BluePride

BlueCross BlueShield Nebraska

Schedule of Benefits Summary SPB20 Silver

In-Network provider network is shown on your ID card. For help in locating In-Network providers, visit www.nebraskablue.com.

PAYMENT FOR SERVICES	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
Deductible (Embedded*) • Individual • Family	 $4,000 $8,000	 $8,000 $16,000
Coinsurance • Covered Person Pays • Plan Pays	 30% 70%	 50% 50%
Out-of-pocket Limit (Embedded*) (includes Deductible, Coinsurance and Copays) • Individual • Family	 $8,150 $16,300	 $16,300 $32,600
Once the annual Out-of-pocket Limit is reached, 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	$50 Copay	Deductible and Coinsurance
• Specialist Physician Office Services	$75 Copay	Deductible and Coinsurance
• Telehealth Services	$15 Copay	Not Covered
Physician Professional Services (outpatient and inpatient services)	Deductible and Coinsurance	Deductible and Coinsurance
Urgent Care Facility Services (a single copay applies to each urgent care visit)	$75 Copay	Deductible and Coinsurance
Emergency Care Services (services received in a Hospital emergency room setting)		
• Facility	Deductible and Coinsurance	In-network level of benefits
• Professional Services	Deductible and Coinsurance	In-network level of benefits
Outpatient Hospital or Facility Services	Deductible and Coinsurance	Deductible and Coinsurance
Inpatient Hospital or Facility Services	Deductible and Coinsurance	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, complete blood count, comprehensive metabolic panel and general health 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 and services.	Same as illness	Same as illness
Immunization		
• Pediatric (up to age 7)	Plan Pays 100%	Coinsurance Only
• 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 SERVICES	**IN-NETWORK PROVIDER**	**OUT-OF-NETWORK PROVIDER**
Inpatient Services	Deductible and Coinsurance	Deductible and Coinsurance
Outpatient Services		
• Office Services	Deductible and Coinsurance	Deductible and Coinsurance
• Telehealth Services	Deductible and Coinsurance	Not Covered
• All other Outpatient items and services	Deductible and Coinsurance	Deductible and Coinsurance
Emergency Care Services (services received in a Hospital emergency room setting)		
• Facility	Deductible and Coinsurance	In-network level of benefits
• Professional Services	Deductible and Coinsurance	In-network level of benefits

OTHER COVERED SERVICES – ILLNESS OR INJURY	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
Ambulance • Ground Ambulance • Air Ambulance	Deductible and Coinsurance Deductible and Coinsurance	In-network level of benefits Deductible and Coinsurance (In-network level of benefits if due to an emergency)
Durable Medical Equipment	Deductible and Coinsurance	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 and Coinsurance Deductible and Coinsurance Deductible and Coinsurance	Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance
Hospice Services	Deductible and Coinsurance	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 and Coinsurance	Deductible and Coinsurance

OTHER COVERED SERVICES – ILLNESS OR INJURY	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
Pediatric Dental (up to age 19) • Preventive and Diagnostic Maintenance and Simple Restorative Complex Restorative • Orthodontic Services NOTE: Age and frequency limits apply	Deductible and Coinsurance Deductible, then Covered Person pays 70% Coinsurance	Deductible and Coinsurance Deductible, then Covered Person pays 70% Coinsurance
Pregnancy and Maternity Services Pre/Post Natal Care and Delivery	Deductible and Coinsurance	Deductible and Coinsurance
Skilled Nursing Facility (limited to 60 days per Calendar Year)	Deductible and Coinsurance	Deductible and Coinsurance
Temporomandibular and Craniomandibular Joint Disorder	Deductible and Coinsurance	Deductible and Coinsurance
Therapy & Manipulations (Medical Conditions) • Physical, occupational or speech therapy services, chiropractic or osteopathic physiotherapy • Habilitative Services: Combined limit to 45 sessions per Calendar Year • Rehabilitative Services: Combined limit to 45 sessions per Calendar Year • Chiropractic or osteopathic manipulative treatments or adjustments (combined limit to 20 sessions per Calendar Year) *NOTE: session limits for rehabilitative and habilitative services are not applicable to mental illness and/or substance dependence and abuse	Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance	Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance

OTHER COVERED SERVICES – ILLNESS OR INJURY	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER

Vision Exams
• Diagnostic (to diagnose an illness)
• Preventive (routine exam including refraction)
  • Pediatric (up to age 19)
  • Adult (age 19 and over)
	See Physician Office Services
	
	See Pediatric Vision Services Section
	Not Covered
		See Physician Office Services
		
		See Pediatric Vision Services Section
		Not Covered

Other Covered Services	Deductible and Coinsurance	Deductible and Coinsurance
PEDIATRIC VISION SERVICES	**IN-NETWORK PROVIDER**	**OUT-OF-NETWORK PROVIDER**
Pediatric Vision Services are limited to Covered Persons up to age 19.		
Vision Examination (including refraction and dilation, limited 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 one purchase of contact lenses per calendar year) • **Lenses** • **Frames** • **Contact Lenses** (in lieu of eyeglasses, includes evaluation and fitting)	 Deductible, then 50% Coinsurance Deductible, then 50% Coinsurance Deductible, then 50% Coinsurance	 In-network level of benefits In-network level of benefits In-network level of benefits
Medically Necessary Contact Lenses (in lieu of eyeglasses, for specific conditions) NOTE: Requires Certification in excess of $600.	Deductible, then 50% Coinsurance	In-network level of benefits
Low Vision Services and Aids • Comprehensive low vision evaluation (limited to one every 5 calendar years) • Follow-up low vision care (limited to four visits in any 5 calendar year period) • Low vision aids NOTE: Low vision services and aids require Certification	Deductible and Coinsurance Deductible and Coinsurance Deductible, then 50% Coinsurance	Deductible and Coinsurance Deductible and Coinsurance In-network level of benefits

PRESCRIPTION DRUGS	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
Retail and Mail order – per 30-day supply • Preferred generic drugs • Non-preferred generic drugs • Preferred brand name drugs • Non-preferred brand name drugs	$10 Copay $30 Copay $50 Copay $125 Copay	In-network level of benefits +25% penalty
NOTE: A 90-day supply is available at a retail Extended Supply Network pharmacy subject to three copays.		
Specialty drugs (specialty drugs must be purchased through a designated specialty pharmacy after two fills) • Preferred specialty drugs • Non-preferred specialty drugs	Deductible + 40% Coinsurance Deductible + 50% Coinsurance	In-network level of benefits +25% penalty
This plan uses a formulary ("preferred" prescription drug list). You can find this prescription drug list on www.nebraskablue.com. Or you may contact the Member Services at the phone number on the back of your ID card.		

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