BlueFreedom

BlueCross BlueShield Nebraska

Schedule of Benefits Summary

Option 43

Payment for Services	In-network Provider	Out-of-network Provider
Covered Services are reimbursed based on the Allowable Charge. Blue Cross and Blue Shield of Nebraska In-network Providers have agreed to accept the benefit payment as payment in full, not including Deductible, Coinsurance and/or Copayment amounts and any charges for non-covered services, which are the Covered Person's responsibility. That means that In-network providers, under the terms of their contract with Blue Cross and Blue Shield, can't bill for amounts over the Contracted Amount. Out-of-network Providers can bill for amounts over the Out-of-network Allowance.		
In-Network provider: The provider network is shown on your ID card. For help in locating In-Network providers, visit www.nebraskablue.com.		
Deductible (the amount the Covered Person pays each Calendar Year for Covered Services before the Coinsurance is payable) • Individual • Family (Embedded*)	 $4,000 $8,000	 $8,000 $16,000
Coinsurance (the percentage amount the Covered Person must pay for most Covered Services after the Deductible has been met) • Covered Person Pays	 0%	 20%
Out-of-pocket Limit (includes the Deductible, Coinsurance and Copayment amounts) • Individual • Family (Embedded*)	 $5,000 $10,000	 $12,000 $24,000
Once the annual Out-of-pocket Limit is reached, most Covered Services are payable by the plan at 100% for the rest of the Calendar Year.		
In-network and Out-of-network Deductible and Out-of-pocket Limits are separate and do not cross accumulate. All other limits (days, visits, sessions, dollar amounts, etc.) do cross accumulate between In-network and Out-of-network, unless noted differently.		
*Embedded – If you have single coverage, you only need to satisfy the individual Deductible and Out-of-pocket Limit amounts. If you have family coverage, no one family member contributes more than the individual amount. Family members may combine their covered expenses to satisfy the required family Deductible and Out-of-pocket amounts.		

Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Physician Office • Primary Care Physician Office Services	$30 Copay	Deductible and Coinsurance
• Specialist Physician Office Services	$50 Copay	Deductible and Coinsurance
• Other Covered Services and supplies provided in the Physician's Office (with or without an office visit billed)	Applicable office visit Copay	Deductible and Coinsurance
• Telehealth Services	$10 Copay	Not Covered
Primary Care Physician is a physician who has a majority of his or her practice in internal or general medicine, obstetrics/gynecology, general pediatrics or family practice. A **physician assistant** is covered in the same manner as a Primary Care Physician. ***Specialist Physician*** is a physician who is not a Primary Care Physician. ***Office Visit Benefits*** for Primary Care and Specialist Physician Office Visit include office visits (including the initial visit to diagnose pregnancy) and consultations. ***Other Covered Services not part of the Physician Office Benefit (Refer to the appropriate category for benefit information) include:*** Advanced Diagnostic Imaging (CT, MRI, MRA, MRS, PET & SPECT scans and other Nuclear Medicine); Pregnancy Services; Preventive Services; Radiation Therapy & Chemotherapy; Surgery & Anesthesia; Therapy & Manipulations; Durable Medical Equipment; Sleep Studies; Biofeedback; Psychological Evaluations, Assessments, and Testing.		
Convenient Care/Retail Clinics (Quick Care)	Same as a Primary Care Physician	Same as a Primary Care Physician
Urgent Care Facility Services (a single copay applies to each urgent care visit)	$75 Copay	Deductible and Coinsurance
Emergency Care Services (services received in a Hospital emergency room setting) • Facility	Deductible	In-network level of benefits
• Professional Services	Deductible	In-network level of benefits
Outpatient Hospital or Facility Services Services such as surgery, laboratory and radiology, cardiac and pulmonary rehabilitation, observation stays, and other services provided on an outpatient basis	Deductible	Deductible and Coinsurance
Inpatient Hospital or Facility Services Services for room and board, diagnostic testing, rehabilitation and other ancillary services provided on an inpatient basis	Deductible	Deductible and Coinsurance

Preventive services	In-network Provider	Out-of-network Provider
Preventive Services		
• Affordable Care Act (ACA) required preventive services (may be subject to limits that include, but are not limited to, age, gender, and frequency)	Plan Pays 100%	Deductible and Coinsurance
• ACA required covered preventive services (outside of limits)	Plan Pays 100%	Deductible and Coinsurance
• Other covered preventive services not required by ACA, such as:		
◦ laboratory tests, as specified by Us, including urinalysis, completed blood count, general health panel, and comprehensive metabolic panel; Prostate cancer screenings (PSA); and hearing exam;	Plan Pays 100%	Deductible and Coinsurance
◦ all other laboratory tests; Radiology; cardiac stress test; EKG, pulmonary function and other screening services.	Same as illness	Same as illness
Immunizations		
• Pediatric (up to age 7)	Plan Pays 100%	Coinsurance
• Age 7 and older	Plan Pays 100%	Deductible and Coinsurance
• Related to an illness	Same as any other illness	Same as any other illness

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

Other Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Advanced Diagnostic Imaging (CT, MRI, MRA, MRS, PET & SPECT scans and other Nuclear Medicine)	Deductible	Deductible and Coinsurance
Ambulance (to the nearest facility for appropriate care) • Ground Ambulance • Air Ambulance	 Deductible Deductible	 In-network level of benefits Deductible and Coinsurance (In-network level of benefits if due to an emergency)
Drugs Administered in an Outpatient Setting (such as home, physician office and other outpatient settings)	Not Covered	Not Covered
(**NOTE:** Some prescription drugs and covered services administered in an outpatient setting, other than a hospital emergency room, are only payable under the Prescription Drug category. A list of these drugs and covered services is available on the website www.nebraskablue.com or by contacting the Member Services Department.)		
Durable Medical Equipment and Supplies (including Prosthetics) (rental or purchase, whichever is least costly; rental shall not exceed the cost of purchasing)	Deductible	Deductible and Coinsurance
Hearing Aids (up to age 19, limited to $3,000 every 48 months)	Same as any other illness	Same as any other illness
Home Health Care • Skilled Nursing Care (limited to 8 hours per day) • Home Health Aide (limited to 60 days per Calendar Year) • Respiratory Care (limited to 60 days per Calendar Year)	 Deductible Deductible Deductible	 Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance
Hospice Services	Deductible	Deductible and Coinsurance
Independent Laboratory • Diagnostic • Preventive	 Plan Pays 100% Same as Preventive Services In-network level of benefits	 In-network level of benefits Same as Preventive Services In-network level of benefits
Oral Surgery and Dentistry Services such as incision and drainage of abscesses and excision of tumors and cysts. Dental treatment when due to an accidental injury to naturally healthy teeth (treatment related to accidents must be provided within 12 months of the date of injury).	Deductible	Deductible and Coinsurance
Organ and Tissue Transplantation	Deductible	Deductible and Coinsurance
Ostomy Supplies	Deductible	Deductible and Coinsurance

Other Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Physician Professional Services Inpatient and Outpatient services, such as, surgery, surgical assistant, anesthesia, inpatient hospital visits and other non-surgical services	Deductible	Deductible and Coinsurance
Pregnancy, Maternity and Newborn Care • Pregnancy and maternity (Payment for prenatal and postnatal care is included in the payment for the delivery) • Newborn care **NOTE**: Newborns are covered at birth, subject to the plan's enrollment provisions.	Deductible Deductible	Deductible and Coinsurance Deductible and Coinsurance
Radiation Therapy and Chemotherapy	Deductible	Deductible and Coinsurance
Radiology (x-ray) Services and other Diagnostic Test	Deductible	Deductible and Coinsurance
Rehabilitation Services – Inpatient Facility	Deductible	Deductible and Coinsurance
Rehabilitation Services • Cardiac rehabilitation (limited to 18 sessions per diagnosis) • Pulmonary Rehabilitation (Chronic lung disease is limited to 18 sessions per diagnosis, not to exceed 18 sessions per Calendar Year. Lung, heart-lung transplants and lung volume are limited to 18 sessions following referral and prior to surgery plus 18 sessions within six months of discharge from hospital following surgery)	Deductible Deductible	Deductible and Coinsurance Deductible and Coinsurance
Renal Dialysis	Deductible	Deductible and Coinsurance
Skilled Nursing Facility (limited to 60 days per Calendar Year)	Deductible	Deductible and Coinsurance
Temporomandibular and Craniomandibular Joint Disorder	Deductible	Deductible and Coinsurance

Other Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Therapy & Manipulations • Physical, occupational or speech therapy services, chiropractic or osteopathic physiotherapy (combined limit to 60 sessions per Calendar Year for both rehabilitative and habilitative services) • Chiropractic or osteopathic manipulative treatments or adjustments (combined limit to 30 sessions per Calendar Year) *NOTE: session limits are not applicable to mental illness and/or substance dependence and abuse	Deductible Deductible	Deductible and Coinsurance Deductible and Coinsurance
Vision Exams • Diagnostic (to diagnose an illness) • Preventive (routine exam including refraction)	See Physician Office Services Not Covered	See Physician Office Services Not Covered
All Other Covered Services	Deductible	Deductible and Coinsurance

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

Rx Option 6

Prescription Drugs	In-network Provider	Out-of-network Provider
Retail and Mail order – per 30-day supply		
• Generic drugs	$15 Copay	In-network level of benefits + 25%
• Formulary Brand Name Drugs	$45 Copay	In-network level of benefits + 25%
• Non-formulary Brand Name Drugs	$80 Copay	In-network level of benefits + 25%
NOTE: A 90-day supply is available at an Extended Supply Network pharmacy subject to 3 copays.		
Specialty drugs (specialty drugs must be purchased through a designated specialty pharmacy after two fills)	$150 Copay	Not Covered

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