDERWRITING GUIDANCE FOR APPLICATIONS SUBMITTED ON OR AFTER MAY 1, 2022

Declinable Health Conditions:

1. Currently confined to a wheelchair or another motorized device.
2. Currently hospitalized, confined to a bed or in a nursing home.
3. Ever diagnosed with HIV, AIDS or ARC.
4. Ever received an organ or stem cell transplant or been advised to have an organ or stem cell transplant (excluding cornea).
5. Experienced a seizure in the last 12 months.
6. Was hospitalized as an inpatient three or more times within the past two (2) years

Declinable Health Conditions within the past two (2) years:

1. Internal cancer, leukemia or melanoma (even if in remission)
2. Coronary artery disease, heart attack, cardiac angioplasty, stent placement or bypass surgery
3. Congestive heart failure, cardiomyopathy, cardiomegaly, atrial fibrillation or other heart rhythm disorder, peripheral vascular disease, carotid artery disease, unoperated valvular heart disease, unoperated aneurysm or implanted pacemaker/ICD
4. Stroke or transient ischemic attack (TIA)
5. Chronic kidney disease (stages 3, 4, 5), kidney failure or kidney disease requiring dialysis
6. Diabetes
   a. Taking more than 50 units of insulin daily OR
   b. Taking three or more medications (oral or injections) to control blood sugar OR
   c. With complications including retinopathy, neuropathy, kidney disease, skin ulcers, high blood pressure, poor circulation, peripheral artery disease or peripheral thrombotic disease
7. Cirrhosis, chronic hepatitis or liver disease
8. Degenerative disc disease, amputations caused by disease, osteoporosis with related fractures, spinal stenosis, rheumatoid arthritis, psoriatic arthritis or arthritis that restricts mobility or activities of daily living
9. Emphysema, Chronic Obstructive Pulmonary Disease (COPD) or any chronic pulmonary disorder or cardiac disorder requiring oxygen
10. Systemic Lupus, Scleroderma or Myasthenia Gravis
11. Alcoholism or drug use
12. Alzheimer's disease, dementia or other cognitive disorder
13. Parkinson's disease, Multiple Sclerosis, Amyotrophic Lateral Sclerosis, Huntington's disease or Cerebral Palsy

Conditions requiring additional information:

1. Advised by a medical professional to have surgery, medical tests, treatment or therapy that has not been performed or any pending test results.
2. Hospitalized for complications arising from SARS-CoV-2 (Coronavirus) or the COVID-19 disease.

Household Discount

As of Jan. 1, 2019, a household discount is available to members who have another person (no more than three people over the age of 60) residing in their home. These people can be the member's legal spouse, or a person at least 18 years of age with whom the member has resided with continuously for the last 12 months.

Application Process for Non-tobacco and/or Household Discount

1. The member must complete a new application
2. BCBSNE will review the member's application and claim history.
3. If the member passes medical underwriting, a communication will be sent to them, advising them of the rate change.
4. If the member does not pass medical underwriting, a communication will be sent to them advising of the denial. The member will remain on their existing policy with no change.

RENEWAL AGREEMENT AND PREMIUM CHANGE PROVISION

A contract is guaranteed renewable. If a member moves out of state the policy will continue in effect as long as the premiums are paid on time or within the grace period. A contract will not be canceled because of a change in health, the number of times claims are filed, the number of claims or age. A contract may not be canceled for any reason other than nonpayment of premiums or material misrepresentation.

Premiums may change due to age, geographic area and other experience factors. A premium change resulting from a change in the geographic area in which a member resides will occur on the first day of the month following 31 days after notice of an address change is received by BCBSNE. Premium changes based on age or other experience factors, if applicable, will be made on the annual renewal date and the rate will be calculated using your attained age as of the renewal date. Otherwise, your premium cannot be changed unless we make the same change on all policies of this form, based on the same rating factors. If we change premiums, we will notify the member in writing at least 31 days before such premium is due.

GUARANTEED ISSUE RIGHTS

Medicare Supplement coverage will be issued without underwriting (guaranteed issue) under the following situations, under federal law, that gives applicants a right to buy a policy, the kind of policy applicants can buy and when applicants can or must apply for it. States may provide additional Medigap guaranteed issue rights.

APPLICANTS HAVE A GUARANTEED ISSUE RIGHT IF:	APPLICANTS WILL HAVE A SPECIAL ENROLLMENT PERIOD (SEP) WITH THE RIGHT TO BUY:	APPLICANTS CAN/MUST APPLY FOR A MEDIGAP POLICY:
Retirement	• Working • 65 years of age or older • Leaving the group due to retirement • A covered spouse of a retiree follows the same guarantee issue guidelines.	**Eligible for Medicare after Jan. 1, 2020:** Individuals may apply for Plan A, B, G or L as long as it is within 63 days of retirement. **Eligible for Medicare prior to Jan. 1, 2020:** Individuals may apply for Plan A, B, C, F, G or L as long as it is within 63 days of retirement.
Application Requirements:	**To waive underwriting:** Provide proof of retirement in the form of a letter from the employer. It must state the member is retiring including the date of retirement.	

LOSS OF COVERAGE	BCBSNE DOES NOT ALLOW DISABLED PERSONS UNDER 65 YEARS OF AGE TO ENROLL IN A MEDICARE SUPPLEMENT POLICY UNLESS ONE OF THE FOLLOWING EXCEPTIONS APPLIES:	
The individual is in a Medicare Advantage plan (like an HMO or PPO), and their plan is leaving Medicare or stops giving care in their area or the member moves out of the plan's service area.	**If the individual is eligible for Medicare prior to Jan. 1, 2020:** Medigap/Medicare Supplement Plan A, B, C, F, G or L. **If the individual is eligible for Medicare after Jan. 1, 2020:** Medigap/Medicare Supplement Plan A, B, G or L. Members only have this right if they switch to Original Medicare rather than join another Medicare Advantage Plan.	As early as 60 calendar days before the date, their health care coverage will end, but no later than 63 calendar days after their health care coverage ends. Medigap coverage cannot start until their Medicare Advantage Plan coverage ends.
Application Requirements:	**To waive underwriting:** Provide a copy of the letter of termination or terminating coverage member ID card.	
The individual has Original Medicare, and an employer group health plan (including retiree or COBRA coverage) or union coverage that pays after Medicare pays and that plan is ending.	**If the individual is eligible for Medicare prior to Jan. 1, 2020:** Medigap/Medicare Supplement Plan A, B, C, F, G or L. **If the individual is eligible for Medicare after Jan. 1, 2020:** Medigap/Medicare Supplement Plan A, B, G or L. If the member has COBRA coverage, they can either buy a Medigap policy right away or wait until the COBRA coverage ends.	**No later than 63 calendar days after the latest of these three dates:** 1. Date the coverage ends. 2. Date on the notice received stating that coverage is ending (if notice is received). 3. Date on a claim denial, if this is the only way the member knows that their coverage has ended.
Application Requirements:	**To waive underwriting:** Provide verification current coverage is terminating. Include a copy of the termination letter or claim denial letter under #3 above.	
The individual has Original Medicare and a Medicare SELECT policy. Moves out of the Medicare SELECT policy's service area. Call the Medicare SELECT insurer for more information about options.	**If the individual is eligible for Medicare prior to Jan. 1, 2020:** Medigap/Medicare Supplement Plan A, B, C, F, G or L. **If the individual is eligible for Medicare after Jan. 1, 2020:** Medigap/Medicare Supplement Plan A, B, G or L.	As early as 60 calendar days before the date, their Medicare SELECT coverage will end, but no later than 63 calendar days after their Medicare SELECT coverage ends.
Trial Right at 65 - The individual joined a Medicare Advantage Plan (like an HMO or PPO) or Programs of All-inclusive Care for the Elderly (PACE) when they were first eligible for Medicare Part A at 65, and within the first year (12 months) of joining, they decide to switch to Original Medicare.	**If the individual is eligible for Medicare prior to Jan. 1, 2020:** Medigap/Medicare Supplement Plan A, B, C, F, G or L. **If the individual is eligible for Medicare after Jan. 1, 2020:** Medigap/Medicare Supplement Plan A, B, G or L.	As early as 60 calendar days before the date, their coverage will end, but no later than 63 calendar days after their coverage ends.
Application Requirements:	**To waive underwriting:** BCBSNE may request documentation of prior coverage to determine eligibility.	

continued on next page

GUARANTEED ISSUE RIGHTS (cont.)

APPLICANTS HAVE A GUARANTEED ISSUE RIGHT IF:	APPLICANTS WILL HAVE A SPECIAL ENROLLMENT PERIOD (SEP) WITH THE RIGHT TO BUY:	APPLICANTS CAN/MUST APPLY FOR A MEDIGAP POLICY:
Trial Right - The individual dropped a Medigap policy to join a Medicare Advantage Plan (or to switch to a Medicare SELECT policy) for the first time, they have been in the plan less than a year, and they want to switch back. They dropped employee retiree coverage which was secondary to Medicare to join a Medicare Advantage Plan for the first time, they have been in the plan less than a year, and they want to switch back.	The Medigap policy they had before joining the Medicare Advantage Plan or Medicare SELECT policy, if the same insurance company they had before still sells it.	As early as 60 calendar days before the date, your coverage will end, but no later than 63 calendar days after their coverage ends.
	IF THE APPLICANT'S PRIOR MEDIGAP POLICY IS NOT AVAILABLE THE MEMBER CAN BUY, BASED ON THEIR ORIGINAL MEDICARE EFFECTIVE DATE:	
	If the individual is eligible for Medicare prior to Jan. 1, 2020: Medigap/Medicare Supplement Plan A, B, C, F, G or L that is sold in the member's state by any insurance company. **If the individual is eligible for Medicare after Jan. 1, 2020:** Medigap/Medicare Supplement Plan A, B, G or L that is sold in the member's state by any insurance company.	
Application Requirements:	**To waive underwriting:** BCBSNE may request documentation of prior coverage to determine eligibility.	
The individual's Medigap insurance company goes bankrupt, and they lose coverage, or their Medigap policy coverage otherwise ends through no fault of their own.	**If the individual is eligible for Medicare prior to Jan. 1, 2020:** Medigap/Medicare Supplement Plan A, B, C, F, G or L that is sold in the member's state by any insurance company. **If the individual is eligible for Medicare after Jan. 1, 2020:** Medigap/Medicare Supplement Plan A, B, G or L that is sold in the member's state by any insurance company.	No later than 63 calendar days from the date their coverage ends.
The individual leaves a Medicare Advantage Plan or drop a Medigap policy because the company has not followed the rules, or it has been misleading.	**If the individual is eligible for Medicare prior to Jan. 1, 2020:** Medigap/Medicare Supplement Plan A, B, C, F, G or L that is sold in the member's state by any insurance company. **If the individual is eligible for Medicare after Jan. 1, 2020:** Medigap/Medicare Supplement Plan A, B, G or L that is sold in the member's state by any insurance company.	No later than 63 calendar days from the date their coverage ends.
Application Requirements:	**To waive underwriting:** Provide proof of termination of existing coverage. i.e., letter of termination.	

VOLUNTARY TRANSFERS

Group Medicare Supplement

Transfers from a BCBSNE group Medicare Supplement plan to individual Medicare Supplement coverage (eligible for Plans A, B or C) can be done without underwriting. Transfers to Plan F, G, L or N require underwriting.

Pre-Modernized Medicare Supplement

No longer offered for sale and are not open for transfers. Members enrolled in premodernized Medicare Supplement plans (effective dates prior to June 1, 2010) may not transfer to plans within a closed block. Changes from a premodernized Medicare Supplement (issued prior to June 1, 2010) will need to go through underwriting and move to a modernized plan available for new sales.

CANCELLATIONS/TERMINATIONS

Cancellation requests must be received in writing with the subscriber's signature. The subscriber is the individual who is named on the identification card. We will not cancel coverage if the notice is signed by anyone other than the subscriber, parent or legal guardian.

The specified cancellation date for Medicare Supplement cannot be earlier than the date of receipt of the notification unless the request meets the definition of an allowable exception. (See the retroactive terminations section).

We will accommodate end-of-the-month terminations if the request is signed by the last day of the month and received within three business days. A request for the cancellation of automatic payments is a separate request from the policy cancellation request. To cancel automatic payments, members are asked to visit **myNebraskaBlue.com** to change future payments.

If a member has health and dental coverage with us, they should specify whether the termination request applies to both coverages, or if they wish to keep one active. If the termination request does not explicitly state which contract to terminate, both the health and dental coverage will be terminated.

Individuals who enroll into the BCBSNE Medicare Advantage (MAPD) plan and have a BCBSNE individual Medicare Supplement policy, upon enrollment of the BCBSNE MAPD plan BCBSNE will automatically terminate the Medicare Supplement policy with the coinciding effective date of the BCBSNE MAPD plan.

Retroactive Terminations

We will allow retro-termination dates, before the date of notification, only in the following situations:

- Death (proof of the date may be required), or
- The person carries both our Medicare Supplement policy and a Medicare Advantage policy, or
- The person is a Medicare Supplement policy subscriber and receives late notification of Medicaid eligibility.

Terminations Due to Death and Refund Rules

Subscriber termination due to death will be on the date of death. Proof of the date may be required.

Upon receipt of a request for a pro-rata refund by a legal representative, BCBSNE will refund the unearned premium prorated to the month of the insured's death if the request has been made within one year after the insured's death, according to Neb. Rev. Stat. 44-310. If the premium refund request is made to BCBSNE beyond a year from the date of death and the member is currently active, we will refund no more than one year's premium. If BCBSNE is contacted of death and the member was already termed beyond a year from date of the request, we are under no obligation to refund past premium.

Reinstatement

The member may request their coverage be reviewed for reinstatement. They must submit payment online, over the phone (IVR), or mail in a cashiers check or money order for all past due, current and the next month's coverage with the reinstatement form. Checks are not accepted for reinstatement review. Reinstatement forms can be obtained **by calling the Member Services number listed on their ID card. If you have questions, please reach out to Group Leader and Broker Services at 888-232-0942.**

PAYMENT OPTIONS

Members may choose to set up the monthly premium to be automatically withdrawn from their bank account via their **myNebraskaBlue.com** account or to choose bill direct on a monthly billing cycle. If a member wishes to set up banking information, they may select:

Automatic Payments

Members may set up automatic payments for the 20th of each month to pay in full for the following month. This date is not flexible; however, if the premium amount changes, members do not need to update their payment information.

Recurring payments

Recurring payments allow the member to schedule any date for the withdrawal and any amount so long as the full premium due is paid by the end of the month. The member is responsible for updating this payment method when the premium amount changes.

Members may also make one-time web payments or pay via phone.

Direct Bill

If the member does not elect online payment options, then they can mail a check with the billing remittance slip to

MAILING ADDRESS

Blue Cross and Blue Shield of Nebraska
PO Box 2638
Omaha, NE 68103-2638

Or overnight your payment to (for carriers other than USPS):

First National Bank of Omaha
Attn: Blue Cross and Blue Shield of Nebraska, Inc.
and LBX # 2638
1620 Dodge St
Omaha, NE 68197-2204

All check payments, including bank bill payments, must include the remittance slip or could risk being returned as unable to process.

Late Payments and Insufficient Funds

A grace period for late premium payment is outlined in the plan contracts. If the premium is not received within 10 days of the due date listed on the invoice, the member will begin to receive notices of past-due premiums.

If there are insufficient funds in the member's bank account on the regularly scheduled withdrawal date, a second withdrawal attempt may be made one to two days later. If there are still insufficient funds, the member will be notified of the returned payment. They have until the end of their contract grace period to make a payment or their policy may terminate for nonpayment, and they will have to go through the reinstatement process, if eligible.

Third-Party Payment Policy

Payments made by a third-party payer for premiums or cost-share amounts on behalf of covered persons will not be accepted unless otherwise agreed to by BCBSNE, or as otherwise required by law. To be considered for a third-party payer option, the payer and member will need to complete additional financial forms. These can be found at **NebraskaBlue.com/Brokers/Forms.**

A third-party payer is defined as any person or entity not covered by this contract remitting payment(s) for premiums or applicable cost-share amounts on behalf of the subscriber.

Medicare Advantage Plans (MAPD)

ABOUT THE PLAN

MAPD plans offer many benefits beyond Original Medicare. For more information, visit:

NebraskaBlue.com/MA

PROVIDER NETWORK

Providers can be found on **NebraskaBlue.com/DoctorFinder** by selecting the Medicare Advantage Network.

AGENT REQUIREMENTS

Agents must be appointed and complete CMS certification each year with no lapse in accreditation or product training to receive renewal commission. Accepted certification:

- AHIP
- Pinpoint
- NAHU

To receive access to the Blue Cross and Blue Shield of Nebraska Medicare Advantage certification portal, contact Broker_Appointment@NebraskaBlue.com.

AGENT OF RECORD (AOR)

An AOR change will occur automatically when a member re-enrolls into another plan. Resubmitting an application for a member into the same plan they are already enrolled in will not change the AOR.

ENROLLMENT

All enrollments must be submitted online through the DRX enrollment portal within 24 hours of receipt of the application.

STAR RATINGS

Both Medicare Advantage Core HMO and Medicare Advantage Access PPO earned a 4 (out of 5) star rating for 2023. The Star Rating System rates plans on the results of several quality measures, with the summary score providing a measure of a plan's overall quality.

This score represents:

- Quality of care
- Access to care
- Responsiveness of the plan
- Member satisfaction

Plans with five stars represent "excellent performance." Both Medicare Advantage and Prescription Drug plans are rated using the system.

PAYMENT OPTIONS

Members have the option to pay via direct bill, automatic withdrawal from their bank account on the first of each month or the next business day or from their Social Security check; this is an option at the time of application.

MAPD Contact Information

PHONE

Enrollment status 888-860-4335
Customer service 888-488-9850

ONLINE

DRX technical questions, including password resets
DRXADMIN@bcbsm.com

MA Broker/Consumer informational site
Medicare.NebraskaBlue.com

MedicareBlue Rx – Prescription Drug Program

ABOUT THE PLAN

MedicareBlue℠ Rx has been active since the inception of the Medicare Part D program on Jan. 1, 2007. The program is part of a seven-state region including Iowa, Nebraska, Montana, South Dakota, Minnesota, North Dakota and Wyoming.

AGENT REQUIREMENTS

Agents must be appointed and complete CMS certification each year with no lapse in accreditation or product training to receive renewal commission. Accepted certification:

- AHIP
- Pinpoint
- NAHU

To receive access to the BCBSNE MedicareBlue Rx certification portal, contact Broker_Appointment@NebraskaBlue.com.

AGENT OF RECORD (AOR)

An AOR change will occur automatically when a member re-enrolls into another plan. Resubmitting an application for a member into the same plan they are already enrolled in will not change the AOR.

ENROLLMENT

All enrollments must be submitted online through the **YourMedicareSolutions.com** enrollment portal within 48 hours of receipt of application. Enrollments can also be completed in person with an applicant, electronically, or agents can take a paper application and submit them electronically within 48 hours.

STAR RATINGS

MedicareBlue Rx earned a 4 (out of 5) star rating for 2023. The Star Rating System rates plans on the results of several quality measures, with the summary score providing a measure of a plan's overall quality.

This score represents:

- Quality of care
- Access to care
- Responsiveness of the plan
- Member satisfaction

Plans with five stars represent "excellent performance." Both Medicare Advantage and Prescription Drug plans are rated using the system.

PAYMENT OPTIONS

Members have the option to pay via direct bill or pull directly from their Social Security check; this is done at the time of application. Automatic withdrawal may be set up after application by calling customer service or downloading the EFT form from **YourMedicareSolutions.com.**

MedicareBlue Rx Contact Information

PHONE
Customer service 888-860-4335

FAX
For all individual and group plans 855-874-4702

MAILING ADDRESS
MedicareBlue Rx Customer Service
PO Box 3178
Scranton, PA 18505

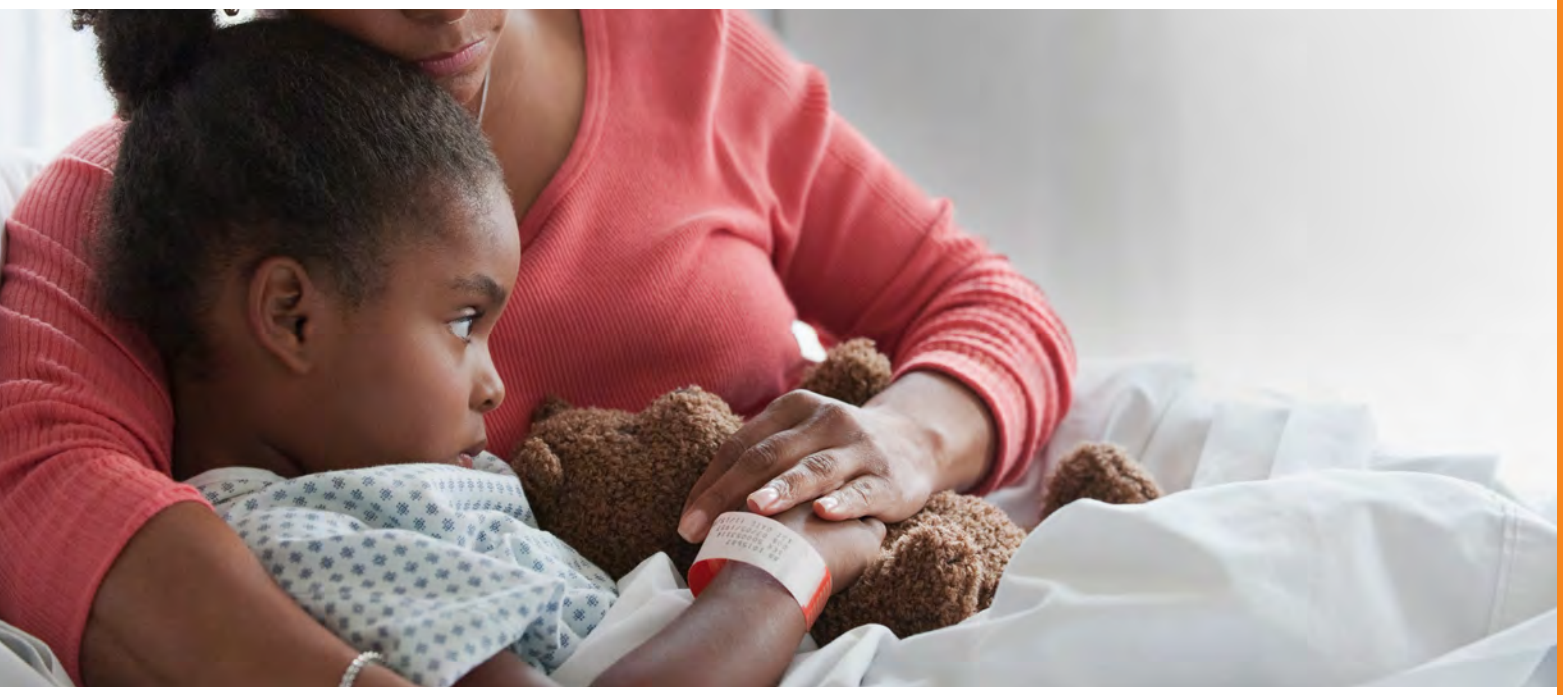
PHONE
Prospective members 888-860-4335

MAILING ADDRESS
MedicareBlue Rx
4301 Cambridge Rd.
Fort Worth, TX 76155

MedicareBlue℠ Rx (PDP) is a Medicare-approved Part D sponsor. Enrollment in MedicareBlue Rx depends on contract renewal. Coverage is available to residents of the service area and separately issued by one of the following plans: Wellmark Blue Cross and Blue Shield of Iowa*; Blue Cross and Blue Shield of Minnesota*; Blue Cross and Blue Shield of Montana*, a division of Health Care Service Corporation, a Mutual Legal Reserve Company; Blue Cross and Blue Shield of Nebraska*; Blue Cross Blue Shield of North Dakota*; Wellmark Blue Cross and Blue Shield of South Dakota*; and Blue Cross Blue Shield of Wyoming*.

* Independent licensee of the Blue Cross Blue Shield Association.

Ancillary and Other Products



LIFESECURE

LifeSecure Insurance Company offers a suite of co-branded products, including Accident, Critical Illness and Hospital Recovery insurance.

Please visit the website for further information:
NebraskaBlue.com/LifeSecure

GEOBLUE

GeoBlue provides health insurance for short-term and frequent leisure, study, mission, marine and business travel.

Please visit the website for further information:
NebraskaBlue.com/GeoBlue

LifeSecure Insurance Company (New Hudson, MI) underwrites and has sole financial responsibility for the Accident, Critical Illness, and Hospital Recovery insurance products. LifeSecure is an independent company providing ancillary products for Blue Cross and Blue Shield of Nebraska. LifeSecure products do not offer qualifying health coverage ("Minimum Essential Coverage" or "MEC") that satisfies the health coverage under the Affordable Care Act. The termination or loss of one of these policies does not entitle you to a Special Enrollment Period to purchase a health benefit plan that qualifies as MEC outside of an Open Enrollment Period. These products have exclusions and limitations.

GeoBlue is a trade name of Worldwide Insurance Services, LLC (Worldwide Services Insurance Agency, LLC in California and New York.

Agent of Record (AOR) - The agent that is assigned to the account to service the business and receive commissions.

Aggregate - Aggregate deductible means that if a member has family coverage, the entire family deductible must be met prior to any benefits becoming available. Aggregate out of pocket means that after the family deductible is met, the entire family out-of-pocket limit must be met before coverage begins to pay at 100%.

AHIP - America's Health Insurance Plans

Allowable Charge - An amount we use to calculate our payment of covered services. This amount will be based on either the contracted amount for in-network providers or the out-of-network allowance.

Automatic Payment - The process by which a member sets up payment preferences via their myNebraskaBlue account and selects the auto-pay feature. This pulls the total amount billed from a member's bank account or credit card on the defined processing date as requested by the carrier.

Benefit Accumulators - Calculations that capture the cumulative total of the member's out-of-pocket expenses and any day or visit limits.

Benefit Year - A period of up to one year in which a policyholder can receive insurance benefits from an insurance policy. The benefit year typically begins with the effective date of the policy.

Broker Business Portal (BBP) - A website portal that allows a broker to quote, submit new applications and service their renewals for BluePride Small Groups and Individual Armor products.

Calendar Year - The period of 365 days (or 366 days in leap years) starting from the first of January.

Cancellation - A request from the policyholder or legal parent or guardian (for child-only policies) to cancel coverage.

Coordination of Benefits - The process used when a member has two health insurance plans. This process allows the two plans to work together, getting members the most out of their coverage. One plan becomes their primary plan, paying claims first. The second plan becomes their secondary plan, which may pay toward the remaining cost, depending on the plan.

DRX - Destination Rx

EFT - Electronic Funds Transfer

Embedded - Embedded deductible and out-of-pocket means that family members may combine their covered expenses to satisfy the required calendar year deductible and out of pocket. However, no one family member contributes more than the individual deductible or out-of-pocket amount.

HMO - Health Maintenance Organization

In-network Hospital, Physician or other Provider - A licensed practitioner of the healing arts, a licensed facility or other qualified provider of health care services who has contracted with BCBSNE to provide services as a part of a preferred provider network in.

Lifetime Maximum - The maximum dollar amount the policy will pay for covered services during a covered person's lifetime.

MAPD - Medicare Advantage Prescription Drug

Medical Underwriting (MUW) - The process by which health insurers use to review an applicant's medical history to determine eligibility for coverage.

myNebraskaBlue - Online account for members to view benefit details such as billing information, managing payments, explanation of benefit documents, locate doctors, view accumulators and contact member services.

NAHU - National Association of Health Underwriters

Noncovered Services - Services that are not payable under the contract.

Nonpayment Termination - The termination of coverage for failure to make payment as outlined in the contract.

One-time Payment - The process by which a member makes a payment via their online account and selects their payment date and amount.

Out-of-network Provider - A provider of health care services who has not contracted with BCBSNE to provide services as a part of the preferred provider network in Nebraska.

PDP - Prescription Drug Plan

POS - Point of Service

PPO - Preferred Provider Organization

Preexisting Condition - Any condition for which the member received medical advice or treatment for within 12 months prior to enrollment

Preferred Provider - A health care provider (hospital, physician or other health care provider) who has contracted with BCBSNE to provide services or if in another state, who is a preferred provider with the BlueCard Program PPO network. (See also in-network Hospital, Physician or other Provider)

Reinstatement - An exception request from the policyholder to reinstate coverage after a nonpayment termination.

Reoccurring Payment - The process by which a member sets up payment preferences via their online account and selects their payment amount and payment date.

Retroactive Termination - A termination of a policy prior to the date of the notification. (Only allowed in certain circumstances at BCBSNE discretion)

Three-tier Plan - A health plan with three levels of network benefits - a select, in-network level, an in-network level and an out-of-network level. Members save money when they use in-network providers and save even more when they use select in-network providers.

Third-party Payer - Any person or entity not covered by the BCBSNE contract, remitting payment(s) for premiums or applicable cost-share amounts on behalf of the subscriber.

Two-tier Plan - A health plan with two levels of benefits - an in-network level and an out-of-network level. Members save money when they use in-network providers

Waiting period - The amount of time an insured must wait before some or all services are covered.

BlueCross BlueShield Nebraska

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