BluePride

BlueCross BlueShield Nebraska

Schedule of Benefits Summary SHB21 HSA 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	 $4,500 $9,000	 $9,000 $18,000
Coinsurance • Covered Person Pays • Plan Pays	 0% 100%	 0% 100%
Out-of-pocket Limit (Embedded*) (includes Deductible, Coinsurance and Copays) • Individual • Family	 $4,500 $9,000	 $9,000 $18,000
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	Deductible & Coinsurance	Deductible & Coinsurance
• Specialist Physician Office Services	Deductible & Coinsurance	Deductible & Coinsurance
• Telehealth Services	Deductible & Coinsurance	Not Covered
Physician Professional Services (outpatient and inpatient services)	Deductible & Coinsurance	Deductible & Coinsurance
Urgent Care Facility Services	Deductible & Coinsurance	Deductible & Coinsurance
Emergency Care Services (services received in a Hospital emergency room setting)		
• Facility	Deductible & Coinsurance	In-network level of benefits
• Professional Services	Deductible & Coinsurance	In-network level of benefits
Outpatient Hospital or Facility Services	Deductible & Coinsurance	Deductible & Coinsurance
Inpatient Hospital or Facility Services	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 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 & Coinsurance
• ACA required covered preventive services (outside of limits)	Plan Pays 100%	Deductible & 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;
  • all other laboratory tests; Radiology; cardiac stress test; EKG; pulmonary function and other screening and services.
	Plan Pays 100%
	Same as illness
		Deductible & Coinsurance
		Same as illness

Immunization • Pediatric (up to age 7) • Age 7 and older • Related to an illness	Plan Pays 100% Plan Pays 100% Same as any other illness	In-network level of benefits Deductible & Coinsurance Same as any other illness
MENTAL ILLNESS AND/OR SUBSTANCE DEPENDENCE AND ABUSE SERVICES	**IN-NETWORK PROVIDER**	**OUT-OF-NETWORK PROVIDER**
Inpatient Services	Deductible & Coinsurance	Deductible & Coinsurance
Outpatient Services • Office Services • Telehealth Services • All other Outpatient items and services	Deductible & Coinsurance Deductible & Coinsurance Deductible & Coinsurance	Deductible & Coinsurance Not Covered Deductible & Coinsurance
Emergency Care Services (services received in a Hospital emergency room setting) • Facility • Professional Services	Deductible & Coinsurance Deductible & Coinsurance	Deductible & Coinsurance Deductible & Coinsurance

OTHER COVERED SERVICES – ILLNESS OR INJURY	IN-NETWORK PROVIDER	OUT-OF-NETWORK PROVIDER
Ambulance • 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)
Durable Medical Equipment	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 • 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 • Diagnostic • Preventive	Deductible & Coinsurance 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

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 & Coinsurance Deductible & Coinsurance	Deductible & Coinsurance Deductible & Coinsurance
Pregnancy and Maternity Services Pre/Post Natal Care and Delivery	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

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 & Coinsurance
	
	Deductible & Coinsurance
	
	Deductible & Coinsurance
		Deductible & Coinsurance
		
		Deductible & Coinsurance
		
		Deductible & 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 & Coinsurance	Deductible & 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 & Coinsurance	Deductible & 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 & Coinsurance Deductible & Coinsurance Deductible & 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 & Coinsurance	In-network level of benefits
Low Vision Services and Aids • Comprehensive low vision evaluation (limited to one every 5 calendar years)	Deductible & Coinsurance	Deductible & Coinsurance

• 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 & Coinsurance Deductible & Coinsurance	Deductible & 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 NOTE: A 90-day supply is available at a retail Extended Supply Network pharmacy subject to three copays.	Deductible & Coinsurance Deductible & Coinsurance Deductible & Coinsurance Deductible & Coinsurance	Deductible & Coinsurance
Specialty drugs (specialty drugs must be purchased through a designated specialty pharmacy after two fills) • Preferred specialty drugs • Non-preferred specialty drugs	Deductible & Coinsurance Deductible & Coinsurance	Deductible & Coinsurance
This plan uses a prescription drug list (PDL). The PDL for this plan is PDL64, and the Pharmacy Network is Network J. **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.**		

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.