BlueCross BlueShield Nebraska

BluePride

Health Plans for Employer Groups With 2-50 Employees

Effective Jan. 1, 2021

THERE WITH YOU

Through births and broken bones, tests and treatments, trauma and triumphs, Blue Cross and Blue Shield of Nebraska (BCBSNE) is there with you. Since 1939, we have ensured access to the providers you trust, coverage for the care you need and support from a team that's right here in Nebraska.

Types of Enrollment

Single Membership: Covers the employee only.

Employee and Spouse Membership: Covers the employee and spouse.

Employee and Child(ren) Membership: Covers the employee and eligible dependent children to age 26, but does not provide coverage to a spouse.

Family Membership: Covers the employee and spouse, as well as eligible dependents to age 26.

Essential Health Benefits

Our health plans are available off the federal government's Small Business Health Options Program (SHOP) Marketplace. These plans comply with the Affordable Care Act requirements and include the following 10 Essential Health Benefits.

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

Let's get started

Finding a health insurance plan doesn't have to be complicated. Let us show you how. Follow these simple steps to find the best plan for you and your employees.

REVIEW NETWORKS AND COVERAGE

Understand provider networks, service areas and prescription drug coverage.

COMPARE PLAN OPTIONS

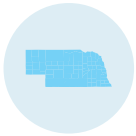
Look closely at the plans to see which one is right for your group.

EXPLORE MEMBER RESOURCES

Discount programs, telehealth and tools to help manage expenses.

REVIEW NETWORKS AND COVERAGE

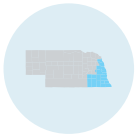
Provider Networks and Service Areas



NEtwork BLUE

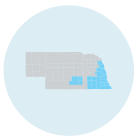
NEtwork BLUE is made up of 96% of Nebraska's doctors and 99% of the state's non-governmental acute care hospitals.*

*According to BCBSNE statistics, June 15, 2020.



Premier Select BlueChoice

Our Premier Select BlueChoice network features Nebraska Methodist Hospital System and Nebraska Medicine. This regional network is available to groups headquartered in Omaha, Lincoln and the surrounding communities in ZIP codes starting with 680, 681, 683, 684 and 685. All other Nebraska providers are out of network.



Blueprint Health

Our Blueprint Health network features CHI Health and other providers and facilities in Nebraska and contiguous counties in Iowa. This regional network is available to groups headquartered in Omaha, Lincoln and the surrounding communities in ZIP codes starting with 680, 681, 683, 684 and 685, as well as Adams, Buffalo, Hall, Kearney and Phelps counties. All other Nebraska providers are out of network.

To locate providers:

Members should visit **NebraskaBlue.com/Find-a-Doctor** or call the number on their member ID card.

Nationwide Access

BCBSNE members have access to a national network called the BlueCard® Program. If Blue members live or travel outside of Nebraska, they may take their health care benefits with them. The BlueCard Program gives members access to doctors and hospitals almost everywhere within the United States. Members are covered whether they need care in urban or rural areas.

Outside of the United States, members have access to doctors and hospitals around the world through the Blue Cross Blue Shield Global® Core Program.

To locate providers nationwide:

Members should visit
NebraskaBlue.com/Find-a-Doctor
or call 800-810-2583.

Prescription Drug Coverage

Prescription drug coverage is available to BCBSNE members through our Rx Nebraska Prescription Drug Program with our pharmacy benefit manager, Prime Therapeutics, LLC.

Pharmacy Networks

BCBSNE members will pay less out of pocket on prescriptions filled with in-network pharmacies. Members may also use Express Scripts® Pharmacy to order up to a 90-day supply of maintenance medications at one time (if allowed by the prescription).

All BluePride plans will use Pharmacy Network J (out-of-network benefits are available).

In-Network

- Walgreens
- Walmart/ Sam's Clubs
- Hy-Vee
- Think
- Baker's
- U Save
- Super Saver

Out-of-Network

- Costco
- CVS
- Target

This a partial list and is subject to change at any time without notice. For a complete list visit **NebraskaBlue.com/Pharmacy**.

Prescription Drug List

Groups who are new or renewing on or after Jan. 1, 2021, will be on PDL 64. To search the list or download a copy, visit **NebraskaBlue.com/DrugList**.

Retail Pharmacies

Members should take their prescription to an in-network pharmacy and show the pharmacist their member ID card. The member will pay the applicable copay, deductible or coinsurance amount.

Please note: Whenever appropriate, generic drugs will be used to fill prescriptions. If a brand-name drug is preferred when a generic equivalent is available, the member will be responsible for the difference in cost, plus the applicable copay or coinsurance amount. Out-of-network deductible and coinsurance will apply to prescriptions filled at an out of network pharmacy or if a BCBSNE member ID card is not presented at an in-network pharmacy.

Prescription Drug Tiers

Prescription drugs are divided into the following six tiers. The cost for each 30-day supply of a covered prescription drug depends on the tier in which the medication is listed.

TIER 1
PREFERRED GENERIC

Commonly prescribed generic drugs.

TIER 2
NON-PREFERRED GENERIC

Higher-priced generic drugs that cost a little more than tier 1.

TIER 3
PREFERRED BRAND

Brand-name drugs that do not have a generic equivalent.

TIER 4
NON-PREFERRED BRAND

Higher-priced brand-name drugs. Often have a generic equivalent.

TIER 5
PREFERRED SPECIALTY

Lower-cost specialty drugs. Used to treat complex conditions like cancer.

TIER 6
NON-PREFERRED SPECIALTY

The most expensive drugs on the drug list which can be generic or brand name.

$ LOWEST COST ⟵ ⟶ HIGHEST COST $$

Prime Therapeutics LLC is an independent company providing pharmacy benefit management services for Blue Cross and Blue Shield of Nebraska.
Express Scripts Pharmacy is contracted to provide mail pharmacy services for Blue Cross and Blue Shield of Nebraska.
Express Scripts Pharmacy is a trademark of Express Scripts Strategic Development, Inc.

Home Delivery Service

If BCBSNE members use Express Scripts® Pharmacy, they may order a 90-day supply of maintenance medication by paying the applicable copay amount for each 30-day supply.

Specialty Pharmacy

For specialty drugs to be considered in network, those drugs must be purchased through a designated specialty pharmacy. Members can receive two fills at retail before they must use a designated specialty pharmacy. After the second fill, if a member uses retail or another mail order facility, benefits will be denied. In-network specialty pharmacies include Accredo (for fully insured and self-funded groups beginning July 1, 2021), as well as Think Whole Person Healthcare, Nebraska Medicine and OptionCare Pharmacy.

Prior Authorization

As part of our efforts to address the serious issue of escalating costs and to continue to provide members with access to quality and cost-effective pharmacy care, we require benefits for certain prescription products to be prior authorized. Those products include: GI protective NSAIDs, proton pump inhibitors, diabetic test strips and testosterone PA programs. For a list of additional products requiring prior authorized, visit **NebraskaBlue.com/DrugList**.

Extended Supply Network Pharmacy Benefit

As part of Network J, BCBSNE offers our Extended Supply Network (ESN) retail pharmacy benefit to all BluePride members. This benefit allows members to get a 90-day supply of prescription medications at one time from a retail pharmacy (if allowed by their prescription).*

Members on these options must pay three copays at one time to purchase a 90-day supply of a preferred generic drug:

BluePride: SPA21, SPB21, SPC21, GPA21, GPB21 and GPC21.

Members on these options must pay the applicable deductible or coinsurance amounts:

BluePride: GHA21, GHB21, SHA21, SHB21, SHC21 and BHA21.

Using the Network J pharmacy benefit for up to a 90-day supply of medications means fewer trips to the pharmacy, saving our members time.

Members may view a list of Network J pharmacies under the Pharmacy Benefits tab at **myNebraskaBlue.com/ToolsAndResources**, or by calling our Member Services department at the number on the back of their member ID card

COST SAVINGS

Members pay less when they choose generic medications from our drug list. Members should talk to their doctor about what is right for them.

CONVENIENCE

Members can use their benefits at many pharmacies. They should show their member ID card at the pharmacy. Find in-network pharmacies at **NebraskaBlue.com/Pharmacy**.

TIME SAVINGS

Maintenance medications are drugs taken on a regular basis. Members may have up to a 90-day supply delivered directly to them through Express Scripts® Pharmacy.

ONLINE RESOURCES

Members may search the drug list, find a pharmacy, view their claims and get an estimate of their cost for a medication 24/7 by logging in to **myNebraskaBlue.com**.

*Except for specialty drugs.

Accredo is contracted to provide services for Blue Cross and Blue Shield of Nebraska. Accredo is a trademark of Express Scripts Strategic Development, Inc.

COMPARE PLANS

Find the Plan That Fits Your Group's Budget and Needs

Compare our plans to find the coverage you need at the price that works for you and your employees. We have 12 unique health insurance plans available.

All BluePride options meet the requirements mandated by the Affordable Care Act (ACA). So, with BluePride you can offer your employees health plans that cover all the essential health benefits, including pediatric dental and vision. These plans offer the highest level of benefits to members when they obtain services from any physician or hospital designated as in network. Selecting an in-network provider means less out-of-pocket costs. If members choose to see an out-of-network provider, they will have higher out-of-pocket costs.

About Qualified High Deductible Health Plans and Health Savings Accounts

BluePride offers Qualified High-Deductible Health Plan (QHDHP) options. These options provide members with the same benefits as a traditional PPO plan. QHDHPs usually have lower monthly premiums and higher out-of-pocket costs. However, QHDHPs work in combination with a Health Savings Account (HSA) to help members save, pay for their health care and experience some tax benefits.

An HSA allows members to pay for qualified medical expenses such as out-of-pocket costs for office visits, prescription drugs, dental expenses and laboratory tests on a tax-free basis.

Contributions to an HSA are tax deductible and can earn tax-free interest. Members decide how and when to use their HSA funds. Unused dollars roll over from year-to-year, making HSAs a convenient way to save for future healthcare expenses.

Check with your tax advisor to see if an HSA plan is right for your group. You can set up an HSA account with any financial institution of your choice or we can help. Just contact a member of your BCBSNE account management team.

Embedded and Aggregate Deductible

All options with the exception of Gold GHA21 and GHB21 require satisfaction of an embedded family deductible and out-of-pocket limit.

Embedded

Embedded family deductible means if the member has family coverage, family members may combine their covered expenses to satisfy the required calendar year family deductible. However, no one family member contributes more than the individual deductible amount to satisfy the family's deductible.

After the required deductible has been satisfied, the member is responsible for paying a certain percentage of covered charges, called coinsurance, until the out-of-pocket limit has been reached. Under family coverage, the family may combine their covered expenses to satisfy the required **embedded family out-of-pocket limit**. No one family member contributes more than the individual out-of-pocket limit to satisfy the family's out-of-pocket limit.

Note: Copay amounts for medical services and prescription drugs do not apply toward the calendar year deductible.

Gold options GHA21 and GHB21 require satisfaction of an aggregate family deductible and out-of-pocket limit.

Aggregate

Aggregate family deductible means if the member has family coverage, the entire family deductible must be met prior to most benefits becoming available. Family members may combine their covered expenses to satisfy the required family deductible. After the required deductible has been satisfied, the member is responsible for paying a certain percentage of covered charges, called coinsurance, until the out-of-pocket limit has been reached. Under family membership, the entire **aggregate family out-of-pocket limit** must be met before covered services are paid at 100%. Family members may combine their covered expenses to satisfy the required out-of-pocket limit.

Plan Options

› GOLD PLANS

Highest premium costs

Lowest out-of-pocket costs

› SILVER PLANS

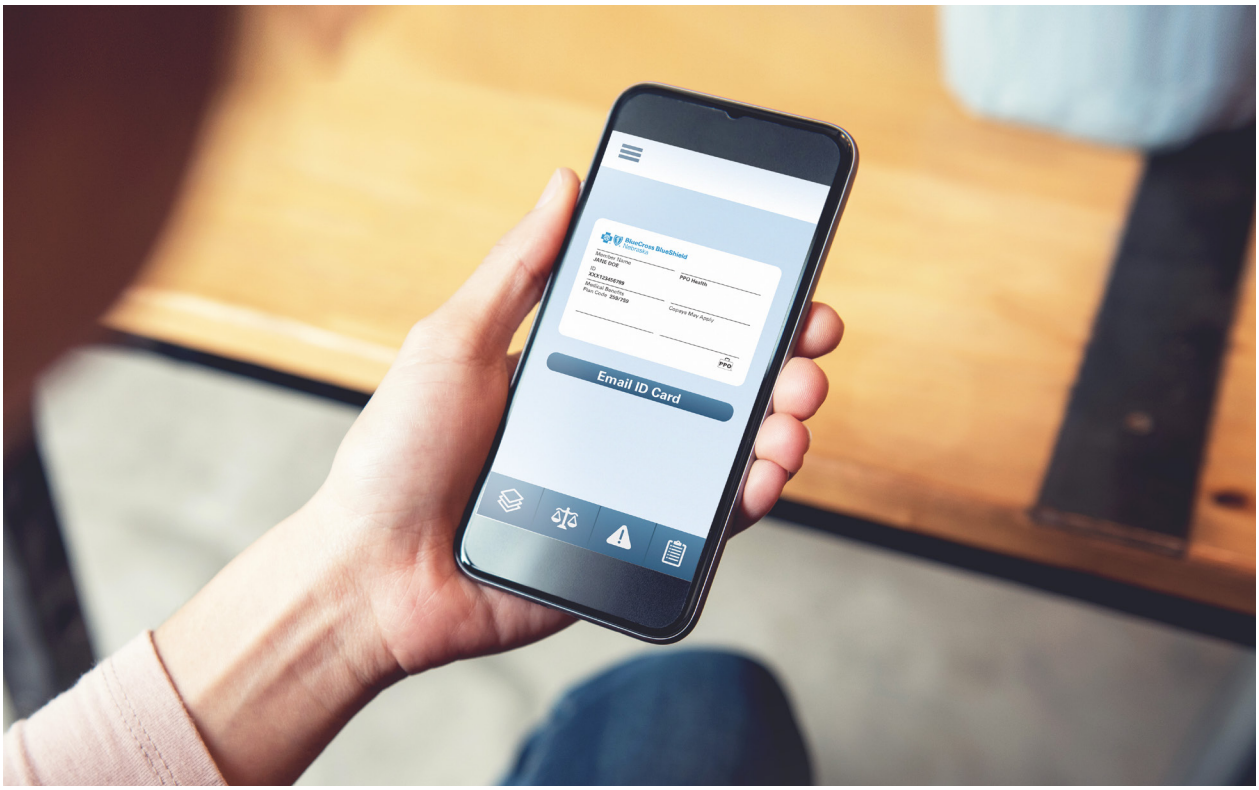
Higher premium costs than Bronze plans

Lower out-of-pocket costs than Bronze plans

› BRONZE PLAN

Lowest premium costs

Higher out-of-pocket costs when members receive care



	BluePride Gold GPA21		BluePride Gold GPB21	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible				
Individual	$1,000	$2,000	$2,000	$4,000
Family	$2,000	$4,000	$4,000	$8,000
Type of Deductible	Embedded	Embedded	Embedded	Embedded
Coinsurance (Amount Member Pays)				
Hospital/Medical/Surgical/Other	40%	50%	30%	50%
Out-of-pocket Limit (Includes Deductible, Coinsurance and Copays)				
Individual	$4,250	$8,500	$6,000	$12,000
Family	$8,500	$17,000	$12,000	$24,000
Type of Out-of-pocket Limit	Embedded	Embedded	Embedded	Embedded
Preventive Care				
Preventive Care Services	0%	Deductible & Coinsurance	0%	Deductible & Coinsurance
Physician Office				
Primary Care Physician Office	$30 Copay	Deductible & Coinsurance	$30 Copay	Deductible & Coinsurance
Specialist Physician Office	$75 Copay	Deductible & Coinsurance	$60 Copay	Deductible & Coinsurance
Telehealth	$10 Copay	Not Covered	$10 Copay	Not Covered
Pregnancy and Maternity Services				
Pre/Postnatal Care and Delivery	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Emergency Care				
Urgent Care Facility Services	$75 Copay	Deductible & Coinsurance	$60 Copay	Deductible & Coinsurance
Emergency Care Services	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits
Ambulance Services	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits
Mental Illness and/or Substance Dependence and Abuse Services				
Inpatient	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Outpatient	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Office Services	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Emergency Care Services	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits
Telehealth	Deductible & Coinsurance	Not Covered	Deductible & Coinsurance	Not Covered
	In-Network	Out-of-Network	In-Network	Out-of-Network
Prescription Drugs (See Pharmacy Pages)				
Preferred Generic	$10 Copay	50% Coinsurance	$10 Copay	50% Coinsurance
Non-Preferred Generic	$30 Copay	50% Coinsurance	$30 Copay	50% Coinsurance
Preferred Brand	$50 Copay	50% Coinsurance	$50 Copay	50% Coinsurance
Non-Preferred Brand	$125 Copay	50% Coinsurance	$125 Copay	50% Coinsurance
Preferred Specialty[1]	Deductible + 40% Coinsurance	Deductible & 50% Coinsurance	Deductible + 40% Coinsurance	Deductible & 50% Coinsurance
Non-Preferred Specialty[1]	Deductible + 50% Coinsurance	Deductible & 50% Coinsurance	Deductible + 50% Coinsurance	Deductible & 50% Coinsurance

1 Specialty drugs must be purchased through a designated specialty pharmacy after two fills.

	BluePride Gold GHA21 QHDHP		BluePride Gold GHB21 QHDHP	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible				
Individual	$1,750	$3,500	$2,700	$5,400
Family	$3,500	$7,000	$5,400	$10,800
Type of Deductible	Aggregate	Aggregate	Aggregate	Aggregate
Coinsurance (Amount Member Pays)				
Hospital/Medical/Surgical/Other	10%	40%	0%	0%
Out-of-pocket Limit (Includes Deductible, Coinsurance and Copays)				
Individual	$3,375	$6,750	$2,700	$5,400
Family	$6,750	$13,500	$5,400	$10,800
Type of Out-of-pocket Limit	Aggregate	Aggregate	Aggregate	Aggregate
Preventive Care				
Preventive Care Services	0%	Deductible & Coinsurance	0%	Deductible & Coinsurance
Physician Office				
Primary Care Physician Office	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Specialist Physician Office	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Telehealth	Deductible & Coinsurance	Not Covered	Deductible & Coinsurance	Not Covered
Pregnancy and Maternity Services				
Pre/Postnatal Care and Delivery	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Emergency Care				
Urgent Care Facility Services	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Emergency Care Services	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits
Ambulance Services	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits
Mental Illness and/or Substance Dependence and Abuse Services				
Inpatient	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Outpatient	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Office Services	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Emergency Care Services	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits
Telehealth	Deductible & Coinsurance	Not Covered	Deductible & Coinsurance	Not Covered
	In-Network	Out-of-Network	In-Network	Out-of-Network
Prescription Drugs (See Pharmacy Pages)				
Preferred Generic	Deductible & Coinsurance	Deductible & 50% Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Non-Preferred Generic	Deductible & Coinsurance	Deductible & 50% Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Preferred Brand	Deductible & Coinsurance	Deductible & 50% Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Non-Preferred Brand	Deductible & Coinsurance	Deductible & 50% Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Preferred Specialty[1]	Deductible & Coinsurance	Deductible & 50% Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Non-Preferred Specialty[1]	Deductible & Coinsurance	Deductible & 50% Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance

1 Specialty drugs must be purchased through a designated specialty pharmacy after two fills.

	BluePride Gold GPC21		BluePride Silver SPA21	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible				
Individual	$2,500	$5,000	$3,000	$6,000
Family	$5,000	$10,000	$6,000	$12,000
Type of Deductible	Embedded	Embedded	Embedded	Embedded
Coinsurance (Amount Member Pays)				
Hospital/Medical/Surgical/Other	30%	50%	50%	50%
Out-of-pocket Limit (Includes Deductible, Coinsurance and Copays)				
Individual	$6,550	$13,100	$8,000	$16,000
Family	$13,100	$26,200	$16,000	$32,000
Type of Out-of-pocket Limit	Embedded	Embedded	Embedded	Embedded
Preventive Care				
Preventive Care Services	0%	Deductible & Coinsurance	0%	Deductible & Coinsurance
Physician Office				
Primary Care Physician Office	$30 Copay	Deductible & Coinsurance	$40 Copay	Deductible & Coinsurance
Specialist Physician Office	$60 Copay	Deductible & Coinsurance	$75 Copay	Deductible & Coinsurance
Telehealth	$10 Copay	Not Covered	$10 Copay	Not Covered
Pregnancy and Maternity Services				
Pre/Postnatal Care and Delivery	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Emergency Care				
Urgent Care Facility Services	$60 copay	Deductible & Coinsurance	$75 Copay	Deductible & Coinsurance
Emergency Care Services	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits
Ambulance Services	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits
Mental Illness and/or Substance Dependence and Abuse Services				
Inpatient	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Outpatient	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Office Services	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Emergency Care Services	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits
Telehealth	Deductible & Coinsurance	Not Covered	Deductible & Coinsurance	Not Covered
	In-Network	Out-of-Network	In-Network	Out-of-Network
Prescription Drugs (See Pharmacy Pages)				
Preferred Generic	$10 Copay	50% Coinsurance	$10 Copay	50% Coinsurance
Non-Preferred Generic	$30 Copay	50% Coinsurance	$30 Copay	50% Coinsurance
Preferred Brand	$50 Copay	50% Coinsurance	$50 Copay	50% Coinsurance
Non-Preferred Brand	$125 Copay	50% Coinsurance	$125 Copay	50% Coinsurance
Preferred Specialty[1]	Deductible + 40% Coinsurance	Deductible & 50% Coinsurance	Deductible + 40% Coinsurance	Deductible & 50% Coinsurance
Non-Preferred Specialty[1]	Deductible + 50% Coinsurance	Deductible & 50% Coinsurance	Deductible + 50% Coinsurance	Deductible & 50% Coinsurance

1 Specialty drugs must be purchased through a designated specialty pharmacy after two fills.

	BluePride Silver SPB21		BluePride Silver SPC21	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible				
Individual	$4,000	$8,000	$6,000	$12,000
Family	$8,000	$16,000	$12,000	$24,000
Type of Deductible	Embedded	Embedded	Embedded	Embedded
Coinsurance (Amount Member Pays)				
Hospital/Medical/Surgical/Other	30%	50%	50%	50%
Out-of-pocket Limit (Includes Deductible, Coinsurance and Copays)				
Individual	$8,150	$16,300	$8,150	$16,300
Family	$16,300	$32,600	$16,300	$32,600
Type of Out-of-pocket Limit	Embedded	Embedded	Embedded	Embedded
Preventive Care				
Preventive Care Services	0%	Deductible & Coinsurance	0%	Deductible
Physician Office				
Primary Care Physician Office	$50 Copay	Deductible & Coinsurance	$50 Copay	Deductible
Specialist Physician Office	$75 Copay	Deductible & Coinsurance	$125 Copay	Deductible
Telehealth	$15 Copay	Not Covered	$15 Copay	Not Covered
Pregnancy and Maternity Services				
Pre/Postnatal Care and Delivery	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible
Emergency Care				
Urgent Care Facility Services	$75 Copay	Deductible & Coinsurance	Deductible & Coinsurance	Deductible
Emergency Care Services	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits
Ambulance Services	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits
Mental Illness and/or Substance Dependence and Abuse Services				
Inpatient	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible
Outpatient	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible
Office Services	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible
Emergency Care Services	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits
Telehealth	Deductible & Coinsurance	Not Covered	Deductible & Coinsurance	Not Covered
	In-Network	Out-of-Network	In-Network	Out-of-Network
Prescription Drugs (See Pharmacy Pages)				
Preferred Generic	$10 Copay	50% Coinsurance	$10 Copay	50% Coinsurance
Non-Preferred Generic	$30 Copay	50% Coinsurance	$30 Copay	50% Coinsurance
Preferred Brand	$50 Copay	50% Coinsurance	$75 Copay	50% Coinsurance
Non-Preferred Brand	$125 copay	50% Coinsurance	Deductible & Coinsurance	Deductible & 50% Coinsurance
Preferred Specialty[1]	Deductible + 40% Coinsurance	Deductible & 50% Coinsurance	Deductible & Coinsurance	Deductible & 50% Coinsurance
Non-Preferred Specialty[1]	Deductible + 50% Coinsurance	Deductible & 50% Coinsurance	Deductible & Coinsurance	Deductible & 50% Coinsurance

1 Specialty drugs must be purchased through a designated specialty pharmacy after two fills.

	BluePride Silver SHA21 QHDHP		BluePride Silver SHB21 QHDHP	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible				
Individual	$3,000	$6,000	$4,500	$9,000
Family	$6,000	$12,000	$9,000	$18,000
Type of Deductible	Embedded	Embedded	Embedded	Embedded
Coinsurance (Amount Member Pays)				
Hospital/Medical/Surgical/Other	30%	50%	0%	0%
Out-of-pocket Limit (Includes Deductible, Coinsurance and Copays)				
Individual	$6,000	$12,000	$4,500	$9,000
Family	$12,000	$24,000	$9,000	$18,000
Type of Out-of-pocket Limit	Embedded	Embedded	Embedded	Embedded
Preventive Care				
Preventive Care Services	0%	Deductible & Coinsurance	0%	Deductible
Physician Office				
Primary Care Physician Office	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible
Specialist Physician Office	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible
Telehealth	Deductible & Coinsurance	Not Covered	Deductible & Coinsurance	Not Covered
Pregnancy and Maternity Services				
Pre/Postnatal Care and Delivery	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible
Emergency Care				
Urgent Care Facility Services	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible
Emergency Care Services	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits
Ambulance Services	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits
Mental Illness and/or Substance Dependence and Abuse Services				
Inpatient	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible
Outpatient	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible
Office Services	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible
Emergency Care Services	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits
Telehealth	Deductible & Coinsurance	Not Covered	Deductible & Coinsurance	Not Covered
	In-Network	Out-of-Network	In-Network	Out-of-Network
Prescription Drugs (See Pharmacy Pages)				
Preferred Generic	Deductible & Coinsurance	Deductible & 50% Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Non-Preferred Generic	Deductible & Coinsurance	Deductible & 50% Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Preferred Brand	Deductible & Coinsurance	Deductible & 50% Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Non-Preferred Brand	Deductible & Coinsurance	Deductible & 50% Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Preferred Specialty[1]	Deductible & Coinsurance	Deductible & 50% Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Non-Preferred Specialty[1]	Deductible & Coinsurance	Deductible & 50% Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance

1 Specialty drugs must be purchased through a designated specialty pharmacy after two fills.

	BluePride Silver SHC21 QHDHP		BluePride Bronze BHA21 QHDHP	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible				
Individual	$5,000	$10,000	$7,000	$14,000
Family	$10,000	$20,000	$14,000	$28,000
Type of Deductible	Embedded	Embedded	Embedded	Embedded
Coinsurance (Amount Member Pays)				
Hospital/Medical/Surgical/Other	20%	50%	0%	0%
Out-of-pocket Limit (Includes Deductible, Coinsurance and Copays)				
Individual	$6,000	$12,000	$7,000	$14,000
Family	$12,000	$24,000	$14,000	$28,000
Type of Out-of-pocket Limit	Embedded	Embedded	Embedded	Embedded
Preventive Care				
Preventive Care Services	0%	Deductible & Coinsurance	0%	Deductible & Coinsurance
Physician Office				
Primary Care Physician Office	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Specialist Physician Office	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Telehealth	Deductible & Coinsurance	Not Covered	Deductible & Coinsurance	Not Covered
Pregnancy and Maternity Services				
Pre/Postnatal Care and Delivery	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Emergency Care				
Urgent Care Facility Services	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Emergency Care Services	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits
Ambulance Services	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits
Mental Illness and/or Substance Dependence and Abuse Services				
Inpatient	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Outpatient	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Office Services	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Emergency Care Services	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits
Telehealth	Deductible & Coinsurance	Not Covered	Deductible & Coinsurance	Not Covered
			In-Network	Out-of-Network
Prescription Drugs (See Pharmacy Pages)				
Preferred Generic	Deductible & Coinsurance	Deductible & 50% Coinsurance	Deductible	Deductible & Coinsurance
Non-Preferred Generic	Deductible & Coinsurance	Deductible & 50% Coinsurance	Deductible	Deductible & Coinsurance
Preferred Brand	Deductible & Coinsurance	Deductible & 50% Coinsurance	Deductible	Deductible & Coinsurance
Non-Preferred Brand	Deductible & Coinsurance	Deductible & 50% Coinsurance	Deductible	Deductible & Coinsurance
Preferred Specialty[1]	Deductible & Coinsurance	Deductible & 50% Coinsurance	Deductible	Deductible & Coinsurance
Non-Preferred Specialty[1]	Deductible & Coinsurance	Deductible & 50% Coinsurance	Deductible	Deductible & Coinsurance

1 Specialty drugs must be purchased through a designated specialty pharmacy after two fills.

MEMBER RESOURCES

Telehealth – a Fast, Easy Way to See a Doctor

BCBSNE offers telehealth services through Amwell, the industry's leading telehealth solution – serving more than 100 million people. With telehealth services, you can offer your members access to a nationwide network of U.S. board-certified physicians, available for live visits over computer, tablet or phone, whenever members need them. Telehealth services cost less than visits to the emergency room, urgent care, or edoctor's office – and they save members two to three hours per consult. Best of all, members love it.

Behavioral Health Services Available

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
- And more

Member Communications

You may use our free telehealth communications toolkit to promote this service to your members. Visit **NebraskaBlue.com/Resources** to view and print. The toolkit includes:

- An article you may post on your intranet or in other member communications
- A flier you may distribute to your members
- Email templates you may send to your members during open enrollment and throughout the year
- A poster to display in your break rooms
- FAQs to post on your intranet or other member communications

Employer Toolkits Available

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

myNebraskaBlue.com

It only takes a couple of minutes for BCBSNE members to gain access to a wealth of online tools that give them more control over their health plan and personal wellness. After signing up at myNebraskaBlue.com, members will instantly access details about their insurance plan and be able to track their spending.

With myNebraskaBlue, members can:

- View their claims activity
- Contact customer service via secure email
- Find a doctor close to work or home
- Access their mobile ID card or order printed cards
- Track their health care spending
- Access pharmacy information
- Select their Explanation of Benefits delivery preference – paper or electronic

To learn more, visit **myNebraskaBlue.com**. You may view the tool as a guest by selecting "Guest" on the **myNebraskaBlue.com** home page.

Prescription Resources with MyPrime®

BCBSNE contracts with Prime Therapeutics® to provide group pharmacy benefits. Members may view information about their pharmacy benefits by logging in to myNebraskaBlue.com. Members select Tools & Resources, Pharmacy Benefits and they will be directed to the **MyPrime.com**. This website is loaded with interactive tools to help members manage their prescription drugs.

With MyPrime, members can find:

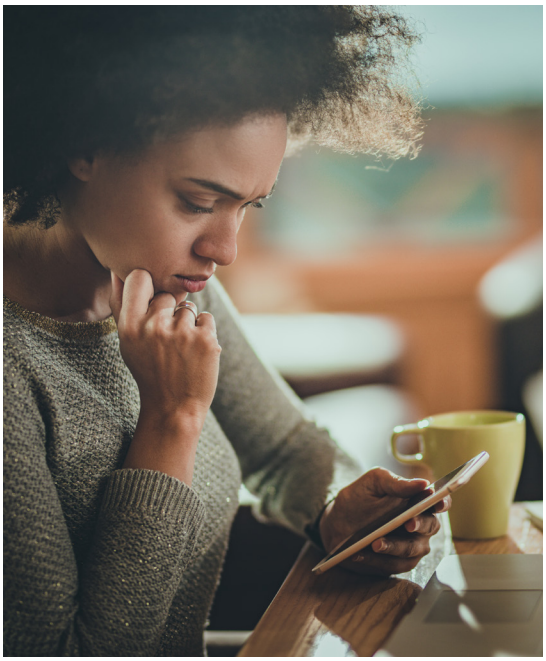
- Their prescription benefits
- Their drug claim history
- Their prescription drug list
- A pharmacy locator
- A drug cost calculator
- A comparison of drug costs

Wellness Services

Our wellness and lifestyle program offers:

- Consultative services and resources to help businesses activate wellbeing initiatives
- Educational information targeting healthier lifestyles
- Personal health assessment tools
- Self-service tools such as calculators and challenges

To check out all the valuable health and wellness resources, visit **NebraskaBlue.com/Wellness.**



Care Management Programs

As part of your health plan, members have access to free resources, including our mobile health app, that can make it easier to manage your care. The free resources include:

- Health Coaching: Work with a nurse health coach to get help with stress, smoking cessation, chronic conditions and other challenges.
- Diabetes Management: Our diabetes educators will create a plan to help members better manage their diabetes and related issues.
- Pregnancy Care: Whether members have a high-risk or healthy pregnancy, our labor and delivery nurses can help answer members' questions and provide support between doctor appointments.

To learn more, visit **NebraskaBlue.com/GettingCare**.

Blue365®
Because health is a big deal℠

Blue365 is a national program that offers members health and wellness discounts and savings. Members can explore special offerings from leading national companies in these categories:

- Apparel and footwear
- Fitness
- Hearing and vision
- Home and family
- Nutrition
- Personal care
- Travel

Visit **NebraskaBlue.com/Blue365** to learn more.

Participation in the Pregnancy Care Program does not affect members' health plan coverage for maternity/pregnancy care or entitle members to benefits not otherwise payable under the BCBSNE plan.

BENEFITS AND RESPONSIBILITIES

General Information

Applications for coverage are subject to our approval.

The Premier Select BlueChoice network is available only to groups that are headquartered in the Omaha, Lincoln and surrounding communities in ZIP codes starting with 680, 681, 683, 684 and 685.

The Blueprint Health network is available only to groups headquartered in the Omaha, Lincoln and surrounding communities in ZIP codes starting with 680, 681, 683, 684 and 685, as well as Adams, Buffalo, Hall, Kearney and Phelps counties.

Types of Enrollment Available

Single Membership: Covers the employee only.

Employee and Spouse Membership: Covers the employee and spouse.

Employee and Child(ren) Membership: Covers the employee and eligible dependent children to age 26, but does not provide coverage to a spouse.

Family Membership: Includes spouse and child(ren) up to the age 26.

Allowable Charge

Claim amounts are based on the allowable charge for a covered service. Generally, the allowable charge for services by in-network providers will be the contracted amount with BCBSNE. The allowable charge for services by non-contracting providers is the amount we determine for out-of-network. Members are responsible for the charges in excess of the allowable charge for services provided by a non-contracted provider.

Copayment (Copay)

A copay is a fixed dollar amount (for instance, $15) of the allowable charge the member pays for a covered service. Copayments are separate from and do not accumulate toward the deductible.

The BluePride plan deductibles, copays and coinsurance are shown on pages 12-17.

Out-of-Pocket Limit

(includes deductible, coinsurance and copayment amounts for medical and pharmacy services)

The policy has a yearly out-of-pocket limit, which is the total amount of cost-sharing members are required to pay toward the cost of health care. After the annual out-of-pocket limit is reached, the plan pays covered services 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. 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.

Inpatient Hospital Benefits
(including long-term acute care)

Benefits are available for (but not limited to):

- Semi-private room, cardiac and intensive care units, treatment rooms and equipment
- Anesthesia
- FDA-approved drugs, intravenous solutions and vaccines administered in the hospital
- Physical, occupational and speech therapy
- Radiology, pathology and radiation therapy
- Respiratory care
- Inpatient physical rehabilitation, subject to certain requirements*
- Up to 60 days per calendar year in a skilled nursing facility when ordered by a physician*

* Requires benefit certification. For more information, see page 27.

Outpatient Hospital Benefits

Benefits for the covered services listed under "Inpatient Hospital Benefits" are also available (subject to certain limitations) when they are received in a hospital outpatient department, emergency room or ambulatory surgical facility. Benefits for outpatient cardiac and pulmonary rehabilitation are available, subject to medical criteria.

Orthopedic Specialty Inpatient Hospital or Facility Services

Benefits are available in which Deductible and Coinsurance may be waived if Covered Services are provided at a designated Preferred Center. See **NebraskaBlue.com/Preferred** for a list of Covered Services and designated hospitals.

Benefits for Physician's Services

Benefits are available for (but not limited to):

- Allergy serums and injections of allergy extracts
- Anesthesia services
- Consultation services
- Tissue examinations
- Physician home and outpatient visits
- Radiation therapy and chemotherapy
- Radiology, pathology and other diagnostic services
- Surgery and surgical assistance (for specified procedures)
- FDA-approved drugs
- Inpatient hospital visits

Primary Care Physician and Specialist Office Services Copays

When a member goes to a network primary care physician or specialist, he or she pays the plan's designated copay for office visit services.* Only covered services and supplies obtained in the physician's office will be payable under the office services copay benefit. For office visits to out-of-network primary care physicians and specialists, benefits for covered services will be subject to the plan's applicable deductible and coinsurance amounts.

Covered services include:

- Physician office visits and consultations
- X-ray, lab and pathology services
- Supplies used to treat the patient during the office visit (excluding home medical equipment)
- Drugs administered during an office visit
- Hearing and vision exams (non-routine/preventive)
- Allergy testing and injections

For purposes of this coverage, a primary care physician is a physician who has a majority of his or her practice in the fields of internal or general medicine, obstetrics/gynecology, general pediatrics or family practice. All other types of physicians are considered specialists.

* The primary care physician/specialist office services copay benefit is not available under all plans. Benefits for all covered services are subject to deductible and coinsurance for plans that do not include the primary care physician/specialist office services copay.

Benefits for Hearing Aids

Benefits are available for hearing aids for members up to age 19. Limitations and exlusions apply.

Benefits for Maternity and Newborn

Maternity coverage is included in all plan options and is available to employees, as well as covered spouses and dependent daughters. If the employee is covered under a single membership, benefits are available for the newborn for 31 days from the date of birth. To continue the newborn's coverage beyond this time period, the employee must request a change to family membership within those 31 days and pay the additional premium.

Benefits are available for screening tests (including newborn/infant hearing) and physician services for routine exams of a newborn well infant while the baby is confined. All covered charges incurred by a newborn from birth will be subject to the baby's calendar year deductible.

Obstetrical benefits include prenatal and postnatal care.

Benefits for Mental Illness and Substance Dependence and Abuse Services

Benefits will be provided for covered services for the treatment of mental illness and substance dependence and abuse. Covered services include inpatient and outpatient services, including but not limited to:

- Psychological therapy and/or substance dependence and abuse counseling by approved providers
- Office visits
- Specified outpatient programs
- Emergency care services

Certain exclusions/limitations may apply.

Benefits for Preventive Services

Benefits will be provided for In-network preventive services as required by the Patient Protection and Affordable Care Act (PPACA) and will not be subject to cost-sharing requirements, such as copayment, coinsurance or deductible. A listing of these services is available upon request.

In addition to those preventive services required by the ACA, benefits will be provided for other preventive services, including:

- Specific laboratory/pathology services
- Hearing screenings and examinations
- Prostate cancer screenings

Benefits for Oral Surgery

Benefits are available for (but not limited to) the following covered services:

- Removal of tumors and cysts
- Nonsurgical treatment of infections
- Treatment of jaw joint dislocation/fracture due to an accident. Services must occur within 12 months of an injury not related to eating, biting or chewing
- Services, supplies or appliances for dental treatment of natural healthy teeth required as the direct result of an accidental Injury. Benefits for such services are limited, however, to covered services provided within 12 months of the date of Injury. Benefits are not available for orthodontics or dental implants. Benefits shall not be provided for services when the Injury occurs as the result of eating, biting or chewing.
- Medically necessary hospitalization and general anesthesia in order for the covered person to safely receive dental care, including covered persons who are under eight years of age.
- Diagnostic services and surgery related to temporomandibular jaw joint (TMJ).

Benefits for Organ and Tissue Transplantation

Benefits are available for services associated with medically necessary organ and tissue transplantation, including (but not limited to) liver, heart, single and double lung, lobar lung, heart-lung, heart valve (heterograft), kidney, kidney-pancreas, pancreas, bone graft, cornea, parathyroid, small intestine, small intestine and liver, small intestine and multiple viscera.

Benefits are also available for bone marrow transplants, including, but not limited to, autologous and allogeneic stem cell transplants.

Transplant procedures require certification by BCBSNE and are subject to medical policy criteria.

Benefits for Home Skilled Nursing Care, Home Health Aide, Hospice Services and Respiratory Care

The following covered services require benefit preauthorization. Limitations and exclusions apply.

- **Skilled nursing care:** Benefits are available for medically necessary physician-ordered care by a registered or licensed practical nurse for up to eight hours per day.
- **Home health aide:** When services are related to active medical treatment, benefits include personal services such as bathing, feeding and performing necessary household duties for a homebound patient.
- **Hospice services:** Benefits include Medicare-certified hospice services for a terminally ill patient, including home health aide and hospice nursing services, respite care, medical social worker visits, crisis care and bereavement counseling.
- **Respiratory care:** Benefits are available for respiratory care services in the home, including airway maintenance, chest physiotherapy, delivery of medications, oxygen therapy, obtaining laboratory samples and pulmonary function testing.

Benefits for Pediatric Dental Services

Pediatric dental services are available to members under the age of 19. Covered members will receive in-network benefits whenever they use dentists in our dental network. This is a provider network of multiple Blue Cross and Blue Shield Plans that, when combined, offers members one of the largest PPO dental networks in the nation. It provides patients with lower out-of-pocket costs and broad access to participating dentists.

Find network providers in Nebraska and anywhere in the United States by visiting **NebraskaBlue.com/Find-a-Doctor**. For a complete list of covered services and exclusions and limitations, please view the master group contract.

Pediatric Dental Covered Services	In-Network	Out-of-Network
Type A Services Preventive and diagnostic dentistry	Deductible and coinsurance	Deductible and coinsurance
Type B Services Maintenance and simple restorative dentistry	Deductible and coinsurance	Deductible and coinsurance
Type C Services Complex restorative dentistry	Deductible and coinsurance	Deductible and coinsurance
Type D Services Orthodontic dentistry • Medical necessity required • Limited to metal braces only	Deductible, then covered person pays 70% coinsurance	Deductible, then covered person pays 70% coinsurance

Benefits for Pediatric Vision Services

Coverage for pediatric vision services is available for covered person up to age 19 under all BluePride plans.

Pediatric vision exclusions:

- Laser vision correction
- Visual therapy
- Replacement of lost or stolen eyewear
- Non-prescription and deluxe eyeglasses (athletic, safety and sunglasses)
- Vision prosthetic devices and related services
- Purchase of insurance on eyewear
- Color contact lenses

Find network providers in Nebraska and anywhere in the United States by visiting **NebraskaBlue.com/Find-a-Doctor**.

For a complete list of covered services and exclusions and limitations, please view the master group contract.

Pediatric Vision Covered Services	In-Network	Out-of-Network
Vision Examination (including refraction and dilation, up to one exam per calendar year)	Deductible and coinsurance	Deductible and coinsurance
Eyeglass Frames/Lenses or Contacts (limited to one set of frames and eyeglass lenses per calendar year, or contact lenses per calendar year)	Deductible, then 50% coinsurance	In-network level of benefits
Medically Necessary Contact Lenses* (in lieu of eyeglasses, includes evaluation and fitting)	Deductible, then 50% coinsurance	In-network level of benefits

* If use of medically necessary contact lenses will result in significantly better visual and/or improved binocular function. Refer to contract for list of specific diseases.

NOTE: Contact lenses, including the evaluation and fitting requires certification in excess of $600.

Other Covered Services

(Please note: Limitations and exclusions apply.)

- Ambulance services
- Diabetes outpatient self-management training and patient management from an approved provider
- Physical, occupational or speech therapy services, chiropractic or osteopathic physiotherapy
  - Habilitative Services: Combined limit of 45 sessions per calendar year
  - Rehabilitative Services: Combined limit of 45 sessions per calendar year
- Chiropractic or osteopathic manipulative treatments or adjustments (combined limit of 20 sessions per calendar year)
- Rental/initial purchase (whichever costs less) of medically necessary home medical equipment ordered by a doctor; limited benefits are available for the repair, maintenance and adjustment of purchased covered medical equipment
- Services in accordance with the Women's Health and Cancer Rights Act, which requires that insurance companies that provide medical and surgical benefits for mastectomies also provide benefits for breast reconstruction, prostheses and treatment for physical complications

Refer to the contract for a complete listing.

Exclusions and Limitations

This document contains only a partial list of the limitations and exclusions that apply to BluePride health plans. For a complete listing, please refer to the master group contract.

No benefits are available for the following except for covered services provided as part of the preventive services benefit:

Services not covered by this contract

- External and surgically implantable devices to improve hearing, including audient bone conductors, and hearing aids and their fitting
- Eye exercises or visual training
- Routine eye exam for members age 19 or older
- Eyeglasses or contact lenses for members age 19 and older
- Infertility treatment and related services, including artificial insemination, embryo transfer procedures, drug and/or hormonal therapy, reversal of voluntary sterilization, ultrasounds, lab work and other testing done in conjunction with fertility treatment
- Massage therapy
- Treatment for weight reduction/obesity, including surgical procedures
- Nutrition care, supplies, supplements or other nutritional substances, including Neocate, Vivonex and other over-the-counter infant formulas and supplements
- Radial keratotomy or any other procedures/ alterations of the refractive character of the cornea to correct myopia, hyperopia and/or astigmatism
- Services we consider to be investigative, not medically necessary, experimental, cosmetic or obsolete
- Services, drugs, medical supplies, devices or equipment that are not cost effective compared to established alternatives or that are provided for the convenience or personal use of the patient
- Services provided before the coverage effective date or after termination
- Services for illness or injury sustained while performing military service
- Services for injury/illness arising out of or in the course of employment
- Charges for services which are not within the provider's scope of practice
- Charges in excess of our contracted amount
- Charges made separately for services, supplies and materials we consider to be included within the total charge payable

Certification Requirements

The purpose of certification is to determine whether a service or admission meets the medical necessity criteria of the policy.

All inpatient hospital admissions must be certified by BCBSNE. This enables us to coordinate discharge planning, case management and disease management services with the patient's providers. If the patient is hospitalized in a contracting (in-network) hospital in Nebraska, notification will be provided by the hospital.

If the patient is hospitalized in a non-contract (out-of-network) hospital in Nebraska or is admitted to an inpatient facility in another state, BCBSNE must be notified by the patient or their provider.

Certification is also required for the following care, regardless of where the care is received, in or out of network:

- Inpatient physical rehabilitation
- Long-term acute care
- Skilled nursing facility care
- Skilled nursing in the home
- Organ and tissue transplants
- Certain prescription drugs

This is not a complete list. Please refer to the contract for additional information.

The covered person is responsible for making sure that certification occurs; however, a hospital or provider may initiate the certification. When possible, certification should be completed prior to receiving the services. Benefits for services that are not certified or that are not medically necessary will be denied, the member will be responsible for the charges.

For certification of benefits for an inpatient admission, call 800-247-1103 or 402-390-1870.

BlueCross BlueShield
Nebraska

NebraskaBlue.com

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