PremierBlue

BlueCross BlueShield Nebraska

Schedule of Benefits Summary

Group Name: CommonSpirit Health

Effective Date: January 1, 2027

For additional information regarding your medical plan, please log into My Total Rewards at home.commonspirit.org/mytotalrewards Hover on the "Benefit Resources" tab, within the "Plan Information" column, select "Summary Plan Descriptions" or Summary Plan Descriptions can be located at NebraskaBlue.com/CommonSpirit

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 (BCBSNE) 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 Noncovered Services, which are the Covered Person's responsibility. That means In-network Providers, under the terms of their contract with BCBSNE, 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. Cost-sharing and reimbursement amounts for categories showing "Same as any other Illness" may vary based on where Services are rendered.		
In-network Provider: The provider network is shown on your I.D. card. For help locating In-network Providers, visit NebraskaBlue.com/DoctorFinder. For certain Durable Medical Equipment, Independent Laboratory and Specialty Drug Services, the Doctor Finder may display providers that are considered Out-of-network for these types of Services. Refer to your benefit book for additional information.		
Deductible (the amount the Covered Person pays each Calendar Year for Covered Services before the Coinsurance is payable)		
• Individual	$3,500	$6,000
• Family (Embedded*)	$7,000	$12,000
Coinsurance (the percentage amount the Covered Person must pay for most Covered Services after the Deductible has been met)		
• Covered Person Pays	15%	60%
• Plan Pays	85%	40%
Out-of-pocket Limit (includes Deductible, Coinsurance and Copayments)		
• Individual	$4,000	$12,000
• Family (Embedded*)	$8,000	$24,000
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.) cross accumulate between In-network and Out-of-network, unless noted differently. Day, session or visit limits for certain Services shown on this summary are not applicable to Mental Health and/or Substance Use Disorder Services. Once the annual Out-of-pocket Limit is reached, most Covered Services are payable by the plan at 100% for the rest of the Calendar Year.		
*Embedded – If you have single coverage, you only need to satisfy the individual Deductible and Out-of-pocket Limit. 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 Limit.		
Copayment(s) (Copay(s)) apply to: • Urgent Care Facility • Emergency Room Services • Prescription Drugs The Copay amount varies by the type of Covered Services. Refer to the appropriate category for benefit information.		
Services may require Preauthorization. Failure to obtain Preauthorization will result in denial of benefits. For additional information regarding Preauthorization procedures visit NebraskaBlue.com/PreAuth.		

Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Primary Care Physician Office Visit	Deductible and Coinsurance	Deductible and Coinsurance
Specialist Physician Office Visit	Deductible and Coinsurance	Deductible and Coinsurance
Benefits for **Primary Care Physician** or **Specialist Physician office visit** include the **office visit**, consultations and medication checks.		
Physician Office Services	Deductible and Coinsurance	Deductible and Coinsurance
Allergy Testing, Injections and Serum	Deductible and Coinsurance	Deductible and Coinsurance
Other Injections	Deductible and Coinsurance	Deductible and Coinsurance
The following **Physician Office Services** are available when provided in a **Primary Care Physician or Specialist Physician's office,** with or without an **office visit;** X-rays, laboratory and pathology Services, supplies and/or drugs administered during the **office visit**, hearing exams or eye exams (excluding refractions) due to Illness or Injury. Other Services provided in the office but **NOT** included in the **Physician's office visit** or **Physician office Services** benefit listed above, include but are not limited to; **allergy testing, injections and serums, other, injections, Preventive Services**, **Mental Health** and/or **Substance Use Disorder Services**, **Biofeedback**, **Advanced Diagnostic Imaging** (CT, MRI, MRA, MRS, PET and SPECT scans and other Nuclear Medicine), **Durable Medical Equipment**, **Pregnancy, Maternity** and **Newborn Care**, **Radiation Therapy** and **Chemotherapy**, **Sleep Studies**, **Therapy** and **Manipulations** and Surgery and Anesthesia. *(Refer to the appropriate categories below and your benefit book for additional information.)*		
Telehealth/Virtual Care Services • Medical • Mental Health	Coinsurance See Mental Health and/or Substance Use Disorder Services	Deductible and Coinsurance See Mental Health and/or Substance Use Disorder Services
Convenient Care/Retail Clinics/Quick Care - Virtual Only	Deductible and Coinsurance	Deductible and Coinsurance
Priority Care	Deductible and Coinsurance	Deductible and Coinsurance
Urgent Care Facility Services	Deductible then $50 Copay	Deductible then $75 Copay
Emergency Room Services • Facility • Professional Services	Deductible then $200 Copay Deductible Only	In-network level of benefits In-network level of benefits
Outpatient Hospital or Facility Services Services include but are not limited to surgery, laboratory and radiology, observation stays, and other Services provided on an Outpatient basis.	Deductible and Coinsurance	Deductible and Coinsurance
Inpatient Hospital or Facility Services Services include but are not limited to charges for room and board, diagnostic testing, rehabilitation Services and other ancillary Services provided on an Inpatient basis.	Deductible and Coinsurance	Deductible and Coinsurance

Preventive Services	In-network Provider	Out-of-network Provider
This group health plan does not provide benefits for ACA-required Preventive Services which are identified as contraceptive methods and counseling Services. These Services may be available under a separate Contraceptive Services only Plan.		
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) • ACA-required covered Preventive Services (outside of limits) • Other covered Preventive Services not required by ACA, such as: - Laboratory tests as specified by Us, including urinalysis and complete blood count; general health panel; metabolic panel; prostate cancer screening (PSA) and hearing screening - All other laboratory tests; radiology, cardiac stress tests; EKG; pulmonary function and other screenings and services	Plan Pays 100% Plan Pays 100% Plan Pays 100% Plan Pays 100%	Plan Pays 100% Plan Pays 100% Plan Pays 100% Plan Pays 100%
For additional information visit NebraskaBlue.com/PreventiveCare		
Immunizations • Pediatric (up to age 7) • Age 7 and older • Related to an Illness	Plan Pays 100% Plan Pays 100% Plan Pays 100%	Plan Pays 100% Plan Pays 100% Plan Pays 100%
Colorectal Cancer Screenings (starting at age 45) • Colonoscopy Screening - Diagnostic or Preventive Screening (one every five years) - Screenings outside the age or frequency limit • Sigmoidoscopy/Proctoscopy Screening and CT of the Colon - Preventive Screening (one every five years) - Screenings outside the age or frequency limit • FIT DNA - Preventive Screening (one every three years) - Screenings outside the age or frequency limit • Fecal Occult Blood Test - Preventive Screening (one per year) - Screenings outside the age or frequency limit • Barium Enema, and other tests as determined under ACA Preventive Services - Preventive Screenings - Diagnostic Screenings	Plan Pays 100% Plan Pays 100% Plan Pays 100% Plan Pays 100% Plan Pays 100% Plan Pays 100% Plan Pays 100% Plan Pays 100% Plan Pays 100% Plan Pays 100%	Plan Pays 100% Deductible and Coinsurance Plan Pays 100% Deductible and Coinsurance Plan Pays 100% Deductible and Coinsurance Plan Pays 100% Deductible and Coinsurance Plan Pays 100% Deductible and Coinsurance
NOTE: Related Services will pay in the same manner as the Colorectal Cancer Screening when performed on the same date of service. Screening limits accumulate based on a Calendar Year.		

Mental Health and/or Substance Use Disorder Services	In-network Provider	Out-of-network Provider
Office Visit	Deductible and Coinsurance	Deductible and Coinsurance
Benefits for **office visit** include the **office visit**, medication checks, psychological therapy and/or Substance Use Disorder counseling.		
Office Services	Deductible and Coinsurance	Deductible and Coinsurance
The following **office Services** are available when provided in the office; X-rays, laboratory tests, supplies and/or drugs administered during the **office visit**.		
All Other Outpatient Items and Services	Deductible and Coinsurance	Deductible and Coinsurance
Other Services provided in the office but **NOT** included in the **office visit** or **office Services** benefit listed above include, but are not limited to; psychological evaluations, assessments, testing, physical therapy, occupational therapy, speech therapy or any other covered Mental Health and/or Substance Use Disorder Services.		
Telehealth/Virtual Care Services	Coinsurance	Deductible and Coinsurance
Emergency Room Services • Facility • Professional Services	 Deductible then $200 Copay Deductible Only	 In-network level of benefits In-network level of benefits
Inpatient Services	Deductible and Coinsurance	Deductible and Coinsurance
For additional resources and support visit NebraskaBlue.com/MentalHealth		

Other Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Acupuncture(limited to 10 visits per calendar year)	Deductible and Coinsurance	Deductible and Coinsurance
Advanced Diagnostic Imaging (CT, MRI, MRA, MRS, PET & SPECT scans and other nuclear medicine)	Deductible and Coinsurance	Deductible and Coinsurance
Ambulance (to the nearest facility for appropriate care) • Ground Ambulance • Air Ambulance	 Deductible Only Deductible Only	 In-network level of benefits In-network level of benefits
Autism Spectrum Disorder • Testing and Diagnosis • Treatment	 Same as Mental Health Same as Mental Health	 Same as Mental Health Same as Mental Health
Biofeedback • Medical • Mental Health	 Deductible and Coinsurance Same as Mental Health	 Deductible and Coinsurance Same as Mental Health
Dermatological Services	Same as any other Illness	Same as any other Illness
Diabetic Services • Services include education, self-management training, podiatric appliances and equipment. • Nephropathy Screening • Retinal exams	 Deductible and Coinsurance Plan Pays 100% Plan Pays 100%	 Deductible and Coinsurance Deductible and Coinsurance Plan Pays 100%
Drugs Administered in an Outpatient Setting (such as home, physician office and other Outpatient settings)	Same as any other Illness	Same as any other Illness
Durable Medical Equipment and Supplies (including Prosthetics) (rental or purchase, whichever is least costly, rental shall not exceed the cost of purchasing)	Deductible and Coinsurance	Deductible and Coinsurance
Hearing Services • Bone Anchored Hearing Aids • Cochlear Implants • Hearing Aids and related Services (up to age 19, limited to $3,000 every 48 months)	 Deductible and Coinsurance Deductible and Coinsurance Not Covered	 Deductible and Coinsurance Deductible and Coinsurance Not Covered

Other Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Home Health Care Services • Home Health Aide • Home Infusion Therapy • Respiratory Care • Skilled Nursing Care	 Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance	 Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance
Hospice Services (when life expectancy is 12 months or less)	Deductible and Coinsurance	Deductible and Coinsurance
Independent Laboratory • Diagnostic • Preventive	 Deductible and Coinsurance Same as Preventive Services In-network level of benefits	 In-network level of benefits Same as Preventive Services In-network level of benefits
Infertility • Services to Diagnose • Treatment to Promote Fertility (up to $15,000 lifetime maximum person)	 Same as any other illness Deductible and Coinsurance	 Deductible and Coinsurance Deductible and Coinsurance
NOTE: Benefits will not be provided for services and supplies rendered or provided for the treatment of fertility in which fertilization takes place outside of the woman's body. Specifically excluded, without limiting this exclusion to these procedures; in-vitro fertilization, artificial insemination, embryo transfers, donor charges, zygote intrafallopian transfer (ZIFT), cryopreservation, or surrogate parent services.)		
Nicotine Addiction • Medical Services and Therapy • Nicotine Addiction Classes & Alternative Therapy, such as Acupuncture	 Same as Substance Use Disorder Services Not Covered	 Same as Substance Use Disorder Services Not Covered
Nutritional Supplements (when administered by tubal feeding)	Deductible and Coinsurance	Deductible and Coinsurance
Obesity • Non-Surgical Treatment • Surgical Treatment (Limited to one per lifetime with allowance for adjustments)	 Not Covered Deductible and Coinsurance	 Not Covered Deductible and Coinsurance
Oral Surgery and Dentistry Services such as incision and drainage of abscesses and excision of tumors and cysts. Dental treatment when due to an accidental Injury to naturally healthy teeth. (treatment related to accidents must be provided within 12 months of the date of Injury)	Deductible and Coinsurance	Deductible and Coinsurance
Organ and Tissue Transplantation • Transplant Services (Blue Distinction Center and CommonSpirit Facilities) • Transportation and lodging required for travel to a Blue Distinction Center for the covered surgical procedure to a facility for Covered Person and one companion subject to a $10,000 maximum per transplant. No benefit is available for travel less than 50 miles.	 Blue Distinction Center and CommonSpirit Facilites: Deductible and Coinsurance Individual: $50 per diem Two or more individuals: $100 per diem	 All non- Blue Distinction, non-CommonSpirit Facilities and Out-of-network providers: Deductible and Coinsurance Not Covered
Please refer to your Summary Plan Description for Additional information regarding Organ and Tissue Transplantation Services.		
Ostomy Supplies	Deductible and Coinsurance	Deductible and Coinsurance
Physician Professional Services include but is not limited to Inpatient and Outpatient professional Services for surgery, surgical assistant, anesthesia, Inpatient Hospital visits and other non-surgical Services.	Deductible and Coinsurance	Deductible and Coinsurance

Other Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Pregnancy, Maternity and Newborn Care • Pregnancy and Maternity - Visits - All Other Services • Newborn Care (newborns are covered at birth, subject to the plans enrollment provisions)	 Plan Pays 100% Deductible and Coinsurance Deductible and Coinsurance	 Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance
NOTE: The plan pays 100% for the initial postpartum depression screening up to one year following a Pregnancy or childbirth.		
Radiation Therapy and Chemotherapy	Deductible and Coinsurance	Deductible and Coinsurance
Radiology (X-ray) Services and Other Diagnostic Tests	Deductible and Coinsurance	Deductible and Coinsurance
Rehabilitation Services – Inpatient Facility	Deductible and Coinsurance	Deductible and Coinsurance
Rehabilitation Services • Cardiac Rehabilitation (Allow 3 sessions per week for up to a 12-week period, 36 sessions, based on Medical Necessity) • Pulmonary Rehabilitation (No limits based on Medical Necessity)	 Deductible and Coinsurance Deductible and Coinsurance	 Deductible and Coinsurance Deductible and Coinsurance
Renal Dialysis	Deductible and Coinsurance	Deductible and Coinsurance
Skilled Nursing Facility	Deductible and Coinsurance	Deductible and Coinsurance
Sleep Studies	Deductible and Coinsurance	Deductible and Coinsurance
Temporomandibular and Craniomandibular Joint Disorder	Deductible and Coinsurance	Deductible and Coinsurance
Therapy & Manipulations • Physical, Occupational and Speech Therapy including osteopathic physiotherapy and manipulations (combined limit of 30 sessions per Calendar Year) • Chiropractic Services including but not limited to office visits, radiology, pathology, physiotherapy, manipulations/adjustments (combined limit to 20 sessions per Calendar Year)	 Deductible and Coinsurance Deductible and Coinsurance	 Deductible and Coinsurance Deductible and Coinsurance
NOTE: Outpatient/office physical, speech and occupational therapy must be medically necessary, approved by the medical carrier, and provided under a physician-established plan of care. **NOTE:** Treatment limits stated for physical therapy, occupational therapy and speech therapy Services are not applicable to treatment provided for Mental Health and/or Substance Use Disorder Services. Evaluations are covered but do not apply to the combined Calendar Year limit.		
Vision Services • Eyeglasses or Contact Lenses (One pair of glasses or contact lenses and eye exam, including refraction is covered after cataract surgery, cornea transplantation or cornea grafting) • Eye Exam - Diagnostic (to diagnose an Illness) - Preventive (routine exam including refraction) limited to one exam per Calendar Year	 Deductible and Coinsurance Deductible and Coinsurance Not Covered	 Deductible and Coinsurance Deductible and Coinsurance Not Covered
Wigs (limited to one wig per year when hair loss is due to medical treatment)	Deductible and Coinsurance	Deductible and Coinsurance
All Other Covered Services	Deductible and Coinsurance	Deductible and Coinsurance

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, 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.

Pharmacy Summary of Benefits
Covered prescription expenses will apply toward the medical in-network out-of-pocket maximum. Once the medical Enhanced network out-of-pocket maximum is met, your covered prescriptions will be 100 percent covered by the plan.

Integrated HDHP/HSA Select Option		
Member Pays		
	Enhanced Network	**Out-of-Network**
Generic Drugs	100% after $5 Copayment and After Deductible	N/A
Brand-name drug on formulary	15% ($20 min/$55 max) After Deductible	N/A
Brand-name drug not on formulary	25% ($32.50 min/$80 max) After Deductible	N/A
Optum Rx Network Retail Pharmacy (30-Day Prescriptions)		
Generic Drugs	100% after $10 Copayment and After Deductible	60% After Deductible
Brand-name drug on formulary	30% ($40 min/$110 max) After Deductible	60% After Deductible
Brand-name drug not on formulary	50% ($65 min/$160 max) After Deductible	60% After Deductible
CommonSpirit Home Delivery (90-Day Prescription)		
Generic Drugs	100% after $12.50 Copayment and After Deductible	N/A
Brand-name drug on formulary	15% ($50 min/$87.50 max) After Deductible	N/A
Brand-name drug not on formulary	25% ($80 min/$162.50 max) After Deductible	N/A

Note: If you fill a brand-name prescription when there is a generic equivalent available, you will pay the applicable tier brand-name prescription coinsurance plus the difference between the generic and brand-name amount. If it is medically necessary for you to have the brand-name prescription, your doctor can contact the CommonSpirit Health prescription administrator to get an exception so you don't have to pay the difference between the generic and the brand-name amount. You will pay the brand-name prescription coinsurance.

Maintenance prescriptions, such as blood pressure medication, must be filled using the CommonSpirit Health Home Delivery pharmacy or a CommonSpirit Health Pharmacy. You can fill a new maintenance medication prescription up to three times at a retail pharmacy before you are required to use CommonSpirit Health Home Delivery or a CommonSpirit Health Pharmacy.

The **Home Delivery pharmacy** requirement for maintenance medications does not apply to employees who work at **St. Mary's Community Hospital in Nebraska City, CHI Health Schuyler, CHI Health Corning, CHI Health Missouri Valley or CHI Health Plainview.**

Specialty prescriptions must be processed through the CommonSpirit Specialty Pharmacy. If the CommonSpirit Specialty can't fill your specialty medication, your prescription will be routed to Optum Rx Specialty Pharmacy partner.