PremierBlue

BlueCross BlueShield Nebraska

Schedule of Benefits Summary

Group Name: CommonSpirit Health

Effective Date: January 01, 2025

For additional information regarding your medical plan, please log into MyBenefits at home.commonspirit.org/employeecentral/mybenefits. 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 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. 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 in locating In-network Providers, visit NebraskaBlue.com/Find-a-Doctor. 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. Please 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	$3,300	$6,000
• Family (Embedded*)	$6,600	$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 Copays)		
• 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.) do 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 Disorders. 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 amounts. If you have family coverage, no one family member contributes more than the individual amount. Family members may combine their covered expenses to satisfy the required family Deductible and Out-of-pocket amounts.		
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 please visit NebraskaBlue.com/PreAuth.**		

Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Physician Office Services • Primary Care Physician Office Visit • Specialist Physician Office Visit • Physician Office Services provided in the office (with or without an office visit)	Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance	Deductible and Coinsurance 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
Primary Care Physician is a physician who has a majority of his or her practice in internal or general medicine, obstetrics/gynecology, general pediatrics or family practice. A **physician assistant** is covered in the same manner as a Primary Care Physician. ***Specialist Physician*** is a physician who is not a Primary Care Physician. ***Office Visit Benefits*** for Primary Care and Specialist Physician Office Visit include office visits (including the initial visit to diagnose pregnancy) consultations and medication checks. ***Physician Office Services*** include but are not limited to: office visits; X-ray, laboratory and pathology services; Allergy Testing, Injections and Serums; Supplies and/or Drugs administered during the office visit; Hearing exams or Eye exams due to Illness or Injury excluding refractions. ***Other Covered Services not part of the Physician Office Services Benefit (Refer to the appropriate category for benefit information) include:*** Advanced Diagnostic Imaging (CT, MRI, MRA, MRS, PET and SPECT scans and other Nuclear Medicine); Pregnancy Services; Preventive Services; Radiation Therapy and Chemotherapy; Surgery and Anesthesia; Therapy and Manipulations; Durable Medical Equipment; Sleep Studies; Biofeedback; Mental Health and Substance Use Disorders.		
Telehealth/Virtual Care Services • Medical • Mental Health	Deductible and 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 (services received in a Hospital emergency room setting) • Facility • Professional Services	Deductible then $200 Copay Deductible	In-network level of benefits In-network level of benefits
Outpatient Hospital or Facility Services Services such as surgery, laboratory and radiology, cardiac and pulmonary rehabilitation, observation stays, and other services provided on an outpatient basis	Deductible and Coinsurance	Deductible and Coinsurance
Inpatient Hospital or Facility Services Charges for room and board, diagnostic testing, rehabilitation 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)	Plan Pays 100%	Plan Pays 100%
• ACA required covered preventive services (outside of limits)	Plan Pays 100%	Plan Pays 100%
• 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	Plan Pays 100%	Plan Pays 100%
- All other laboratory tests; radiology, cardiac stress tests; EKG; pulmonary function and other screenings and services	Plan Pays 100%	Plan Pays 100%
Immunizations		
• Pediatric (up to age 7)	Plan Pays 100%	Plan Pays 100%
• Age 7 and older	Plan Pays 100%	Plan Pays 100%
• Related to an illness	Plan Pays 100%	Plan Pays 100%
Colorectal Cancer Screenings (starting at age 45)		
• Colonoscopy Screening		
- Diagnostic or Preventive Screening (one every five years)	Plan Pays 100%	Plan Pays 100%
- Screenings outside the age or frequency limit	Plan Pays 100%	Deductible and Coinsurance
• Sigmoidoscopy/Proctoscopy Screening and CT of the Colon		
- Preventive Screening (one every five years)	Plan Pays 100%	Plan Pays 100%
- Screenings outside the age or frequency limit	Plan Pays 100%	Deductible and Coinsurance
• FIT DNA		
- Preventive Screening (one every three years)	Plan Pays 100%	Plan Pays 100%
- Screenings outside the age or frequency limit	Plan Pays 100%	Deductible and Coinsurance
• Fecal occult blood test		
- Preventive Screening (one per year)	Plan Pays 100%	Plan Pays 100%
- Screenings outside the age or frequency limit	Plan Pays 100%	Deductible and Coinsurance
• Barium enema, and other tests as determined under ACA Preventive Services		
- Preventive Screenings	Plan Pays 100%	Plan Pays 100%
- Diagnostic Screenings	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
Inpatient Services	Deductible and Coinsurance	Deductible and Coinsurance
Outpatient Services		
• Office Services	Deductible and Coinsurance	Deductible and Coinsurance
• Telehealth/Virtual Care Services	Deductible and Coinsurance	Deductible and Coinsurance
• All Other Outpatient Items & Services	Deductible and Coinsurance	Deductible and Coinsurance
Office Services include office visits, medication checks, psychological therapy and/or substance use disorder counseling, x-rays, laboratory tests, supplies and/or drugs administered during the office visit. ***Other Covered Services not part of the Office Benefit Services are covered under All Other Outpatient Items & Services.*** This includes but is 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.		
Emergency Room Services (services received in a Hospital emergency room setting)		
• Facility	Deductible then $200 Copay	In-network level of benefits
• Professional Services	Deductible Only	In-network level of benefits
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	Deductible	In-network level of benefits
• Air Ambulance	Deductible	In-network level of benefits
Autism Spectrum Disorder		
• Testing and Diagnosis	Same as mental health	Same as mental health
• Treatment	Same as mental health	Same as mental health
Biofeedback		
• Medical	Deductible and Coinsurance	Deductible and Coinsurance
• Mental Health	Same as mental health	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.	Deductible and Coinsurance	Deductible and Coinsurance
• Nephropathy Screening	Plan Pays 100%	Deductible and Coinsurance
• Retinal exams	Plan Pays 100%	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	Deductible and Coinsurance	Deductible and Coinsurance
• Cochlear Implants	Deductible and Coinsurance	Deductible and Coinsurance
• Hearing Aids (up to age 19, limited to $3,000 every 48 months.)	Not Covered	Not Covered

Other Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Home Health Care Services		
• Home Health Aide	Deductible and Coinsurance	Deductible and Coinsurance
• Home Infusion Therapy	Deductible and Coinsurance	Deductible and Coinsurance
• Skilled Nursing Care	Deductible and Coinsurance	Deductible and Coinsurance
• Respiratory Care	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	Deductible and Coinsurance	In-network level of benefits
• Preventive	Same as Preventive Services In-network level of benefits	Same as Preventive Services In-network level of benefits
Infertility		
• Services to Diagnose	Same as any other illness	Deductible and Coinsurance
• Treatment to Promote Fertility (up to $15,000 lifetime maximum person)	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	Same as Substance Use Disorder Services	Same as Substance Use Disorder Services
• Nicotine addiction classes & alternative therapy, such as acupuncture	Not Covered	Not Covered
Nutritional Supplements (when administered by tubal feeding)	Deductible and Coinsurance	Deductible and Coinsurance
Obesity		
• Non-Surgical Treatment	Not Covered	Not Covered
• Surgical Treatment (Limited to one per lifetime with allowance for adjustments)	Deductible and Coinsurance	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))	Blue Distinction Center and CommonSpirit Facilities: Deductible and Coinsurance	All non- Blue Distinction, non-CommonSpirit Facilities and Out-of-network providers: Deductible and Coinsurance
• 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.	Individual: $50 per diem Two or more individuals: $100 per diem	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

Other Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Physician Professional Services Inpatient and Outpatient services, such as, surgery, surgical assistant, anesthesia, inpatient hospital visits and other non-surgical services	Deductible and Coinsurance	Deductible and Coinsurance
Pregnancy, Maternity and Newborn Care • Pregnancy and maternity (Payment for prenatal and postnatal care is included in the payment for the delivery) • Newborn care (Newborns are covered at birth, subject to the plan's enrollment provisions)	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 to 30 sessions per Calendar Year for Out-of-network providers) • 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: Treatment limits stated for physical therapy, occupational therapy and speech therapy services are not applicable to treatment provided for Mental Health or Substance Use Disorders. Evaluations are covered and 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) • Vision 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 contract limitations, please refer to the master group 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		
	In-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
Capital 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 Capital Rx Specialty Pharmacy partner.