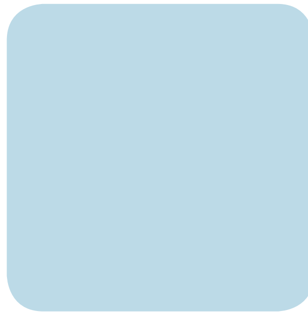

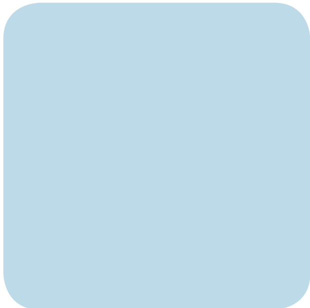

A Guide to Your Health Benefits

ACA Required Contraceptive Only Plan

98-925 1/2023

Schedule of Benefits Summary

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 In-network providers, under the terms of their contract with Blue Cross and Blue Shield, can't bill for amounts over the Contracted Amount. In some situations, Out-of-network Providers can bill for amounts over the Out-of-network Allowance.		
In-network Provider: NEtwork BLUE		
Deductible (the amount the Covered Person pays each Calendar Year for Covered Services before the Coinsurance is payable) • Covered Person Pays	$0	$2,000
Coinsurance (the percentage amount the Covered Person must pay for most Covered Services after the Deductible has been met) • Covered Person Pays	0%	50%

Medical Services	In-network Provider	Out-of-network Provider
Contraceptive Services Affordable Care Act (ACA) required Preventive contraceptive services including women's services included in the guidelines written by the Health Resources and Services Administration (HRSA). These include FDA approved contraceptive methods, sterilization procedures, patient education and counseling for all women with reproductive capacity.	Plan Pays 100% of the Allowable Charge	Deductible and Coinsurance

Prescription Drugs	In-network Provider	Out-of-network Provider
Contraceptives	Plan Pays 100%	50% Coinsurance
You can find a list of covered contraceptives on www.NebraskaBlue.com. Or you may contact Member Services at the phone number on the back of your I.D. card. **The Pharmacy Network is Network C**		

IMPORTANT TELEPHONE NUMBERS

Member Services
Omaha and Toll-free 1-844-201-0763

Coordination of Benefits
Omaha 402-390-1840
Toll-free 1-800-462-2924

Certification
Omaha 402-390-1870
Toll-free 1-800-247-1103

BlueCard Provider Information
Toll-free 1-800-810-BLUE (2583)
Website .... www.bcbs.com

Network Pharmacy Locator
Toll-free 1-877-800-0746

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This document is a description of the ACA-Required Contraceptive Only Plan (the "Plan"), administered by Blue Cross and Blue Shield of Nebraska, Inc. (BCBSNE), an independent licensee of the Blue Cross and Blue Shield Association.

Under the Affordable Care Act (the "ACA"), all non-grandfathered health plans must provided coverage for approved contraceptive Services for women without charging plan participants and beneficiaries a Copayment, Coinsurance or Deductible. The ACA grants an accommodation to this requirement for employers that object to contraceptive Services for religious or moral reasons. When your employer opts for an accommodation with respect to this requirement, it means your employer will not contract, arrange, pay or refer for contraceptive coverage.

Instead, BCBSNE will administer the Plan, which provides coverage for contraceptive Services, separate from the Group health plan. Your employer will not administer the Plan or provide payments for the Services covered under the Plan.

Coverage under the Plan will take effect for you and your Eligible Dependents when you satisfy all the eligibility requirements of your employer's Group health plan and are enrolled in your employer's Group health plan.

How To Use This Document

For your convenience, defined terms are capitalized throughout this document. For an explanation of a defined term, refer to the Section titled "Definitions."

Please take some time to read this document and become familiar with it. We encourage you to review the benefits and limitations by reading the Schedule of Benefits Summary and the sections describing Covered Services. If you have a question about your coverage or Claim, please contact BCBSNE Member Services Department.

About Your I.D. Card

BCBSNE will issue you an identification card (I.D. card). Your I.D. number is a unique alpha numeric combination. Present your I.D. card to your health care provider when you receive Services. With your BCBSNE I.D. card, Hospitals and Physicians can identify your coverage and will usually submit Claims for you.

If you want extra cards for covered family members or need to replace a lost card, please contact BCBSNE Member Services Department, or you may access through the website, www.NebraskaBlue.com.

What's A Schedule Of Benefits?

Your Schedule of Benefits is a personalized document that provides you with a basic description of your coverage.

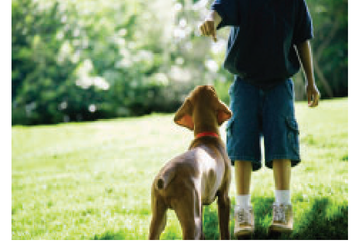
Your Rights And Responsibilities As A Blue Cross And Blue Shield Of Nebraska Member

You have the right to:

- be treated with respect and dignity;
- privacy of your personal health information that We maintain, following state and federal laws;
- receive information about the benefits, limitations and exclusions of your health plan, including how to access Our network of hospitals, physicians and other health care providers;
- work with your doctor and other health care professionals about decisions regarding your treatment;
- discuss all of your treatment options, regardless of cost or benefit coverage;
- make a complaint or file an appeal about your health plan, any care you receive or any benefit determination your health plan makes;
- make recommendations to Us about this rights and responsibilities policy;
- give Us suggestions about how we can better serve you and other members.

You have the responsibility to:

- read and be familiar with your health plan coverage information and what your plan covers and doesn't cover, or ask for help if you need it;
- if your plan has different In- and Out-of-network benefits, understand how your choice of an In- or Out-of-network Provider will impact what you pay out of your own pocket, or ask for help if you need it;
- give Us all the information We need to process your claims and provide you with the benefits you're entitled to under your plan;
- give all your health care providers the information they need to appropriately treat you;
- advise Us of any changes that affect you or your family, such as a birth, marriage/divorce or change of address.



THE PLAN AND HOW IT WORKS

About The Plan

The Plan, issued by Blue Cross and Blue Shield of Nebraska, Inc. (BCBSNE), may provide coverage for certain contraceptive Services at no cost to you when you use an In-network Provider. There is no Copay, Deductible or Coinsurance even if your Deductible and/or Out-of-Pocket maximum has not been met. Coverage for contraceptive Services may vary depending on the plan you are enrolled in.

Preferred Provider (PPO) networks have been established by BCBSNE through contracts with a panel of Hospitals, Physicians and other health care providers who have agreed to furnish medical Services to you and your family in a manner that will help manage health care costs. These providers are referred to as "In-network" or "Preferred Providers."

The In-network (Preferred) Provider network name for this plan is shown on your I.D. Card.

Blue Cross and Blue Shield Plans in other states (referred to as "Host Blue") have also contracted with health care providers in their geographic areas who are referred to as "Preferred Providers."

Use of the network is voluntary, and selection of a health care provider is always your choice. If you choose to use providers who do not participate in BCBSNE's or the Host Blue's network for non-emergency situations, you can expect to pay more than your applicable Coinsurance, Copayment and/or Deductible amounts. After the plan pays its required portion of the bill, Out-of-network Providers may bill you for any amount not paid. This balance billing does not happen when you use In-network or Preferred Providers because these providers have agreed to accept a discounted payment for Services with no additional billing to you. In-network Providers will also file claims for you.

For help in locating In-network Providers please visit BCBSNE online at www.NebraskaBlue.com. You may also call Member Services using the toll-free number on your I.D. card or refer to the Important Telephone Numbers in the front of this book. If you would like a printed provider list, BCBSNE will furnish one without charge.

For help in locating a Preferred Provider in another Blue Cross and/or Blue Shield Service Area, including providers outside the U.S., you may call the special toll-free number of the Blue Cross and Blue Shield BlueCard Program (1-800-810-2583) for assistance.

How The Plan Components Work

Your applicable Deductible, Copayment, and/or Coinsurance (cost-sharing) are shown on your Schedule of Benefits Summary. The following is an explanation of each.

Allowable Charge — An amount BCBSNE uses to calculate the payment of Covered Services. This amount will be based on either the Contracted Amount for In-network Providers or the Out-of-network Allowance for Out-of-network Providers.

Coinsurance — This is the percentage you must pay for Covered Services, after the Deductible is applied.

Copayment (Copay) — A fixed dollar amount payable by the Covered Person for a Covered Service.

Deductible* — You are responsible for your annual expenses until you reach the Plan's Deductible. After the Deductible is met, benefits for the rest of that calendar year will not be subject to any further Deductible. A Deductible is only applicable for Services provided by an Out-of network Provider.

*Copays/Coinsurance and charges for Non-covered Services or amounts in excess of the Allowable Charge do not count toward your Deductible. In addition, Deductible amounts incurred under this plan and your Group health plan are separate and do not cross accumulate.

Out-of pocket Limit — The maximum amount of cost-sharing you must pay in a calendar year. This Plan Does not have an Out-of-pocket Limit.

Utilization Review — Benefits are available for **Medically Necessary** and **Scientifically Validated** Services. Services provided by all health care providers are subject to utilization review by BCBSNE. Services will not automatically be considered Medically Necessary because they have been ordered or provided by a Physician. BCBSNE will determine whether Services provided are Medically Necessary under the terms of the plan, and if benefits are available.

Certification Requirements — Prior Certification is required for all Inpatient Hospital admissions, as well as certain surgical procedures, and specialized Services and supplies. In-network Hospitals will notify BCBSNE of an Inpatient admission. However, when you are admitted as an Inpatient to an Out-of-network Hospital, or to a Hospital outside the state of Nebraska, it is your responsibility to see that BCBSNE is notified of your admission. For more information, please refer to the section of this book titled "Certification Requirements."

Continuity of Care — In the event a Covered Person is receiving an active course of treatment for certain types of care from an In-network Provider on the date that Our contracting agreement with that provider is terminated, the provider will continue to render Covered Services to the Covered Person, and the contracting agreement shall continue to apply to those Covered Services after the termination takes effect, for up to 90 days or until the Covered Person is not longer a continuing care patient. The types of care that qualify and the length of time that the contracting agreement shall continue to apply are stated in the BCBSNE Provider Policies and Procedures Manual. The terms of the Provider Policies and Procedures Manual may be updated by BCBSNE from time to time. For additional information, you may contact BCBSNE Member Services Department.

How The Network Works

Using In-network Providers:

- present I.D. card;
- receive highest level of benefits;
- provider files Claims for you;
- provider accepts insurance payment as payment in full;
- no balance billing.

Using Out-of-network Providers:
- you may be required to pay full cost at time of service;
- you may be reimbursed at a lower benefit level;
- you may have to file Claims;
- you're responsible for amounts that exceed the Allowable Charge.

These amounts are separate and do not apply to your Group health plan Deductible and/or Out-of-pocket Limit.

Remember, if more than one Physician is involved in your care, it is important for you to check the status of each provider.

Exception
Emergency Services and post-stabilization Services provided at an Out-of-network health care facility, limited to a hospital emergency, general acute hospital, satellite emergency department, or Ambulatory Surgical Facility, or by an ancillary individual Out-of-network health care professional or air ambulance, will be considered as having been provided by an In-network Provider, and the Covered Person will not be responsible for amounts over the Allowable Charge, as required by law. Benefits for Inpatient care will continue to be paid subject to the In-network cost-sharing level, as long as the Services are for an Emergency Medical Condition.

For non-emergency Services, if a Covered Person receives Services at an In-network health care facility but the Physician or other provider is Out-of-network, benefits for those Covered Services will be subject to the In-network Deductible, Coinsurance, and/or Copayment. Providers may not bill the Covered Person for charges over the Allowable Charge payable under this Plan, unless otherwise allowed by law.

If a Covered Person receives a bill from an Out-of-network Provider, and the Covered Person did not provide consent to the Out-of-network Provider to receive such Services, the Covered Person should send the bill to the Member Services Department for further review by either sending a secure e-mail through www.mynebraskablue.com or by mail at the following address:

Blue Cross and Blue Shield of Nebraska
P.O. Box 3248
Omaha, NE 68180

Out-of-Area Services
BCBSNE has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. These relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross and Blue Shield Association ("Association"). Whenever you access health care services outside the geographic area BCBSNE serves, the claim for those services may be processed through one of these Inter-Plan Arrangements.

When you access care outside BCBSNE's service area, you will receive it from one of two kinds of providers. Most providers ("participating providers") contract with the local Blue Cross and Blue Shield Licensee in that geographic area ("Host Blue"). Some providers ("non-participating providers") don't contract with the Host Blue. We explain below how we pay both kinds of providers.

Inter-Plan Arrangements Eligibility - Claim Types — All claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for dental care benefits (except when paid as medical benefits), and any prescription drug programs or vision care benefits that may be administered by a third party contracted by BCBSNE to provide the specific service or services.

BlueCard® Program
Under the BlueCard® Program, when you receive Covered Services within the geographic area served by a Host Blue, BCBSNE will remain responsible for doing what we agreed to in the Contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating providers.

When you receive Covered Services outside BCBSNE's service area and the claim is processed through the BlueCard Program, the amount you pay for Covered Services is calculated based on the lower of:
- the billed charges for your Covered Services, or
- the negotiated price that the Host Blue makes available to BCBSNE.

Often, this "negotiated price" will consist of a simple discount which reflects an actual price that the Host Blue pays to your health care provider. Sometimes, it is an estimated price that takes into account special arrangements with your health care provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of health care providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price BCBSNE used for your claim because they will not be applied after a claim has already been paid.

Negotiated (non-BlueCard® Program) Arrangements
With respect to one or more Host Blues, instead of using the BlueCard Program, BCBSNE may process your claims for Covered Services through Negotiated Arrangements for National Accounts.

The amount you pay for Covered Services under this arrangement will be calculated based on the lower of either billed covered charges for Covered Services or the negotiated price (refer to the description of negotiated price under BlueCard® Program) made available to BCBSNE by the Host Blue.

If reference-based benefits, which are service-specific benefit dollar limits for specific procedures, based on a Host Blue's local market rates, are made available to you, you will be responsible for the amount that the health care provider bills above the specific reference benefit limit for the given procedure. For a participating provider, that amount will be the difference between the negotiated price and the reference benefit

limit. For a non-participating provider, that amount will be the difference between the provider's billed charge and the reference benefit limit. Where a reference benefit limit is greater than either a negotiated price or a provider's billed charge, you will incur no liability, other than related patient cost-sharing under the Contract.

Special Cases – Total Care

- BlueCard Program: If you receive Covered Services under a Total Care value-based program inside a Host Blue's service area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement except when a Host Blue passes these fees to BCBSNE through average pricing or fee schedule adjustments.
- Negotiated (non-BlueCard Program) Arrangements: If BCBSNE has entered into a Negotiated Arrangement with a Host Blue to provide Total Care to your Group on your behalf, BCBSNE will follow the same procedures for Total Care administration and Care Coordinator Fees noted above for the BlueCard Program.

Inter-Plan Programs – Federal/State Taxes/Surcharges/Fees
Federal or state laws or regulations may require a surcharge, tax or other fee that applies to insured accounts. If applicable, BCBSNE will include any such surcharge, tax or fee as part of the claim charge passed on to you.

Non-Participating Providers Outside Our Service Area
Subscriber Liability Calculation — When Covered Services are provided outside of BCBSNE's service area by non-participating providers, the amount you pay for such Services will normally be based on either the Host Blue's non-participating provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be responsible for the difference between the amount that the non-participating provider bills and the payment BCBSNE will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

If you need Emergency Services, BCBSNE will cover you at the highest level that federal regulations allow. You will have to pay any Deductibles, Coinsurance, Copayments, and charges for Noncovered Services, and any excess charge over the amount payable under the Contract, unless prohibited by law.

Exceptions — In certain situations, BCBSNE may use other payment bases, such as billed charges for Covered Services, the payment BCBSNE would make if the health care Services had been obtained within BCBSNE's service area, or a special negotiated payment, to determine the amount BCBSNE will pay for Services provided by non-participating providers. In these situations, you may be liable for the difference between the amount that the non-participating provider bills and the payment BCBSNE will make for the Covered Services set forth in this paragraph.

Blue Cross Blue Shield Global® Core
If you are outside the United States, (hereinafter "BlueCard service area"), you may be able to take advantage of Blue Cross Blue Shield Global Core when accessing Covered Services. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although Blue Cross Blue Shield Global Core assists you with accessing a network of inpatient, outpatient and professional providers, the network is not served by Host Blue. As such, when you receive care from providers outside the BlueCard service area, you will typically have to pay the providers and submit the claims yourself to obtain reimbursement for these services. If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, you should call the Blue Cross Blue Shield Global Core Service Center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

- Inpatient Services: In most cases, if you contact the Blue Cross Blue Shield Global Core Service Center for assistance, hospitals will not require you to pay for covered inpatient services, except for your cost-share amounts. In such cases, the hospital will submit your claim to the Service Center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for Covered Services. You must contact BCBSNE to obtain certification for non-emergency inpatient services.
- Outpatient Services: Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for Covered Services.
- Submitting a Blue Cross Blue Shield Global Core Claim: When you pay for Covered Services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global Core claim form and send the claim form with the provider's itemized bill(s) to the Service Center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from BCBSNE, the Service Center or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the Service Center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week.

CERTIFICATION REQUIREMENTS

Certification Process

BCBSNE requires that all Hospital stays, certain surgical procedures, and specialized Services and supplies be Certified prior to receipt of such Services or supplies. Ultimately, it is your responsibility to see that Certification occurs; however, a Hospital or Provider may initiate the Certification.

When BCBSNE receives a request for Certification, the appropriateness of the setting and the level of medical care as well as the timing and duration of the admission is assessed by BCBSNE (or by persons designated by BCBSNE).

To initiate the Certification process, BCBSNE must be contacted by the Hospital or Physician, or you or a family member or someone acting on behalf of you or your family member. Notification of the intended receipt of Services may be made by telephone or in writing. We may require that the Certification include written documentation from the attending Physician, dentist or other medical provider demonstrating the Medical Necessity of the procedure or Service and the location where the Service will be provided.

In the case of an ongoing Inpatient admission, the care should continue to be Certified in order to assure that it is being provided in the most appropriate setting.

Please remember that Certification does not guarantee payment. All other Group health plan provisions apply. For example: Copayments, Deductibles, Coinsurance, eligibility and exclusions.

Benefits Requiring Certification

The following Services, supplies or drugs must be Certified:

- Durable Medical Equipment (DME) - subsequent purchases of DME or DME identified on the Certification/Preauthorization list;
- Inpatient Hospital admissions;
- Services subject to surgical, radiology or other preauthorization programs, as defined by BCBSNE; and
- other Services as may be specifically stated elsewhere in this booklet.

A list of Services subject to Certification or preauthorization may be obtained at www.NebraskaBlue.com. Certification and preauthorization requirements are subject to change.

Certification Exceptions

Emergencies

BCBSNE must be notified of an admission for an Emergency Medical Condition within 24 hours of the admission or the next business day. If Certification is not received, the 24-hour period prior to the time of admission and the 24-hour period after such admission will be reviewed to determine if the Covered Person's condition and treatment would have hindered his or her ability to provide notice.

NOTE: Admission through the emergency room does not necessarily constitute an emergency admission.

Effect on Benefits

Failure to comply with the Certification requirements may result in a penalty or denial of benefits and unanticipated costs associated with the incurred expenses.

Note: Certain surgical, radiology or other preauthorization programs require that benefit approval be obtained prior to the service being provided, with failure to do so resulting in a denial of benefits for the Service.

If Services are not properly Certified and benefits are reduced or denied, you are responsible for paying any amount due. However if the Hospital, Inpatient facility or Physician is a Contracting Provider with BCBSNE, they are liable for their Services which are determined by BCBSNE to be not Medically Necessary, (or for denial due to failure to Certify/preauthorize if required), unless you have agreed in writing to be responsible for such Services, or the provider has documented in the medical record that you were notified of the Certification determination. Any such reductions in benefits are not considered when computing your Deductible.

Benefits are not payable for Services determined to be not Medically Necessary.

This section provides a general overview of covered Services.
The Plan only covers ACA required preventive contraceptive supplies and Services.

What's Covered
The following list includes examples of the Services that are covered under the medical provisions of the Plan when Medically Necessary, provided by an Approved Provider and billed with a contraceptive diagnosis:

- *contraceptive injections;*
- *diaphragms and cervical caps* (device and fitting)*;*
- *implanted devices,* including insertion and removal*;*
- *intrauterine device (IUD),* including device, insertion and removal;
- *natural family planning counseling Services;*
- *Physician visits and follow up care;*
- *tubal ligation,* including surgical procedure and related Services when performed as the primary procedure.

ACA-required Preventive contraceptive supplies and Services may include age, gender and frequency limits. A list of these Preventive Services is available at www.NebraskaBlue.com, or you may contact the BCBSNE Member Services Department.

NOTE: *The Plan does not provide benefits for male sterilization, contraceptives, supplies/devices, or for sterilization reversal.*

This section provides a general overview of covered prescription drugs for women with reproductive capacity. Please refer to the Schedule of Benefits Summary in the front of this book to determine if your plan includes coverage for ACA required preventive contraceptive pharmacy benefits.

Non-formulary drugs are not covered under this Plan. In order for contraceptive medications to be covered with no member cost share, the medications must be listed on the formulary or contraceptive drug list which is available at www.nebraskablue.com. Or you may contact the BCBSNE Member Services Department.

If your plan provides Prescription Drug Benefits, and you use a pharmacy in the Plan's network, there is no Copay, Deductible or Coinsurance for covered contraceptive drugs. A list of covered contraceptives is available at www.NebraskaBlue.com, or you may contact the BCBSNE Member Services Department.

Accessing Benefits

If the covered prescription or supply is purchased at an In-network pharmacy, and you present your BCBSNE identification card to the pharmacist at the time of purchase, you will not have any liability at the time the prescription is filled. See the section titled Drug Copayment Program below for additional information regarding amounts you may be required to pay.

If the covered prescription is filled at an Out-of-network Pharmacy, or if you do not present your I.D. card at the time of purchase at an In-network Pharmacy, you will be required to pay the pharmacy's usual retail price. You must file a claim with BCBSNE. Eligible claims will be reimbursed based on the Allowance for the drug less the applicable Copay, Deductible and/or Coinsurance.

Other Coverage: If a Covered Person has prescription drug coverage under more than one health plan, Coordination of Benefits provisions will apply when the Services are covered under both the primary and secondary plan's pharmacy benefits.

To locate contracting In-network pharmacies nationwide, call toll-free: 1-877-800-0746.

Limitations

- Benefits are not available for covered prescription amounts in excess of the supply limit (day or quantity).
- Lost, destroyed or stolen medications are limited to one replacement up to a 30-day supply per prescription per calendar year.
- Injectables are limited to Claims from providers who are contracting with Prime Therapeutics, and filed as a pharmacy Claim.
- Certain prescription drugs, based on the route or method of administration, may be payable only under the medical provisions of the Plan, and not under the prescription drug coverage.
- Excessive pattern of drug usage:
  - If a Covered Person's usage of prescription drugs indicates an excessive pattern of usage that is not Medically Necessary (as determined by BCBSNE), the Covered Person will be limited to one In-network Pharmacy and/or prescribing provider of his/her choice for obtaining covered prescription drugs. If such a limitation applies, benefits will not be available for prescription drugs obtained from any other pharmacy or prescribing provider.

Preauthorization

Under the Rx Nebraska Drug Coverage Program preauthorization is required for prescriptions as determined by BCBSNE. We reserve the right to change drugs requiring preauthorization at any time without prior notice. For more information on prescription medications requiring preauthorization, visit the BCBSNE website, www.NebraskaBlue.com, or call the Member Services Department at the phone number shown on the back of your I.D. card.

Requesting Preauthorization

A written request to BCBSNE must be made prior to the initial purchase of the prescription. This request must be accompanied by appropriate documentation from the Covered Person's Physician, Dentist or other medical provider demonstrating the Medical Necessity of the drug. This written request should be directed to:

Blue Cross and Blue Shield of Nebraska
Attention: Pharmacy
P.O. Box 3248
Omaha, Nebraska 68180-0001

Preauthorization forms can be found on the BCBSNE website: www.NebraskaBlue.com

Upon receipt of the necessary information, BCBSNE will respond in writing advising the provider and the Covered Person whether or not benefits are available.

Note: The limitation, preauthorization and covered contraceptive list may be updated at any time without notice. Additional information about your pharmacy benefits can be found on the BCBSNE website at www.NebraskaBlue.com.

Drug Copayment Program

Your health plan includes a drug Copayment program that utilizes manufacturer coupon assistance for the payment of select drugs purchased at designated pharmacies. For Covered Persons enrolled inthis program, a variable Copayment may apply, which takes into account the manufacturer subsidy available toward the Covered Person's cost for the drug. Under this program, cost-share may be zero, and in no case will it be more than the applicable cost-share required under the plan. Subsidy amounts paid by the manufacturer, or the plan, do not apply to the Deductible or Out-of-pocket Limit. If a Covered Person is not enrolled in the program, their standard cost-share will apply. This program may not be available to Covered Persons enrolled in an HSA-eligible plan.

Definitions

The following terms are specifically used in conjunction with the Rx Nebraska Prescription Drug Program.

Allowance: The amount determined by BCBSNE to be payable to the Covered Person who has used an Out-of-network Pharmacy for a Covered Service. The Allowance may be one of the following:

- the lesser of the usual retail price or the applicable Contracted Amount payable for similar Services by similar In-network Pharmacies; or
- as otherwise determined by BCBSNE or our Pharmancy Benefit Manager (PBM) to be appropriate based on industry standards for similar Covered Services.

Brand Name Drug: Single source and multisource brand drugs as set forth in the Medi-Span Master Drug Database File or such other recognized source relied upon by the PBM or BCBSNE. All products identified as "brand-name" by a manufacturer, pharmacy, or a provider may not be classified as Brand Name Drugs by the PBM or BCBSNE.

Compound Medication: A prescribed medication in which the ingredients are combined, mixed or altered specifically to meet the needs of a patient. A covered Compound Medication must contain at least one FDA-approved prescription ingredient.

Contracted Amount: The amount the In-network Pharmacy has agreed to accept as payment in full for a covered prescription drug product pursuant to an agreement with the PBM.

Generic Drug: A Generic Drug as set forth in the Medi-Span Master Drug Database File or such other recognized source relied upon by the PBM or BCBSNE. All products identified as "generic" by a manufacturer, pharmacy, or provider may not be classified as Generic Drugs by the PBM or BCBSNE.

In-network Pharmacies: Licensed pharmacies that have entered into written agreements with the Pharmacy Benefit Manager as designated by BCBSNE. The prescription drug coverage for your Plan may include more than one level of In-network (Preferred) Pharmacies.

Narrow Therapeutic Index: Medications that generally require careful dosage adjustment and patient monitoring due to small variances in a patient's blood levels which can change the effectiveness and toxicity of the drug.

Out-of-network Pharmacies: Licensed pharmacies that have not entered into written agreements with the Pharmacy Benefit Manager as designated by BCBSNE.

Pharmacy Benefit Manager (PBM): Prime Therapeutics, LLC, (Prime) has been retained by BCBSNE to administer the Prescription Drug Program.

Pharmacy and Therapeutics Committee: The PBM/BCBSNE panel of physicians, pharmacists and other health care professionals who are responsible for pharmacy management activities such as managing and updating the Prescription Drug List.

Preauthorization: The process of obtaining authorization from BCBSNE or the PBM for specified medications or specified quantities of medications.

Your employer determines eligibility requirements and validates eligibility for enrollment and coverage under the Plan.

Who's Eligible

To be eligible for contraceptive only coverage, you will be subject to your Group's requirements with regard to any applicable minimum number of hours that you must work and any applicable Eligibility Waiting Period. For detailed information regarding eligibility requirements, please contact your Human Resource Department.

The individual who enrolls for coverage or the "employee" is referred to as a Subscriber. Dependents are generally your spouse and children. In order to be an Eligible Dependent, they must meet the definition of an Eligible Dependent as determined by your employer. You and/or your Eligible Dependents may participate in the Plan as long as you remain enrolled in your employer's Group health plan.

If You Receive Covered Services From An In-network Provider

Contracting Providers and many other Hospitals and Physicians will file the Claim to BCBSNE on your behalf. Out-of-state Contracting Providers will file a Claim with their local Blue Cross and Blue Shield plan for processing through the BlueCard Program. When BCBSNE receives a Claim from a Contracting Provider, payment will be made directly to the provider, unless otherwise provided by state or federal law.

Filing A Claim

You must file your own Claim if your health care provider is not a Contracting Provider and does not file for you. You can obtain a Claim form by contacting BCBSNE's Member Services Department, or you can find a form on the website: www.NebraskaBlue.com.

All submitted Claims must include:

- correct BCBSNE ID number, including the alpha prefix;
- name of patient;
- diagnosis;
- an itemized statement of services, including the date of service, description and charge for the service;
- complete name, address and professional status (M.D., R.N., etc.) of the health care provider;
- prescription number, if applicable;
- the name and identification number of other insurance, including Medicare; and
- the primary plan's explanation of benefits (EOB), if applicable.

Claims cannot be processed if they are incomplete, and may be denied for "lack of information" if required information is not received.

Claims should be filed by a Provider or a Covered Person as soon as possible after the date of service. Contracting Providers will file claims on the Covered Person's behalf; the Covered Person is responsible to provide their identification number in order for the claim to be filed. Claims that are not filed by a BCBSNE Contracting Provider in accordance with BCBSNE's timely filing requirements will become the Contracting Provider's liability.

A Covered Person is responsible to file a claim for Services provided by a non-contracting Provider if the provider does not submit on his or her behalf.

If a claim is not filed within 15 months of the date of service (except in the absence of legal capacity), benefits will not be allowed.

In Nebraska, Claim forms should be sent to:

Blue Cross and Blue Shield of Nebraska
P.O. Box 3248
Omaha, Nebraska 68180-0001

If health care Services are provided in a state other than Nebraska, Claims should be filed to the Blue Cross and Blue Shield plan servicing the area where the Services were received. If you need assistance in locating the plan, please contact BCBSNE's Member Services Department.

Payment Of Benefits For Non-Contracting Provider Claims

Payment will be made, at BCBSNE's option, to the Covered Person, to his or her estate, to the provider, or as required by state or federal law. Benefits may also be paid to an alternate recipient or custodial parent, if pursuant to a QMCSO.

No assignment, whether made before or after Services are provided, of any amount payable according to this plan shall be recognized or accepted as binding upon BCBSNE, unless otherwise provided by state or federal law.

Payment For Services That Are The Covered Person's Responsibility

Under certain circumstances, if BCBSNE pays the provider amounts that are your responsibility, such as Copays, Deductibles, or Coinsurance, we may collect such amounts from you. You agree that BCBSNE has the right to collect such amounts from you.

Claim Determinations

A "Claim" may be classified as a "Preservice" or "Postservice."

Preservice Claims - In some cases, under the terms of this plan, the Covered Person is required to certify benefits in advance of a Service being provided, or benefits for the Service may be reduced or denied. This required request for a benefit is a "Preservice Claim." Preservice Claim determinations that are not Urgent Care Claims will be made with 15 calendar days of receipt, unless an extension is needed to obtain necessary information. If an extension is needed, BCBSNE will provide the Covered Person and/or his or her provider with notice prior to the expiration of the initial 15-day period. If additional information is requested, the Covered Person or his or her provider may be given up to 45 calendar days from receipt of notice to submit the specified information. A Claim determination will be made within 15 days of receipt of the information, or the end of the extension period.

(See the section of this book titled "Certification Requirements" for more information on certifying benefits.)

Urgent Care - If your Preservice Claim is one for Urgent Care, the determination will be made within 72 hours of receipt of the Claim, unless further information is needed. If additional information is necessary, the Covered Person or his or her provider will be given no less than 48 hours to provide the specified information. Notification of the decision will be provided not later than 48 hours after the earlier of: our receipt of the information, or the end of the period allowed to submit the information.

Concurrent Care - If you request to extend a course of treatment beyond the care previously approved and it involves urgent care, a decision will be made within 24 hours of the request, if you submitted the request at least 24 hours before the course of treatment expires. In all other cases, the request for an extension will be decided as appropriate for Preservice and Postservice Claims.

Postservice Claims - A Postservice Claim is any Claim that is not a Preservice Claim. In most cases, a Postservice Claim is a request for benefits or reimbursement of expenses for medical care that has been provided to a Covered Person. The instructions for filing a Postservice Claim are outlined earlier in this section. Upon receipt of a completed Claim form, a Postservice Claim will be processed within 30 days, unless additional information is needed. If additional information is requested, the Covered Person may be given not less than 45 days to submit the necessary information. A Claim determination will be made within 15 days of receipt of the information, or the expiration of the 45-day extension period. You will receive an EOB when a Claim is processed which explains the manner in which your Claim was handled.

Explanation Of Benefits

Every time a Claim is processed for you, an Explanation of Benefits (EOB) form will be sent. The front page of the EOB provides you with a summary of the payment including:

- the patient's name and the Claim number;
- the name of the individual or institution that was paid for the Service;
- the total charge associated with the Claim;
- the covered amount;
- any amount previously processed by this plan, Medicare or another insurance company;
- the amount(s) that you are responsible to pay the provider;
- the total Deductible and/or Coinsurance that you have accumulated to date; and
- other general messages.

A more detailed breakdown of the charges including provider discounts, amount paid, and cost sharing amounts (e.g. noncovered charges, Deductible and Copays) are shown on the back of your EOB.

Also included on your EOB is information regarding your right to appeal a benefit determination, or request additional information.

Save your EOBs in the event that you need them for other insurance or for tax purposes.

BCBSNE has the discretionary authority to determine eligibility for benefits under the Plan, and to construe and interpret the terms of the Plan.

You have the right to seek and obtain a review of "adverse benefit determinations" arising under The Plan.

Appeal Procedure Definitions

Adverse Benefit Determination: A determination by BCBSNE or its Utilization Review designee, of the denial, reduction, or termination of a benefit, or a failure to provide or make payment (in whole or in part) of a benefit. This includes any such determination that is based on:

- the application of Utilization Review;
- a determination that the Service is Investigative;
- a determination that the Service is not Medically Necessary or appropriate;
- an individual's eligibility for coverage or to participate in a plan;
- an unexpected ("surprise") balance bill from an Out-of-network Provider for emergency and certian non-emergency Services.

An Adverse Benefit Determination also includes any rescission of coverage, which is defined as a cancellation or discontinuance of coverage that has a retroactive effect, except if for failure to timely pay required premiums or contribution for coverage.

Final Internal Adverse Benefit Determination: An Adverse Benefit Determination that has been upheld by BCBSNE, or its Utilization Review designee, at the completion of the internal appeal process as described in this document.

Preservice Claim(s): Any Claim for a benefit under the Plan with respect to which the terms of the Contract require approval of the benefit in advance of obtaining medical care, and failure to do so will cause benefits to be denied or reduced.

Postservice Claim(s): Any Claim that is not a Preservice Claim.

Urgent Care Claim: A Claim for medical care or treatment for which the application of the time periods for making non-urgent care determinations:

- could seriously jeopardize the life or health of the Covered Person or the ability of the Covered Person to regain maximum function; or
- would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Claim.

How To Appeal An Adverse Benefit Determination

A Covered Person or a person acting on his/her behalf (the "claimant") is entitled to an opportunity to appeal initial or final Adverse Benefit Determinations.

For detailed information on appealing an Adverse Benefit Determination please refer to your employer Group health plan's appeal procedures or contact the Member Services Department at the number on the back of your I.D. Card.

When You Have Coverage Under More Than One Plan

This Plan includes a Coordination of Benefits (COB) provision. COB provisions apply when a Covered Person has coverage under more than one Plan. This provision establishes a uniform order in which the Plans pay their Claims, limits the duplication of benefits, and provides for transfer of information between the Plans.

The order of benefit determination rules described in this section determine which Plan will pay as the primary Plan without regard to any benefits that might be payable by another Plan.

Definitions

For the purpose of this section, the terms are defined as:

Allowable Expense: A health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense.

The amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of Plan provisions include second surgical options, precertification of admissions, and preferred provider arrangements.

Closed Panel Plan: A Plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

Custodial Parent: The parent awarded custody by a court decree or, in the absence of a court decree, the parent with whom the child resides more than one half of the calendar year excluding temporary visitation.

Plan: As used in this section, any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts:

a. Plan includes: group and nongroup insurance contracts and subscriber contracts, health maintenance organization (HMO) contracts, Closed Panel Plans; other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits coverage in motor vehicle "no-fault" and traditional "fault" type contracts; group and nongroup insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care; and Medicare or any other federal governmental Plan, as permitted by law.

b. Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage other than the medical benefits coverage in motor vehicle "no fault" and traditional "fault" contracts; uninsured or underinsured coverage under a motor vehicle policy; specified disease or specified accident coverage; limited benefit health coverage, as defined in state law; school accident coverage; disability income insurance; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; and coverage under other federal governmental Plans, unless permitted by law.

Each contract for coverage under a. or b. is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

Primary Plan: The Plan that will determine payment for its benefits first before those of any other Plan without considering any other Plan's benefits.

Secondary Plan: The Plan that will determine its benefits after those of another Plan and may reduce the benefits so that all Plan benefits do not exceed 100% of the total Allowable Expense. The Secondary Plan will not pay more than the Primary Plan's contracted reimbursement rate.

This Plan: The part of the contract providing health care benefits to which the COB provision applies and which may be reduced because of the benefits of other Plans. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

Order Of Benefit Determination Rules

1. The Primary Plan pays or provides its benefits according to its terms or coverage and without regard to the benefits under any other Plan.
2. A Plan that does not contain a coordination of benefits provision that is consistent with this Part is always primary unless the provisions of both Plans stated that the complying Plan is primary.
3. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.
4. Each Plan determines its order of benefits using the first of the following rules that apply:

   - **Subscriber And Dependent —** The Plan that covers the person as other than a dependent, such as a subscriber/policyholder/employee is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent and primary to the Plan covering the person as a subscriber, then the order of benefits between the two Plans is reversed so that the Plan covering the person as a subscriber is the Secondary Plan and the other Plan is the Primary Plan.

- **Dependent Child Covered Under More Than One Plan —** Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:
  - For a dependent child whose parents are married or are living together, whether or not they have ever been married, the Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan. If both parents have the same birthday, the Plan that has covered the parents the longest is the Primary Plan (birthday rule).
  - For a dependent child whose parents are divorced, separated or not living together, whether or not they have ever been married, if a court decree states that one of the parents is responsible for the child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, the Plan of that parent's spouse is primary. This rule applies to Plan years beginning after the Plan is given notice of the court decree.
  - If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the order of benefits shall be determined by the "birthday rule" stated above.
  - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the order of benefits shall be determined by the "birthday rule" stated above.
  - If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
    - the Plan covering the custodial parent;
    - the Plan covering the spouse of the custodial parent;
    - the Plan covering the non-custodial parent; and then
    - the Plan covering the spouse of the non-custodial parent.
  - For a dependent child covered under more than one Plan of individuals who are not parents of the child, the above provisions shall apply as if those individuals were the parents.
  - For an Eligible Dependent child covered under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule below for "Longer or Shorter Length of Coverage" applies. In the event the Eligible Dependent child's coverage under the spouse's plan began on the same date as his or her coverage under the parents' plan(s), the order of benefits shall be determined by applying the "birthday rule" above, to the child's parent(s) and to his or her spouse.
- **Active Employee, Retired or Laid-Off Employee —** The Plan that covers a person as an active employee, that is, an employee who is neither retired nor laid off, is the Primary Plan. The Plan covering that same person as a retired or laid-off employee is the Secondary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the first rule (Subscriber and Dependent) can determine the order of benefits.
- **COBRA or State Continuation Coverage —** If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as a subscriber/member/employee/retiree or covering the person as a dependent of a subscriber/member/employee/retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the first rule (Subscriber and Dependent) can determine the order of benefits.
- **Longer or Shorter Length Of Coverage —** The Plan that has covered the person longer is the Primary Plan and the Plan that has covered the person the shorter period of time is the Secondary Plan. The start of a new Plan does not include a change in the amount or scope of a Plan's benefits; a change in the entity that pays, provides or administers the Plan's benefits; or a change from one type of Plan to another, such as from a single employer Plan to a multiple employer Plan.

If the above rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

Administration Of Coordination Of Benefits

The order of benefit determination rules govern the order in which each Plan will pay a Claim for benefits. The Plan that pays first is called the Primary Plan. The Plan that pays after the Primary Plan is called the Secondary Plan.

If This Plan is the Primary Plan, there shall be no reduction of benefits. Benefits will be paid without regard to the benefits of any other Plan.

If This Plan is the Secondary Plan, it may reduce its benefits so that the total benefits paid or provided by all Plans for any Claim are not more than the total Allowable Expenses. In determining the amount to be paid for any Claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the Claim do not exceed the total Allowable Expense for that Claim. In addition, the Secondary Plan shall credit to its Plan Deductible any amounts it would have credited to its Deductible in the absence of other health coverage. Also, if the Primary Plan is medical payments coverage under a motor vehicle policy, the Secondary Plan shall credit payments from the motor vehicle insurance policy to Deductibles, Copayments and Coinsurance after discounts under the health plan.

Miscellaneous Provisions

If these COB rules do not specifically address a particular situation, BCBSNE may, at its discretion, rely on the National Association of Insurance Commissioners Coordination of Benefits Model Regulation as an interpretive guide.

To properly administer these COB rules, certain facts are needed. This Plan may obtain or release information to any insurance company, organization or person. BCBSNE need not notify, or obtain the consent of any person to do so. Any person who claims benefits under This Plan agrees to furnish the information that may be necessary to apply COB rules and determine benefits.

If another Plan pays benefits that should have been paid under This Plan, this Plan may reimburse the other Plan amounts determined to be necessary. Amounts paid to other Plans in this manner will be considered benefits paid under This Plan and This Plan is released from liability for any such amounts.

If the amount of the benefits paid by This Plan exceeds the amount it should have paid, This Plan has the right to recover any excess from any other insurer, any other organization, or any person to or for whom such amounts were paid, including Covered Persons under This Plan.

Termination Of Coverage
Coverage under this plan will coincide with your Group health plan. Please contact your employer for details regarding the specific date coverage under the Group health plan will be terminated.

Continuation Of Coverage Under The Federal Continuation Law (COBRA)
If you terminate your employment, or if a dependent loses coverage due to certain “Qualifying Events,” continued coverage under the Group health plan may be available. Payment for continued coverage under the federal continuation law is at the employee’s or dependent’s own expense.

What Is The Federal Continuation Law?
The Consolidated Omnibus Budget Reconciliation Act (COBRA), is a federal law which provides that a Covered Person who would lose coverage due to the occurrence of a “Qualifying Event,” may elect to continue coverage under the Group health plan. If COBRA is elected, the benefits under this contraceptive only plan will also be continued.

Plan Document
This document provides an overview of your benefits. It is not intended to be a complete description of every detail of the Plan.

Fraud Or Misrepresentation
The coverage of any Covered Person may be canceled or rescinded for fraud or intentional misrepresentation of material fact about a claim or eligibility for this coverage.

If coverage is rescinded, the amount of premium paid will be reduced by any benefits that were paid, and will be refunded. If benefits paid exceed the premium received, We may recover the difference.

Legal Actions
The Subscriber cannot bring a legal action to recover under the Contract for at least 60 days after written proof of loss is given to Us. The Subscriber cannot start a legal action after three years from the date written proof of loss is required.

Your ERISA Rights
If your Group health Plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), as a participant in this plan, you are entitled to certain rights and protections under this law.

ERISA provides that all plan participants shall be entitled to:

- Receive Information About Your Plan and Benefits
  - Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the plan, including insurance contracts, and collective bargaining agreements, and a copy of the latest annual report filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
  - Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts, collective bargaining agreements, copies of the latest annual report and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
  - Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
- Continue Group Health Plan Coverage
  - Continue health coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event (COBRA). You or your dependents may have to pay for such coverage. Review your Summary Plan Description and the documents governing the Plan for the rules regarding your COBRA continuation rights.

Prudent Actions By Plan Fiduciaries
In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights
If your Claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a Claim or benefits which is denied or ignored in whole or in part, you may file suit in a state or federal court. If you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in a federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay these costs and fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs or fees, for example, if it finds your Claim is frivolous.

Assistance With Your Questions
If You have any questions about your plan, you should contact the Plan Administrator. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

ACA: The Patient Protection and Affordable Care Act and implementing regulations and sub-regulatory guidance.

Approved Provider: A Licensed practitioner of the healing arts who provides Covered Services within the scope of his or her License or a Licensed or Certified facility or other health care provider, payable according to the terms of the Contract, Nebraska law or pursuant to the direction of BCBSNE.

BCBSNE: Blue Cross and Blue Shield of Nebraska, Inc.

BlueCard Program: This Blue Cross and Blue Shield Association (BCBSA) program is a collection of policies, provisions and guidelines that enables BCBSNE to process Claims incurred by Covered Persons residing or traveling outside its Service Area by utilizing the discounts negotiated by the Host Blue plan and its Contracting Providers.

Certification (Certify And Certified): A determination by BCBSNE or Our designee, that an admission, extension of stay or other health or dental care Service has been reviewed and, based on the information provided, meets the clinical requirements for Medical Necessity, appropriateness, level of care, or effectiveness under the auspices of the applicable health benefit plan. Preauthorization requirements are included within this term.

Certification also refers to successful voluntary compliance with certain prerequisite qualifications specified by regulatory entities. Agencies and programs may be deemed to be in compliance when they are accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Commission on the Accreditation of Rehabilitation Facilities (CARF), American Association for Ambulatory Health Care (AAAHC), American Association for Accreditation of Ambulatory Plastic Surgery Facilities (AAAAPSF), Medicare or as otherwise provided in the Contract provisions or state law.

Claim: A request for benefits under the Plan.

Coinsurance: The percentage amount the Covered Person must pay for Covered Services.

Contract: The agreement between BCBSNE and the Group which includes the Contract and any endorsements; the Master Group Application, any Subgroup Application, addenda, and the individual enrollment information of Subscribers and their Eligible Dependents.

Contracted Amount: The Allowable Charge agreed to by BCBSNE or a Host Blue plan and Contracting Providers for Covered Services received by a Covered Person.

Contracting Provider: An In-Network Provider, a Blue Cross and Blue Shield of Nebraska Participating Provider, or a BlueCard Program Preferred or Participating Provider.

Convenient Care/Retail Clinic: A medical clinic located in a retail location such as a grocery or drug store, where a Provider offers treatment of minor medical conditions, immunizations and physicals without an appointment.

Copayment (Copay): A fixed dollar amount of the Allowable charge, payable by the Covered Person for a Covered Service, as indicated in the Master Group Application and/or Schedule of Benefits Summary. Copayments are separate from and do not accumulate to the Deductible.

Covered Person: Any person entitled to benefits for Covered Services pursuant to the Contract underwritten and administered by BCBSNE.

Covered Services: ACA required preventive contraceptive supplies and services.

Deductible: An amount of Allowable Charges which the Covered Person must pay each calendar year for Covered Services before benefits are payable by this plan.

Durable Medical Equipment: Equipment and supplies which treat an Illness or Injury, to improve the functioning of a particular body part, or to prevent further deterioration of the Covered Person's medical condition. Such equipment and supplies must be designed and used primarily to treat conditions which are medical in nature, and able to withstand repeated use. Durable Medical Equipment includes such items as prosthetic devices that replace a limb or body part, orthopedic braces, crutches and wheelchairs. It does not include sporting or athletic equipment or items purchased for the convenience of the family.

Eligibility Waiting Period: Applicable to new Subscribers only, the period between the first day of employment and the first date of coverage under the Contract. This period may include the probationary period.

Eligible Dependent: Your employer determines eligibility and validates eligibility for enrollment.

Emergency Medical Condition: A medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including, but not limited to, severe pain that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in: 1) placing the health of the person afflicted with such condition in serious jeopardy or, in the case of a behavioral condition, placing the health of such persons or others in serious jeopardy, 2) serious impairment to such person's bodily functions, 3) serious impairment of any bodily organ or part of such person, or 4) serious disfigurement of such person.

Emergency Services: Health care Services Medically Necessary to screen and stabilize a Covered Person in connection with an Emergency Medical Condition and the provider or facility determines such individual is able to travel using nonmedical transportation.

Essential Health Benefits: The ACA identifies ten categories of Covered Services as Essential Health Benefits: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Group: The employer/entity providing group health coverage under the Contract for its employees/participants.

Hospital: A Hospital is an institution or facility duly Licensed by the State of Nebraska or the state in which it is located, which provides medical, surgical, diagnostic and treatment Services with 24 hour per day nursing Services, to two or more nonrelated persons with an Illness, Injury or Pregnancy, under the supervision of a staff of Physicians Licensed to practice medicine and surgery.

Host Blue (Plan): A Blue Cross and/or a Blue Shield Plan in another Blue Cross and Blue Shield Association Service Area, which administers Claims through the BlueCard Program for Nebraska Covered Persons residing or traveling in that service area.

Illness: A condition which deviates from or disrupts normal bodily functions or body tissues in an abnormal way, and is manifested by a characteristic set of signs or symptoms.

In-network Hospital, Physician Or Other Provider: A Licensed practitioner of the healing arts, a Licensed facility or other qualified provider of health care Services who has contracted with Us to provide Services as a part of a Preferred Provider network in Nebraska.

Inpatient: A Covered Person admitted to a Hospital or other institutional facility for bed occupancy to receive Services consisting of active medical and nursing care to treat conditions requiring continuous nursing intervention of such an intensity that it cannot be safely or effectively provided in any other setting.

Investigative: A technology, a drug, biological product, device, diagnostic, treatment or procedure is investigative if it has not been Scientifically Validated. BCBSNE will determine whether a technology is Investigative.

Master Group Application: A form completed by the Group which indicates the coverage options and provisions chosen by the Group.

Medically Necessary (or used as "Medical Necessity"): Health care Services ordered by a Treating Physician exercising prudent clinical judgment, provided to a Covered Person for the purposes of prevention, evaluation, diagnosis or treatment of that Covered Person's Illness, Injury or Pregnancy, that are:

- consistent with the prevailing professionally recognized standards of medical practice; and, known to be effective in improving health care outcomes for the condition for which it is recommended or prescribed. Effectiveness will be determined by validation based upon scientific evidence, professional standards and consideration of expert opinion; and
- clinically appropriate in terms of type, frequency, extent, site and duration for the prevention, diagnosis or treatment of the Covered Person's Illness, Injury or Pregnancy. The most appropriate setting and the most appropriate level of Service is that setting and that level of Service, considering the potential benefits and harms to the patient. When this test is applied to the care of an Inpatient, the Covered Person's medical symptoms and conditions must require that treatment cannot be safely provided in a less intensive medical setting; and
- not more costly than alternative interventions, including no intervention, and are at least as likely to produce equivalent therapeutic or diagnostic results as to the prevention, diagnosis or treatment of the patient's Illness, Injury or Pregnancy, without adversely affecting the Covered Person's medical condition; and
- not provided primarily for the convenience of the following:
  - the Covered Person;
  - the Physician;
  - the Covered Person 's family;
  - any other person or health care provider; and
- not considered unnecessarily repetitive when performed in combination with other prevention, evaluation, diagnoses or treatment procedures.

BCBSNE will determine whether Services are Medically Necessary. Services will not automatically be considered Medically Necessary because they have been ordered or provided by a Treating Physician.

Medicare: Health Insurance for the Aged and Disabled, Title XVIII of the Social Security Act, as amended.

Noncovered Services: Services that are not payable under the Plan.

Out-of-network Allowance: The amount used by BCBSNE to calculate payment for Covered Services to an Out-of-network Provider. This amount will be determined by BCBSNE or by the Host Blue Plan, as applicable.

- If determined by BCBSNE: the Out-of-network Allowance is calculated as the lesser of the billed charge or an allowance established using a pre-determined method based on the type of service. Such methods include, but are not limited to :
  - a fee schedule based on a percentage of the Medicare allowance for the service;
  - a per diem or daily rate allowance;
  - a percentage of billed charges;
  - an APR-DRG grouping methodology.
- If determined by a Host Blue Plan: the out-of-network Allowance will be the amount that the Host Blue Plan passes to BCBSNE. The Host Blue Plan's allowance may be based on:
  - a negotiated price for their participating providers;
  - the billed charge;
  - their local payment for nonparticipating providers;
  - price arrangement required by any applicable state law.

Out-of-network Provider: A provider of health care Services who has not contracted with BCBSNE to provide Services as a part of a Preferred Provider network in Nebraska.

Out-of-pocket Limit: The maximum amount of cost-share each Covered Person or Membership Unit must pay in a calendar year before benefits are payable without application of a cost-share amount.

Outpatient: A person who is not admitted for Inpatient care, but is treated in the Outpatient department of a Hospital, in an observation room, in an Ambulatory Surgical Facility, Urgent Care Facility, a Physician's office, or at home. Ambulance Services are also considered Outpatient.

Physician: Any person holding a License and duly authorized to practice medicine and surgery.

Plan Administrator: The administrator of the Plan as defined by the Employee Retirement Income Security Act (ERISA).

Preferred Provider Organization: A panel of Hospitals, Physicians and other health care providers who belong to a network of Preferred Providers, which agrees to more effectively manage health care costs.

Preferred Provider: A health care provider (Hospital, Physician or other health care provider) who has contracted to provide Services as a part of the network in Nebraska, or if in another state, who is a Preferred Provider with the BlueCard Program PPO network.

Preventive (Services): Services which focus on the prevention of disease and health maintenance, including the early diagnosis of disease, discovery and identification of high risk for a specific problem, and interventions to avert a health problem in nonsymptomatic individuals.

Primary Care Physician: 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.

Qualified Beneficiary: Under COBRA, an individual who must in certain circumstances, be offered the opportunity to elect COBRA coverage under a group health plan. The term generally includes a covered employee's spouse or dependent children who were covered under the group health plan on the day before a Qualifying Event, as well as a covered employee who was covered under the group health plan on the day before a Qualifying Event that is a termination of employment or a reduction in hours. The term also includes a child born to or adopted by a covered employee during a period of COBRA coverage.

Schedule of Benefits Summary: A summarized personal document which provides information such as Copayments, Deductibles, percentages payable, special benefits, maximums and limitations of coverage.

Scientifically Validated: A technology, a drug, biological product, device, diagnostic, treatment or procedure is Scientifically Validated if it meets all of the factors set forth below:

1. Technologies, drugs, biological products, devices and diagnostics must have final approval from the appropriate government regulatory bodies. A drug or biological product must have final approval from the Food and Drug Administration (FDA). A device must have final approval from the FDA for those specific indications and methods of use that is being evaluated. FDA or other governmental approval is only one of the factors necessary to determine Scientific Validity.
2. The Scientific Evidence must permit conclusions concerning the effect of the technology on health outcomes. The evidence should consist of well-designed and well-conducted investigations published in peer-reviewed journals. The quality of the body of studies and the consistency of the results are considered in evaluating the evidence.

   The evidence should demonstrate that the technology can measure or alter the physiological changes related to a disease, injury, Illness or condition. In addition there should be evidence based on established medical facts that such measurement or alteration affects the health outcomes.

   Opinions and evaluations by national medical associations, consensus panels or other technology evaluation bodies are evaluated according to the scientific quality of the supporting evidence and rationale. Our evidence includes, but is not limited to: Blue Cross and Blue Shield Association Technology Evaluation Center technology evaluations; Hayes Directory of New Medical Technologies' Status; Centers for Medicare and Medicaid Services (CMS) Technology Assessments, and United States Food and Drug Administration (FDA) approvals.

3. The technology must improve the health outcome.
4. The technology must improve the health outcome as much as or more than established alternatives.
5. The improvement must be attainable outside the investigational settings.

BCBSNE will determine whether a technology is Scientifically Validated.

Services: Hospital, medical or surgical procedures, treatments, drugs, supplies, Durable Medical Equipment, or other health, mental health or dental care, including any single service or combination of such services.

Service Area: The geographic area in which a Blue Cross and Blue Shield plan is authorized to use the Blue Cross and Blue Shield brands pursuant to its license agreement with Blue Cross and Blue Shield Association.

Specialist: A Physician who has a majority of his or her practice in fields other than internal or general medicine, obstetrics/gynecology, general pediatrics or family practice.

Subscriber: An individual who enrolls for coverage and is named on an identification card issued pursuant to this plan.

Total Care: Also known as value-based programs. Total Care is an outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local providers that is evaluated against cost and quality metrics/factors and is reflected in provider payment. Total Care (value-based programs) may include, but are not limited to, Accountable Care Organizations, Global Payment Costs of Care arrangements, Patient Centered Medical Homes and Shared Savings arrangements.

Treating Physician: A Physician who has personally evaluated the Covered Person. This may include a Physician or oral surgeon, a Certified nurse midwife, a Certified nurse practitioner or Certified Physician's assistant, within the practitioner's scope of practice.

Urgent Care Facility: A facility, other than a Hospital, that provides covered health Services that are required to prevent serious deterioration of a Covered Person's health, and that are required as a result of an unforeseen sickness, Injury or the onset of acute or severe symptoms.

We, Our or Us: Blue Cross and Blue Shield of Nebraska, Inc. (BCBSNE).

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