

Schedule of Benefits Summary

Option 68

Payment for Services	In-network Provider	Out-of-network Provider
<p>Covered Services are reimbursed based on the Allowable Charge. Blue Cross and Blue Shield of Nebraska In-network Providers have agreed to accept the benefit payment as payment in full, not including Deductible, Coinsurance and/or Copayment amounts and any charges for non-covered services, which are the Covered Person’s responsibility. That means 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.</p>		
<p>In-Network provider: The provider network is shown on your ID card. For help in locating In-Network providers, visit www.nebraskablue.com.</p>		
<p>Deductible (the amount the Covered Person pays each Calendar Year for Covered Services before the Coinsurance is payable)</p> <ul style="list-style-type: none"> Individual Family (Embedded*) 	<p>\$2,500 \$5,000</p>	<p>\$5,000 \$10,000</p>
<p>Coinsurance (the percentage amount the Covered Person must pay for most Covered Services after the Deductible has been met)</p> <ul style="list-style-type: none"> Covered Person Pays 	<p>50%</p>	<p>50%</p>
<p>Out-of-pocket Limit (includes the Deductible, Coinsurance and Copayment amounts)</p> <ul style="list-style-type: none"> Individual Family (Embedded*) 	<p>\$7,000 \$14,000</p>	<p>\$14,000 \$28,000</p>
<p>Once the annual Out-of-pocket Limit is reached, most Covered Services are payable by the plan at 100% for the rest of the Calendar Year.</p>		
<p>In-network and Out-of-network Deductible and Out-of-pocket Limits are separate and do not cross accumulate. All other limits (days, visits, sessions, dollar amounts, etc.) do cross accumulate between In-network and Out-of-network, unless noted differently.</p>		
<p>*Embedded – If you have single coverage, you only need to satisfy the individual Deductible and Out-of-pocket Limit amounts. If you have family coverage, no one family member contributes more than the individual amount. Family members may combine their covered expenses to satisfy the required family Deductible and Out-of-pocket amounts.</p>		

Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Physician Office <ul style="list-style-type: none"> Primary Care Physician Office Services Specialist Physician Office Services Other Covered Services and supplies provided in the Physician’s Office (with or without an office visit billed) Telehealth Services 	\$25 Copay \$100 Copay Applicable office visit Copay \$10 Copay	Deductible & Coinsurance Deductible & Coinsurance Deductible & Coinsurance Not Covered
<p>Primary Care Physician is a physician who has a majority of his or her practice in internal or general medicine, obstetrics/gynecology, general pediatrics or family practice. A physician assistant is covered in the same manner as a Primary Care Physician.</p> <p>Specialist Physician is a physician who is not a Primary Care Physician.</p> <p>Office Visit Benefits for Primary Care and Specialist Physician Office Visit include office visits (including the initial visit to diagnose pregnancy) and consultations.</p> <p>Other Covered Services not part of the Physician Office Benefit (Refer to the appropriate category for benefit information) include: Advanced Diagnostic Imaging (CT, MRI, MRA, MRS, PET & SPECT scans and other Nuclear Medicine); Pregnancy Services; Preventive Services; Radiation Therapy & Chemotherapy; Surgery & Anesthesia; Therapy & Manipulations; Durable Medical Equipment; Sleep Studies; Biofeedback; Psychological Evaluations, Assessments, and Testing.</p>		
Convenient Care/Retail Clinics (Quick Care)	Same as a Primary Care Physician	Same as a Primary Care Physician
Urgent Care Facility Services	\$50 Copay	Deductible & Coinsurance
Emergency Care Services (services received in a Hospital emergency room setting) <ul style="list-style-type: none"> Facility Professional Services 	Deductible & Coinsurance Deductible & Coinsurance	In-network level of benefits In-network level of benefits
Outpatient Hospital or Facility Services Services such as surgery, laboratory and radiology, cardiac and pulmonary rehabilitation, observation stays, and other services provided on an outpatient basis	Deductible & Coinsurance	Deductible & Coinsurance
Inpatient Hospital or Facility Services Services for room and board, diagnostic testing, rehabilitation and other ancillary services provided on an inpatient basis	Deductible & Coinsurance	Deductible & Coinsurance
Orthopedic Specialty Inpatient Hospital or Facility Services	Deductible & Coinsurance	Deductible & Coinsurance
NOTE: Deductible and Coinsurance may be waived if Covered Services are provided at a designated Preferred Center. See www.nebraskablue.com for a list of Covered Services and designated hospitals.		

Preventive services	In-network	Out-of-network
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	Provider	Provider
Preventive Services <ul style="list-style-type: none"> Affordable Care Act (ACA) required preventive services (may be subject to limits that include, but are not limited to, age, gender, and frequency) ACA required covered preventive services (outside of limits) Other covered preventive services not required by ACA, such as: <ul style="list-style-type: none"> laboratory tests, as specified by Us, including urinalysis, completed blood count, comprehensive metabolic panel, and general health panel; Prostate cancer screenings (PSA); and hearing exam; all other laboratory tests; Radiology; cardiac stress test; EKG, pulmonary function and other screening services. 	Plan Pays 100% Plan Pays 100% Plan Pays 100% Same as illness	Deductible & Coinsurance Deductible & Coinsurance Deductible & Coinsurance Same as illness
Immunizations <ul style="list-style-type: none"> Pediatric (up to age 7) Age 7 and older Related to an illness 	Plan Pays 100% Plan Pays 100% Same as any other illness	Coinsurance Deductible & Coinsurance Same as any other illness

Mental Illness and/or Substance Dependence and Abuse covered services	In-network Provider	Out-of-network Provider
Inpatient Services	Deductible & Coinsurance	Deductible & Coinsurance
Outpatient Services <ul style="list-style-type: none"> Office Services Telehealth Services All Other Outpatient Items & Services 	Plays Pays 100% Deductible & Coinsurance Deductible & Coinsurance	Deductible & Coinsurance Not Covered Deductible & Coinsurance
Emergency Care Services (services received in a Hospital emergency room setting) <ul style="list-style-type: none"> Facility Professional Services 	Deductible & Coinsurance Deductible & Coinsurance	In-network level of benefits 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 & Coinsurance	Deductible & Coinsurance
Ambulance (to the nearest facility for appropriate care) <ul style="list-style-type: none"> • Ground Ambulance • Air Ambulance 	Deductible & Coinsurance Deductible & Coinsurance	In-network level of benefits Deductible & 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
<p>(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.)</p>		
Durable Medical Equipment and Supplies (including Prosthetics) (rental or purchase, whichever is least costly; rental shall not exceed the cost of purchasing)	Deductible & Coinsurance	Deductible & 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 <ul style="list-style-type: none"> • 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 & Coinsurance Deductible & Coinsurance Deductible & Coinsurance	Deductible & Coinsurance Deductible & Coinsurance Deductible & Coinsurance
Hospice Services	Deductible & Coinsurance	Deductible & Coinsurance
Independent Laboratory <ul style="list-style-type: none"> • Diagnostic • Preventive 	Plan Pays 100% Same as Preventive Services In-network level of benefits	In-network level of benefits Same as Preventive Services In-network level of benefits
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 & Coinsurance	Deductible & Coinsurance
Organ and Tissue Transplantation	Deductible & Coinsurance	Deductible & Coinsurance
Ostomy Supplies	Deductible & Coinsurance	Deductible & 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 & Coinsurance	Deductible & Coinsurance
Pregnancy, Maternity and Newborn Care <ul style="list-style-type: none"> • Pregnancy and maternity (Payment for prenatal and postnatal care is included in the payment for the delivery) • Newborn care NOTE: Newborns are covered at birth, subject to the plan’s enrollment provisions.	Deductible & Coinsurance Deductible & Coinsurance	Deductible & Coinsurance Deductible & Coinsurance
Radiation Therapy and Chemotherapy	Deductible & Coinsurance	Deductible & Coinsurance
Radiology (x-ray) Services and other Diagnostic Test	Deductible & Coinsurance	Deductible & Coinsurance
Rehabilitation Services – Inpatient Facility	Deductible & Coinsurance	Deductible & Coinsurance
Rehabilitation Services <ul style="list-style-type: none"> • Cardiac rehabilitation (limited to 18 sessions per diagnosis) • Pulmonary Rehabilitation (Chronic lung disease is limited to 18 sessions per diagnosis, not to exceed 18 sessions per Calendar Year. Lung, heart-lung transplants and lung volume are limited to 18 sessions following referral and prior to surgery plus 18 sessions within six months of discharge from hospital following surgery) 	Deductible & Coinsurance Deductible & Coinsurance	Deductible & Coinsurance Deductible & Coinsurance
Renal Dialysis	Deductible & Coinsurance	Deductible & Coinsurance
Skilled Nursing Facility (limited to 60 days per Calendar Year)	Deductible & Coinsurance	Deductible & Coinsurance
Temporomandibular and Craniomandibular Joint Disorder	Deductible & Coinsurance	Deductible & Coinsurance

Other Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
<p>Therapy & Manipulations</p> <ul style="list-style-type: none"> Physical, occupational or speech therapy services, chiropractic or osteopathic physiotherapy (combined limit to 60 sessions per Calendar Year for both rehabilitative and habilitative services) Chiropractic or osteopathic manipulative treatments or adjustments (combined limit to 30 sessions per Calendar Year) <p>*NOTE: session limits are not applicable to mental illness and/or substance dependence and abuse</p>	<p>Deductible & Coinsurance</p> <p>Deductible & Coinsurance</p>	<p>Deductible & Coinsurance</p> <p>Deductible & Coinsurance</p>
<p>Vision Exams</p> <ul style="list-style-type: none"> Diagnostic (to diagnose an illness) Preventive (routine exam including refraction) 	<p>See Physician Office Services</p> <p>Not Covered</p>	<p>See Physician Office Services</p> <p>Not Covered</p>
<p>All Other Covered Services</p>	<p>Deductible & Coinsurance</p>	<p>Deductible & Coinsurance</p>

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 1

Prescription Drugs	In-network Provider	Out-of-network Provider
<p>Retail and Mail order – per 30-day supply</p> <ul style="list-style-type: none"> • Generic drugs • Preferred brand name drugs • Non-preferred brand name drugs 	<p>\$10</p> <p>\$30</p> <p>\$50</p>	<p>50% Coinsurance</p> <p>50% Coinsurance</p> <p>50% Coinsurance</p>
<p>NOTE: A 90-day supply is available at an Extended Supply Network pharmacy subject to 3 copays</p>		
<p>Specialty drugs (specialty drugs must be purchased through a designated specialty pharmacy after two fills)</p>	<p>\$100</p>	<p>Not Covered</p>
<p>This plan uses a prescription drug list (PDL). The PDL for this plan is PDL40, and the Pharmacy Network is Network C.</p> <p>You can find this prescription drug list and network listing on www.nebraskablue.com. Or you may contact the Member Services at the phone number on the back of your ID card.</p>		

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