BlueCross BlueShield Nebraska

An overview of your medical, prescription drug and dental benefits

EHA

Educators health alliance direct bill plan

For members retiring early ages 50 to 64

Effective Sept. 1, 2025

When you retire early, your current Blue Cross and Blue Shield of Nebraska (BCBSNE) Educators Health Alliance (EHA) health care coverage will end. However, there are medical and dental plans available to ensure you and your eligible dependents have continuous health care coverage. To be eligible, you must be 50 to 64 years of age and have had 60 months of continuous health coverage through BCBSNE.

You must enroll in both medical and dental coverage. Eligible dependent family members may elect medical only, dental only or both medical and dental: only if eligible dependent family members were covered under medical and/or dental on the active EHA plan.

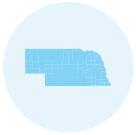
EHA makes five health plan options and one dental option available to Direct Bill Plan members. Please review the network information and plan option summaries on the following pages.

Please note: When you reach age 65 and become eligible for Medicare, you will no longer be eligible for the Direct Bill Plan (unless family coverage is needed to cover eligible dependents). However, you will be eligible to enroll in the Educators' Medicare Supplement Group Plan F or Plan G coverage through BCBSNE. Approximately 90 days prior to your 65th birthday, BCBSNE will send you (and your spouse, if applicable) information about the Educators' Medicare Supplement coverage.

UNDERSTAND HEALTH INSURANCE

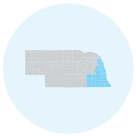
Network options

We understand the importance of having access to high-quality health care services. You may choose from one of these networks to meet your needs:



NEtwork BLUE

NEtwork BLUE is our statewide network, made up of 98% of Nebraska's doctors and 99% of non-governmental acute care hospitals.*

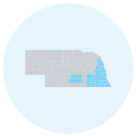


Premier Select BlueChoice

Premier Select BlueChoice is a regional network available in Omaha, Lincoln and surrounding communities in ZIP codes starting with 680, 681, 683, 684 and 685. All other Nebraska providers are out of network.

Some of the key hospitals and health care providers include:

- Boys Town National Research Hospital
- Bryan Health
- Children's Nebraska
- Methodist Hospital System
- Nebraska Medicine



Blueprint Health

Blueprint Health is a regional network available in Omaha, Lincoln and surrounding communities in ZIP codes starting with 680, 681, 683, 684 and 685, as well as Adams, Buffalo, Hall, Kearney and Phelps counties. All other Nebraska providers are out of network.

Some of the key hospitals and health care providers include:

- Boys Town National Research Hospital
- CHI Health System
- Children's Nebraska
- Nebraska Spine Hospital LLC

*Source: BCBSNE statistics, Apr. 23, 2024.

Nationwide access

BCBSNE members have access to a national network called the BlueCard® Program. If Blue members live or travel outside of Nebraska, they may take their health care benefits with them. The BlueCard Program gives members access to doctors and hospitals almost everywhere within the United States. Members are covered whether they need care in urban or rural areas.

Outside of the United States, members have access to doctors and hospitals in nearly 200 countries and territories around the world through the Blue Cross Blue Shield Global® Core Program.

To locate providers:

Members should visit
NebraskaBlue.com/DoctorFinder
or call **844-201-0763**

HEALTH PLAN OPTIONS

Below are high-level summaries of the health plan options available to early retirees. ID cards will be mailed to members selecting a different plan option or selecting an early retiree plan for the first time. You will also receive a detailed Summary of Benefits.

Please note the provider network shown for each plan has changed (refer to the previous page for network information). The provider network can be found on your member ID card. For help locating in-network providers, visit **NebraskaBlue.com/DoctorFinder**.

OPTION 1 - $1,050 deductible NEtwork BLUE

Benefit	In network	Out of network
Deductible		
Individual	$1,050	$2,100
Family (Embedded*)	$2,100	$4,200
Coinsurance		
	20%	40%
Out-of-pocket Limit		
Individual	$5,900	$11,800
Family (Embedded*)	$11,800	$23,600
Office Visits		
Primary Care	$35 copay	Deductible and coinsurance
Specialist	$55 copay	Deductible and coinsurance
Telehealth	$10 copay	Not covered
Hospital Services		
Inpatient	Deductible and coinsurance	Deductible and coinsurance
Outpatient	Deductible and coinsurance	Deductible and coinsurance
Emergency Services		
Urgent Care	$55 copay then deductible and coninsurance	Deductible and coinsurance
Emergency room	$85 copay then deductible and coninsurance	In-network level of benefits
Preventive Services (services outside of limits, deductible and coinsurance will apply)		
	Plan pays 100%	Deductible and coinsurance
Prescription Drugs Retail - 30-day supply		
Generic drugs	25% coinsurance, $10 minimum copay, $40 maximum copay	25% coinsurance, $10 minimum copay, $40 maximum copay + 25% penalty
Preferred brand name	25% coinsurance, $50 minimum copay, $100 maximum copay	25% coinsurance, $50 minimum copay, $100 maximum copay + 25% penalty
Non-preferred brand name	50% coinsurance, $75 minimum copay, $150 maximum copay	50% coinsurance, $74 minimum copay, $150 maximum copay + 25% penalty
Specialty	25% coinsurance, $125 minimum copay, $250 maximum copay	Not covered
Home Delivery - per 180-day supply		
Generic	25% coinsurance, $50 minimum copay, $200 maximum copay	Not covered
Preferred brand name	25% coinsurance, $250 minimum copay, $500 maximum copay	Not covered
Non-preferred brand name	50% coinsurance, $375 minimum copay, $750 maximum copay	Not covered

*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.

OPTION 2 - $2,500 deductible NEtwork BLUE

Benefit	In network	Out of network
Deductible		
Individual	$2,500	$5,000
Family (Embedded*)	$5,000	$10,000
Coinsurance		
	30%	40%
Out-of-pocket Limit		
Individual	$8,350	$16,700
Family (Embedded*)	$16,700	$33,400
Office visits		
Primary Care	$50 copay	Deductible and coinsurance
Specialist	$70 copay	Deductible and coinsurance
Telehealth	$15 copay	Not covered
Hospital services		
Inpatient	Deductible and coinsurance	Deductible and coinsurance
Outpatient	Deductible and coinsurance	Deductible and coinsurance
Emergency services		
Urgent Care	$70 copay then deductible and coninsurance	Deductible and coinsurance
Emergency room	$100 copay then deductible and coninsurance	In-network level of benefits
Preventive services (services outside of limits, deductible and coinsurance will apply)		
	Plan pays 100%	Deductible and coinsurance
Prescription drugs retail - 30-day supply		
Generic drugs	30% coinsurance, $12 minimum copay, $45 maximum copay	30% coinsurance, $12 minimum copay, $45 maximum copay + 25% penalty
Preferred brand name	30% coinsurance, $55 minimum copay, $110 maximum copay	30% coinsurance, $55 minimum copay, $110 maximum copay + 25% penalty
Non-preferred brand name	50% coinsurance, $75 minimum copay, $150 maximum copay	50% coinsurance, $75 minimum copay, $150 maximum copay + 25% penalty
Specialty	25% coinsurance, $125 minimum copay, $250 maximum copay	Not covered
Home delivery - per 180-day supply		
Generic	30% coinsurance, $60 minimum copay, $225 maximum copay	Not covered
Preferred brand name	30% coinsurance, $275 minimum copay, $550 maximum copay	Not covered
Non-preferred brand name	50% coinsurance, $375 minimum copay, $750 maximum copay	Not covered

*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.

OPTION 3 - $3,800 deductible HSA-Eligible NEtwork BLUE

Benefit	In network	Out of network
Deductible		
Individual	$3,800	$7,600
Family (Aggregate)	$7,600	$15,200
Coinsurance		
	10%	20%
Out-of-pocket Limit		
Individual	$5,350	$15,000
Family (Aggregate)	$10,700	$30,000
Office visits		
Primary Care	Deductible and coinsurance	Deductible and coinsurance
Specialist	Deductible and coinsurance	Deductible and coinsurance
Telehealth	Deductible and coinsurance	Not covered
Hospital services		
Inpatient	Deductible and coinsurance	Deductible and coinsurance
Outpatient	Deductible and coinsurance	Deductible and coinsurance
Emergency services		
Urgent Care	Deductible and coinsurance	Deductible and coinsurance
Emergency room	Deductible and coinsurance	In-network level of benefits
Preventive services (services outside of limits, deductible and coinsurance will apply)		
	Plan pays 100%	Deductible and coinsurance
Prescription drugs retail - 30-day supply		
Generic drugs	Deductible and coinsurance	Deductible and coinsurance + 25% penalty
Preferred brand name	Deductible and coinsurance	Deductible and coinsurance + 25% penalty
Non-preferred brand name	Deductible and coinsurance	Deductible and coinsurance + 25% penalty
Specialty	Same as retail	Not covered
Home delivery - per 180-day supply		
Generic	Deductible and coinsurance	Not covered
Preferred brand name	Deductible and coinsurance	Not covered
Non-preferred brand name	Deductible and coinsurance	Not covered

*Aggregate - If you have single coverage, you only need to satisfy the individual deductible and out-of-pocket limit. If you have family coverage the individual amounts do not apply - the entire family deductible must be met prior to any benefits becoming available, and the entire family out-of-pocket must be met before cost-sharing no longer applies. Family members may combine their covered expenses to satisfy the required family deductible and out-of-pocket amounts.

OPTION 4 - $4,000 deductible HSA-Eligible NEtwork BLUE

Benefit	In network	Out of network
Deductible		
Individual	$4,000	$8,000
Family (Embedded*)	$8,000	$16,000
Coinsurance		
	30%	50%
Out-of-pocket Limit		
Individual	$7,300	$14,600
Family (Embedded*)	$14,600	$29,200
Office visits		
Primary Care	Deductible and coinsurance	Deductible and coinsurance
Specialist	Deductible and coinsurance	Deductible and coinsurance
Telehealth	Deductible and coinsurance	Not covered
Hospital services		
Inpatient	Deductible and coinsurance	Deductible and coinsurance
Outpatient	Deductible and coinsurance	Deductible and coinsurance
Emergency services		
Urgent Care	Deductible and coinsurance	Deductible and coinsurance
Emergency room	Deductible and coinsurance	In-network level of benefits
Preventive services (services outside of limits, deductible and coinsurance will apply)		
	Plan pays 100%	Deductible and coinsurance
Prescription drugs retail - 30-day supply		
Generic drugs	Deductible and coinsurance	Deductible and coinsurance + 25% penalty
Preferred brand name	Deductible and coinsurance	Deductible and coinsurance + 25% penalty
Non-preferred brand name	Deductible and coinsurance	Deductible and coinsurance + 25% penalty
Specialty	Same as retail	Not covered
Home delivery - per 180-day supply		
Generic	Deductible and coinsurance	Not covered
Preferred brand name	Deductible and coinsurance	Not covered
Non-preferred brand name	Deductible and coinsurance	Not covered

*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.

OPTION 5 - $400 deductible **Alternative Networks** - including Premier Select BlueChoice and Blueprint Health

Benefit	In network	Out of network
Deductible		
Individual	$400	$800
Family (Embedded*)	$800	$1,600
Coinsurance		
	20%	40%
Out-of-pocket Limit		
Individual	$6,000	$12,000
Family (Embedded*)	$12,000	$24,000
Office visits		
Primary Care	$35 copay	Deductible and coinsurance
Specialist	$55 copay	Deductible and coinsurance
Telehealth	$10 copay	Not covered
Hospital services		
Inpatient	Deductible and coinsurance	Deductible and coinsurance
Outpatient	Deductible and coinsurance	Deductible and coinsurance
Emergency services		
Urgent Care	$55 copay then deductible and coninsurance	Deductible and coinsurance
Emergency room	$85 copay then deductible and coninsurance	In-network level of benefits
Preventive services (services outside of limits, deductible and coinsurance will apply)		
	Plan pays 100%	Deductible and coinsurance
Prescription drugs retail - 30-day supply		
Preferred Generic	25% coinsurance, $10 minimum copay, $40 maximum copay	25% coinsurance, $10 minimum copay, $40 maximum copay + 25% penalty
Non-preferred generic	25% coinsurance, $10 minimum copay, $40 maximum copay	25% coinsurance, $10 minimum copay, $40 maximum copay + 25% penalty
Preferred brand name	25% coinsurance, $50 minimum copay, $100 maximum copay	25% coinsurance, $50 minimum copay, $100 maximum copay + 25% penalty
Non-preferred brand name	50% coinsurance, $75 minimum copay, $150 maximum copay	50% coinsurance, $75 minimum copay, $150 maximum copay + 25% penalty
Specialty		
Preferred	25% coinsurance, $125 minimum copay, $250 maximum copay	Not covered
Non-preferred	25% coinsurance, $125 minimum copay, $250 maximum copay	Not covered
Home delivery - per 180-day supply		
Generic	25% coinsurance, $50 minimum copay, $200 maximum copay	Not covered
Non-preferred generic	25% coinsurance, $50 minimum copay, $200 maximum copay	Not covered
Preferred brand name	25% coinsurance, $250 minimum copay, $500 maximum copay	Not covered
Non-preferred brand name	50% coinsurance, $375 minimum copay, $750 maximum copay	Not covered

*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.

EHA PLAN INFORMATION

A health care plan exclusively for educators health alliance members

What is a PPO?

A PPO, or preferred provider organization, is a special arrangement between an insurer and a network of hospitals, doctors and other types of providers to pay for health care services. As a result of these special arrangements, you save money, because in most cases, you pay less in deductible and coinsurance when you use PPO network providers. If you go outside the network for medical care, you'll pay more money out of pocket.

Your PPO network in Nebraska

Your PPO networks make it easy to find care in Nebraska. Our in-network providers have agreed to accept our benefit payment for covered services as payment in full, except for any deductible, copays and coinsurance amounts and charges for noncovered services, which are your responsibility. That means in-network providers, under the terms of their contract with us, can't bill you for amounts over our benefit allowance. Out-of-network providers can bill you for amounts exceeding the payable amount under the contract.

In-network providers have agreed to accept our benefit payment for covered services as payment in full, except for any deductible, copays and coinsurance amounts and charges for noncovered services, which are your responsibility. That means NEtwork BLUE providers, under the terms of their contract with us, can't bill you for amounts over our benefit allowance. Out-of-network providers can bill you for amounts exceeding the payable amount under the contract.

NEtwork BLUE providers also file your claims for you, meaning you have less paperwork to worry about. And as an added time-saving convenience for you, we send our benefit payment directly to in-network providers.

*Source: BCBSNE statistics, June 21, 2022.

What is an HSA-Eligible HDHP?

Direct Bill Options 3 and 4 are QHDHPs that are eligible for a Health Savings Account (HSA). An HSA is a special tax-exempt account established through a qualified financial institution to pay for medical expenses.

In general, any individual who is covered under a qualified high deductible health plan (QHDHP) is eligible to establish an HSA. To qualify as a QHDHP, the plan must satisfy certain requirements with respect to deductibles and out-of-pocket expenses.

Funds in an HSA may be used to pay qualified medical expenses not reimbursed by insurance. Examples include deductibles and coinsurance, eye exams, glasses, contacts, dental services, prescription drugs, and qualified long-term care insurance premiums.

HSA withdrawals for other purposes are taxable and, for individuals who are not disabled or over age 65, subject to a 20% penalty.

Note: QHDHP deductible and out of pockets may be increased annually to conform with cost-of-living adjustments permitted by Section 223 of the Internal Revenue Code and subsequent amendments.

DENTAL

Schedule of benefits summary

Covered services are reimbursed based on the allowable charge. BCBSNE in-network providers have agreed to accept the benefit payment as payment in full, not including deductible, coinsurance and/or copay amounts and any charges for non-covered services, which are the member's responsibility. That means that in-network providers, under the terms of their contract with BCBSNE, can't bill for amounts over the contracted amount. Out-of-network providers can bill for amounts over the out-of-network allowance.

Payments for services	In Network	Out of Network
Deductible (the amount the member pays each calendar year for combined covered services before the coinsurance is payable)		
Individual	$25	$50
Family	$50	$100
Calendar year deductible applies to the following coverage benefits	B & C services	B & C services
Coinsurance (The percentage amount the member must pay for most covered services after the deductible has been met)		
Coverage A (preventive and diagnostic)	0%	50%
Coverage B (maintenance, simple restorative, oral surgery, periodontics and endodontics)	25%	50%
Coverage C (complex restorative)	50%	50%
Coverage D (orthodontic dentistry)	Not covered	Not covered

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.

Coverage for dental services

Coverage A – preventive and diagnostic

- Comprehensive and/or periodic oral exams[1]
- Prophylaxis (cleaning, scaling and polishing)[1]
- Sealants (permanent first or second molar teeth) *(Covered Persons up to age 16) once every four calendar years*
- Pulp vitality tests
- Fluoride varnishes[1]
- Topical fluoride *(Covered Persons up to age 16)*[1]
- Space maintainers, including re-cementation (prematurely lost primary teeth) *(Covered Persons up to age 16)*
- X-rays (bitewing, intraoral, occlusal, periapical, extraoral)
  - supplement bitewings, including vertical bitewings *one set of four every calendar year*
  - intraoral, occlusal, periapical and extraoral
  - panorex or full mouth series *one every three calendar years*

Coverage B – maintenance, simple restorative, oral surgery, periodontic, endodontics

- Oral surgery consisting of:
  - simple extractions, including root removal 1st and 2nd bicuspids (orthodontic extractions are Not covered)
  - impacted extractions
  - transseptal fiberotomy/supra crestal fiberotomy
  - bone replacement graft
  - appliance removal not by dentist who placed device
  - oroantral fistula closure
  - primary closure of a sinus perforation
  - alveoplasty
  - frenectomy/frenuloplasty
  - removal of torus
  - root removal
  - tooth replantation
  - excision of hyperplastic tissue
- Periodontic services (Non-surgical)
  - periodontic cleanings *four per calendar year*
  - scaling and root planing *four every two calendar years*
  - periodontal evaluations[1]
  - provisional or permanent periodontal splinting
  - treatment of acute infection and oral lesions
  - full mouth debridement *one every three calendar years*
- Periodontic Services (Surgical)
  - gingivectomy[3]
  - gingival flap procedures[3]
  - osseous surgery, including flap entry and closure[3]
  - osseous graft[3]
  - guided tissue regeneration including biologic materials
  - pedicle tissue graft procedures[3]
  - free soft tissue grafts[3]
  - connective tissue graft and double pedicle graft[3]
  - bone graft[3]
  - biologic materials to aid in soft and osseous tissue regeneration[3]
  - distal or proximal wedge procedures[3]
- Periodontic Services (Surgical) *continued*
  - soft tissue allografts[3]
  - crown exposure
  - crown lengthening[4]
- General anesthesia (medically necessary)
- Limited oral evaluation
- Restorations *one per tooth every two calendar years*
- Pin retention
- Palliative treatment
- Dry socket treatment
- Repair and re-cement of dentures, bridges, crowns, inlays/onlays and cast restorations
- Emergency oral examinations
- Consultation with dental consultant (medically necessary) Pre-formed crowns[2]
- Temporary crown (within 72 hours of accident)
- Endodontic services (Non-surgical)
  - pulp cap
  - vital pulpotomy[4]
  - pulpal therapy[4]
  - pulpal debridement[4]
  - root canal therapy (treatment plan, x-rays, clinical procedures and follow up care)
  - retreatment of previous root canal therapy covered *after six months when performed by a different provider*
  - apexification
- Endodontic Services (Surgical)
  - apiocoetomy[4]
  - retrograde filling[4]
  - bone graft[4]
  - biologic materials to aid in soft/osseous tissue regeneration in connection with periradicular surgery[4]
  - guided tissue regeneration[4]
  - periradicular surgery[4]
  - root amputation[4]
  - hemisection[4]

Coverage C – complex restorative dentistry

- Pontics[2]
- Retainer (cast metal for resin bonded fixed prosthesis) *one every five calendar years*
- Inlays/onlays (used as abutments for fixed bridgework)[2]
- Inlays/onlay restorations[2]
- Sedative filling
- Crowns[2]
- Permanent bridge installation *one every five calendar years*
- Dentures – full and partial *one every five calendar years*
- Denture adjustments *after six months from the date of installation*
- Denture relining *one every three calendar years*
- Post and core
- Core buildup

Coverage D – orthodontic dentistry (not covered)

- Surgical access, exposure or immobilization (unerupted teeth)
- Placement of device to facilitate eruption (impacted teeth)
- Diagnostic casts *one every two calendar years*
- Orthodontic appliances (initial and subsequent installations)
- Cephalometric X-rays
- Extractions
- Casts and models

1 two every calendar year 2 one per tooth every five calendar years 3 four every five calendar years 4 once per tooth while covered under the Plan

Noncovered dental services

The following is a partial listing of the exclusions and limitations that apply to EHA Direct Bill dental coverage; a complete list is in the master contract:

- Services not identified as covered under Coverages A, B and C in the contract
- Dental services related to congenital malformations or primarily for cosmetic purposes
- Services for orthodontic dentistry and treatment of the temporomandibular jaw joint
- Supplies, education or training for dietary or nutrition counseling, personal oral hygiene or dental plaque control
- Services received before the effective date of coverage or after termination of coverage
- Services determined to be not medically necessary, investigative, or obsolete
- Charges in excess of our contracted amount
- Services covered under Workers' Compensation or Employers' Liability Law
- Services provided by a person who is not a dentist, or by a dental hygienist not under the dentist's direct supervision
- Charges made separately for services, supplies and materials considered to be included within the total charge payable

How using in-network dentists benefits you

Our dental network in Nebraska is part of a larger provider network of multiple Blue Cross and Blue Shield Plans that, when combined, offers one of the largest national PPO dental networks. It provides you and your covered family members with lower out-of-pocket costs and broad access to participating dentists.

If you or your covered family members live or travel outside of Nebraska, you will be able to obtain covered services at the in-network level of benefits through the combined PPO dental network.

How to locate dentists

Phone: **877-721-2583**
Website: **NebraskaBlue.com/DoctorFinder**

Switching to a plan option with a different deductible

You may review your eligibility to switch options by filling out the form found on **NebraskaBlue.com/EHARetirees**.

Approved plan changes go into effect on Sept. 1 and Jan. 1 each year. Please keep the following in mind:

- You may move to a plan with a higher deductible on the approved dates without restriction.
- You will be responsible for the difference in the increased deductible amount from Sept. 1 through Dec. 31 if you go to a higher deductible plan effective Sept. 1.
- If you elect Option 2, 3 or 4, you are required to maintain your selection for at least three plan years before you may move to a lower deductible plan.
- You may move to a lower deductible plan on the approved dates if you have been enrolled in the same plan option for a minimum of three years.
- Download and complete the enrollment form no later than Aug. 1, to request a plan change effective Sept. 1.
- Download and complete the enrollment form no later than Dec. 1, to request a plan change effective Jan. 1.

Calendar-year deductible

Options 1, 2 and 5

If you're covered under a single membership, you must satisfy one individual deductible each calendar year. The family deductible is equal to two times the individual deductible. Family members may combine their covered expenses to satisfy the required deductible amount. No one family member pays more than the individual deductible amount.

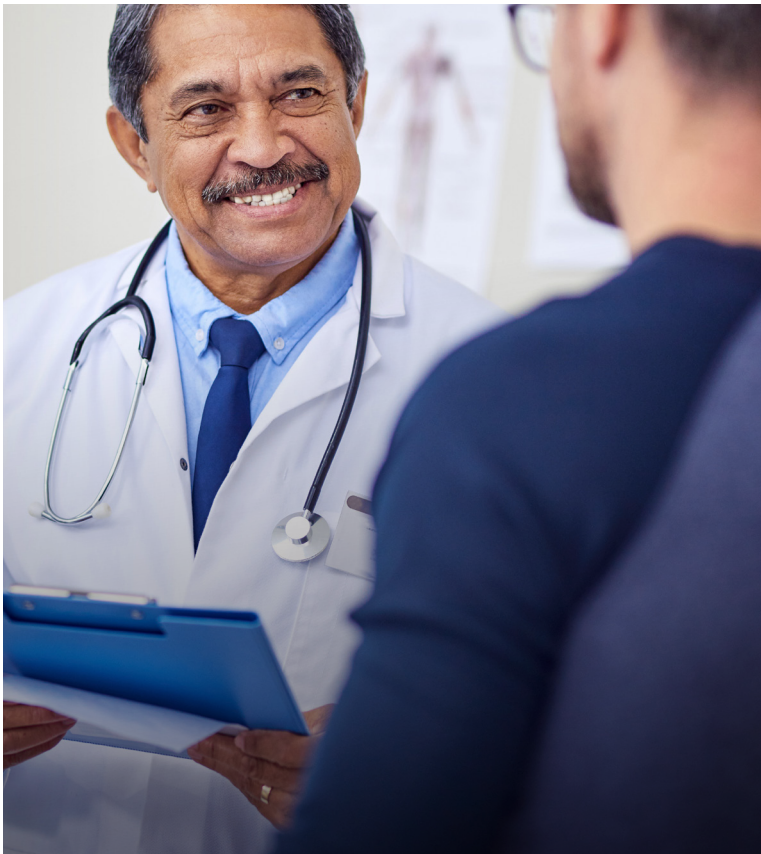
If you don't meet your deductible in a given year, covered charges incurred during October, November and December of that year may be carried over and applied toward the following year's deductible.

Option 3 (HDHP $3,800 deductible)

If you're covered under a single membership, you must satisfy one individual deductible each calendar year. This plan requires satisfaction of an aggregate family deductible. Aggregate deductible means that if you have family, retiree/spouse or retiree/children coverage, the entire family deductible must be met prior to any benefits becoming available. Family members may combine their covered expenses to satisfy the required family deductible.

Option 4 (HDHP $4,000 deductible)

If you're covered under a single membership, you must satisfy one individual deductible each calendar year. The family deductible is equal to two times the individual deductible. Family members may combine their covered expenses to satisfy the required deductible amount. No one family member pays more than the individual deductible amount.



Coinsurance and your calendar-year out-of-pocketlLimit

Options 1, 2, 4 and 5

The out-of-pocket limit is the maximum amount of cost-sharing each covered person must pay in a calendar year before benefits are payable without application of a cost-share amount. The out-of-pocket limit includes deductible, coinsurance and copayment amounts for medical and pharmacy services. Once you reach your out-of-pocket limit, you pay nothing for most covered services for the rest of the calendar year.

Under family membership, family members may combine their covered expenses to satisfy the required family out-of-pocket limit. No one family member contributes more than the individual out-of-pocket limit.

Option 3 (HDHP $3,800 deductible)

After you meet your calendar year deductible, you are responsible for paying a certain percentage of covered charges (called "coinsurance") until you reach your out-of-pocket limit. Once you reach your out-of-pocket limit, you pay nothing for most covered services for the rest of the calendar year.

Under this plan's family membership, the entire aggregate family limit must be met before benefits for covered services are paid at 100% of the allowable charge. Family members may combine their covered expenses to satisfy the required out-of-pocket limit.

Office visit exam copay

Options 1, 2 and 5

When you go to an in-network doctor, you pay a copay for a diagnostic (non-routine) office visit exam (does not apply to mental illness/substance abuse office visits). X-ray and lab charges and any tests or services the doctor may order will be subject to Deductible and coinsurance. Refer to the charts at the beginning of this booklet for your plan's copay amount.

Benefits for preventive services

Preventive services benefits are available under all EHA health plan options. When a network provider is used, benefits are paid at 100% of the allowable charge (Deductible and coinsurance are waived).*

Benefits are available for (but not limited to) the following covered services:

- Office visits, well-woman visits, and periodic exams to determine physical development
- Radiology/X-ray/pathology/lab
- Mammograms and Pap smears
- Immunizations (including pediatric**)
- Colorectal cancer screenings and related services
- Cardiac stress tests
- Hearing exams
- Contraceptive methods, as well as contraceptive prescriptions for women (most paid at 100%)
- Breast pumps and supplies, as well as counseling for breastfeeding
- Developmental/autism screening for infants, children, and adolescents

*Preventive benefits may be subject to age, gender and frequency limits. Preventive services benefits outside these limits, as well as services received out-of-network, are subject to the plan's applicable Deductible and coinsurance, unless otherwise stated. For a list of the preventive services mandated under the Patient Protection and Affordable Care Act (PPACA), along with their corresponding age, gender and frequency limits, please visit **NebraskaBlue.com/PreventiveCare**.

**Deductible (if applicable) is waived for out-of-network pediatric immunizations.

Prescription drug coverage

Options 1, 2 and 5

Your coverage is based on BCBSNE's prescription drug list, which is a list of generic and brand-name prescription medications. Your prescription drug benefits are divided into four tiers: generic drugs, preferred brand drugs that are included on the prescription drug list, non-preferred brand-name drugs that are not and specialty drugs. The coinsurance amount you pay for up to a 30-day supply of a covered prescription drug depends on what tier your medication is in.

To review the drug formulary online, go to **NebraskaBlue.com/DrugList** or call the Member Services number on the back of your BCBSNE member ID card.

Option 3 and 4 (HDHPs)

With options 3 and 4, your prescription drug benefits are subject to your plan's in-network deductible and coinsurance.

When you use a participating Rx Nebraska pharmacy, you'll automatically receive a special pre-negotiated discount on most of your prescription drugs. (The actual discount you receive depends on the pharmacy and the type of drug you purchase.)

Using your prescription drug benefits

To use your prescription drug benefits, take your BCBSNE member ID card and your prescription to an Rx Nebraska participating pharmacy and pay the applicable coinsurance amount.

Please note: To be considered in-network, specialty drugs must be purchased through a designated specialty pharmacy. One of BCBSNE's designated specialty pharmacies is Accredo, an Express Scripts pharmacy. For more information, visit **NebraskaBlue.com/Pharmacy**.

Whenever appropriate, generic drugs will be used to fill your prescriptions. If you prefer a brand-name drug, you will be responsible for the difference in cost plus the applicable coinsurance amount.

If you have to file a claim (for example, if you have the prescription filled at a non-participating pharmacy, or if you don't present your card at a participating pharmacy), you will be reimbursed for the cost of the drug less the applicable coinsurance amount and a 25% penalty. Prescription drug coinsurance amounts do not apply toward the health plan's deductible but do apply toward the calendar year out-of-pocket maximum.

Using your home delivery pharmacy benefit

When you use the home delivery program, you may order up to a 180-day supply of a covered medication at one time (if allowed by your prescription). The minimum and maximum coinsurance amounts apply per 30-day supply, with a maximum of five times the amount per 180-day supply.

Please note: If you are ordering a 180-day supply, make sure the prescription is written for a 180-day supply, not including refills. For questions regarding available medications, please visit **MyPrime.com**.

To locate participating pharmacies nationwide, call toll-free 877-800-0746.

Prime Therapeutics is an independent company providing pharmacy benefit management services for Blue Cross and Blue Shield of Nebraska.
Accredo® is a specialty pharmacy that is contracted to provide services to Blue Cross and Blue Shield of Nebraska.

Certification

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.

To initiate the certification process, BCBSNE must be contacted by you, your family member, the physician, the hospital or someone acting on behalf of you or your family member.

The following must be certified:

- Organ and tissue transplants
- Subsequent purchases of home medical equipment
- Specified medications and/or quantities of medications
- Skilled nursing care in the home
- Skilled nursing facility care
- Hospice care
- All inpatient hospital admissions
- Inpatient mental illness and/or substance abuse
- Inpatient physical rehabilitation
- Long-term acute care
- Services subject to surgical preauthorization programs

If certification requirements are not met, the following penalties may apply:

- Payable benefits may be reduced, and/or
- Benefits for all services may be denied.

Please note: Certification does not guarantee payment. All other group plan provisions apply, including copayments, deductibles, coinsurance, eligibility and exclusions.

For certification of benefits, call 402-390-1870 or 800-247-1103.

Inpatient hospital and long-term acute care benefits

Benefits are available for (but not limited to) the following covered services:

- Semiprivate room; cardiac and intensive care units; treatment rooms and equipment
- Anesthesia
- Respiratory care
- FDA-approved drugs, intravenous solutions and vaccines administered in the hospital
- Chemotherapy
- Radiology, pathology and radiation therapy
- Physical, occupational and speech therapy
- Inpatient physical rehabilitation, subject to benefit precertification and certain requirements
- Physician-ordered skilled nursing facility services, up to 60 days per calendar year; subject to medical necessity criteria

Outpatient hospital benefits

Benefits for the services listed under "Inpatient Hospital and Long-term Acute Care Benefits" are also available (subject to certain limitations) when they are received in a hospital outpatient department, emergency room or freestanding ambulatory surgical facility. In addition, benefits for outpatient cardiac and pulmonary rehabilitation are available, subject to preauthorization requirements and medical criteria.

Physician benefits

Benefits are available for (but not limited to) the following covered services:

- Surgery and surgical assistance (for specified procedures)
- Anesthesia
- Radiation therapy and chemotherapy
- Radiology and pathology, including tissue exams and interpretation of Pap smears
- Routine screening mammograms
- Allergy tests and extracts
- Physician home, office, inpatient and outpatient visits for diagnosis/treatment of an illness or injury

Please note: Some physician services such as total knee replacement, total hip replacement, and back surgery require pre-authorization. For questions regarding specific procedures, please contact BCBSNE's Member Services department at the number shown on the back of your BCBSNE member ID card.

Maternity and newborn coverage

Maternity coverage is available to subscribers, covered spouses and dependent daughters. All newborns are covered for 31 days from the date of birth, including those born to dependent daughters or sons. In order for newborns to be added to the policy, application must be made within 31 days of the birth of the child, regardless of the employee's current coverage tier.

If the newborn is born to a dependent daughter or son, the employee must provide proof of legal guardianship for the newborn in order for the newborn's coverage to be continued under the employee's plan. For more information, please contact your employer or BCBSNE's Member Services department.

Benefits for covered newborn care include hospital room and board, screening tests (including newborn hearing), physician services and other medically necessary treatment. Obstetrical benefits include prenatal and postnatal care.

Oral surgery benefits

Benefits are available for (but not limited to) the following covered services:

- Removal of tumors and cysts
- Bone grafts to the jaw
- Osteotomies
- Treatment of natural teeth due to an accident which occurs within 12 months of an injury not related to eating, biting or chewing
- Medically necessary services for the treatment of temporomandibular joint (TMJ) and craniomandibular disorder

Home health aide, skilled nursing care and hospice benefits

The following covered services require benefit preauthorization. Limitations and exclusions apply.

Home health aide: When related to active medical treatment, benefits include personal services (e.g. bathing, feeding and performing necessary household duties). Benefits are subject to a 60-day per calendar year limit.

Skilled nursing care: Benefits are available for medically necessary physician-ordered care by a registered or licensed practical nurse, up to eight hours per day.

Hospice care: Benefits include Medicare-certified home health aide services for a terminally ill patient, including nursing services, respite care, medical social worker visits, crisis care and bereavement counseling. Limited benefits for inpatient hospice care are also available.

Organ and tissue transplant benefits

Benefits are available for covered services associated with medically necessary organ and tissue transplants, including (but not limited to) liver, heart, lung, heart-lung, kidney, pancreas, pancreas-kidney and cornea. Limited benefits are also available for allogeneic/autologous bone marrow transplants for the specific conditions listed in the contract.

Other covered services

- Ambulance services
- Outpatient occupational therapy, physical therapy, speech therapy, cognitive training and chiropractic/osteopathic physiotherapy, up to a combined maximum of 60 sessions per calendar year
- Chiropractic and osteopathic manipulative treatments, up to 30 sessions per calendar year
- Inpatient and outpatient treatment of mental illness and/or substance abuse*
- Rental/initial purchase (whichever costs less) of medically necessary home medical equipment ordered by a doctor. Limited benefits are available for the repair, maintenance and adjustment of purchased covered medical equipment
- Diabetes outpatient self-management training and patient management; podiatric appliances
- Services in accordance with the Women's Health and Cancer Rights Act, which requires that a group health plan providing medical and surgical benefits for mastectomies also provide benefits for breast reconstruction, prostheses and treatment of physical complications

*Inpatient is defined as a patient 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.

Outpatient is defined as 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.

A more complete list of limitations and exclusions can be found in the Master group contract or by referring to the Certificate of coverage and schedule of benefits summary.

Noncovered services

This brochure contains only a partial listing of the limitations and exclusions that apply to your health care coverage. A more complete list may be found in the master group contract or by referring to the certificate of coverage and schedule of benefits.

No benefits are available for the following:

- Audiological exams (except newborn); hearing aids and their fitting
- Abortions (except to save the life of the mother)
- Blood, plasma, or services by or for blood donors
- Eye exams, refractions, eyeglasses, contact lenses, eye exercises or visual training
- Artificial insemination; in vitro fertilization; fertility treatment, and related testing
- Massage therapy
- Treatment for weight reduction/obesity, including surgical procedures
- Nutrition care, supplies, supplements or other nutritional substances, including Neocate, Vivonex and other over-the-counter infant formulas and supplements
- Radial keratotomy or any other procedures/alterations of the refractive character of the cornea to correct myopia, hyperopia and/or astigmatism
- Services we consider to be investigative, not medically necessary, experimental, cosmetic or obsolete
- Services, drugs, medical supplies, devices or equipment that are not cost effective compared to established alternatives or that are provided for the convenience or personal use of the patient
- Services provided before the coverage effective date or after termination
- Services for illness or injury sustained while performing military service
- Services for injury/illness arising out of or in the course of employment
- Charges for services which are not within the provider's scope of practice
- Charges in excess of our contracted amount
- Charges made separately for services, supplies and materials we consider to be included within the total charge payable

Types of enrollment

Single /1-person membership: Covers the employee only.

Employee and spouse: Covers the employee and their spouse.

Employee and child(ren): Covers the employee and eligible dependent children, but does not provide coverage for a spouse.

Family membership: Covers the employee, spouse, and eligible dependent children.

The employee's dependent children (excluding foster children) are covered to age 26. Reaching age 26 will not end the covered child's coverage as long as the child is and remains both incapable of self-sustaining employment by reason of mental or physical handicap and dependent upon the subscriber for support and maintenance.

Allowable charge

Payment is based on the allowable charge for a covered service. Generally, the allowable charge for services by in-network providers will be the contracted amount. The allowable charge for services by out-of-network providers will be based on the contracted amount for BCBSNE providers or an amount determined by the local Blue plan for out-of-network providers.

Late and special enrollment

A "late enrollee" is defined as an employee or dependent for whom coverage is not requested within 31 days of their initial eligibility or during a special enrollment period. No late enrollees are accepted into the Direct Bill Program. Depending on your eligibility, other enrollment restrictions may apply. For further information, please contact our Member Services Department.

Your eligible dependents are not considered late enrollees if they:

- were covered under other qualifying previous coverage at the time of your initial eligibility for this group coverage; and
- lost coverage under the qualifying previous coverage as a result of: termination of employment; termination of eligibility; involuntary termination of the qualifying previous coverage; death of a spouse; divorce of a spouse; and
- requested enrollment within 31 days after termination of qualifying previous coverage; or within 60 days of the loss of Medicaid or SCHIP coverage

EDUCATORS HEALTH ALLIANCE

Renewal rates for health and dental coverages

Effective September 1, 2025

Direct bill health coverage	Network	Renewal rates 9/1/2025 - 8/31/2026			
		Single/ 1- person	Employee & child(ren)	Employee & spouse	Family
Option 1 $1,050 deductible	**NEtwork BLUE**	$966.81	$1,713.89	$2,030.28	$2,566.45
Option 2 $2,500 deductible	**NEtwork BLUE**	$815.75	$1,446.05	$1,713.02	$2,165.37
Option 3 $3,800 deductible HSA-Eligible	**NEtwork BLUE**	$815.75	$1,446.05	$1,713.02	$2,165.37
Option 4 $4,000 deductible HSA-Eligible	**NEtwork BLUE**	$725.13	$1,285.43	$1,522.76	$1,924.82
Option 5 $400 deductible	**PSBC/Blueprint Health**	$894.95	$1,586.52	$1,879.37	$2,375.69

Direct bill dental coverage	Network	Renewal Rates 9/1/2025 - 8/31/2026			
		Single/ 1- person	Employee & child(ren)	Employee & spouse	Family
PPO - 0%** A, 25%** B, 50%** C Coverage	**NEtwork BLUE dental**	$31.78	$58.76	$66.70	$89.61

** Member coinsurance based on the allowable charge for a covered service.

Note: When the situation warrants, it is less costly to choose two Single/1-Person coverages then to choose Employee & Spouse coverage.

MEMBER RESOURCES

Online member account

Create you online member account at **myNebraskaBlue.com**. Here you can view your claims status, deductible and out-of-pocket limits, benefit details and more.

Telehealth

With telehealth services through Amwell®, you can video chat with a doctor from the privacy of your home. The average wait time is less than 10 minutes and often costs less than a visit to the emergency room or urgent care.

Telehealth services are available 24/7, so you can get care when you need it. To learn more, visit **NebraskaBlue.com/Telehealth**.

Nurse-supported programs

Free with your health plan, you have access to EHA Population Health program that includes nurses who will work one-on-one to help you on your health journey. The program includes:

- **Heart Health**: Get help lowering your blood pressure and cholesterol levels, and managing other heart issues.
- **Diabetes Management**: Our diabetes educators will create a plan to help you better manage your diabetes and related issues.
- **Wellness**: Get help with weight management, smoking cessation and stress.

➔ To learn more, visit **NebraskaBlue.com/EHABenefits**

Visa is an independent company that provides promotional financial services for Blue Cross and Blue Shield of Nebraska.

Wellness

Congratulations on your retirement! As you move into the next phase of your life, we want to welcome you to the Retiree Wellness Program offered through the Educators Health Alliance. As long as you continue to have your insurance through the Direct Bill plan (or until you turn 65), you are eligible to participate in the wellness program.

All of the great opportunities you participated in are offered to Retirees – including the $25 Visa® gift card for completing the PHA. Now that you're retired, you may find yourself with a few more minutes in the day to add some activity or try new, healthy recipes! Email **Contact@EHAWellness.org** today to update your account to continue to participate.

NOTES

NOTES

Non-discrimination and Translation Notice

Discrimination is Against the Law

Blue Cross and Blue Shield of Nebraska (BCBSNE) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. BCBSNE does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.
BCBSNE:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Customer Service at 800-991-5840, TTY 711 between 7:30 a.m. to 6 p.m., Central time, Monday through Friday.

If you believe that Blue Cross and Blue Shield of Nebraska has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Manager, Corporate Compliance
Blue Cross and Blue Shield of Nebraska
P.O. Box 3248
Omaha, NE 68180-001
800-991-5840, TTY: 711
CivilRights@NebraskaBlue.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, our Manager of Corporate Compliance is available to help you.
You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at hhs.gov/sites/default/files/ocr-cr-complaint-form-package.pdf.
For quick processing, use the OCR online portal to file a complaint.

ATTENTION: This notice may have important information about your application or coverage. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or get help with costs. If you or someone you're helping has questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-800-991-5840. This notice is translated as federally required.

Arabic

تنبيه: قد يتضمن هذا الإشعار معلومات مهمة عن تطبيقك أو تأمينك. ابحث عن التواريخ الرئيسية في هذا الإشعار. قد يلزمك اتخاذ إجراء قبل المواعيد النهائية المحددة للحفاظ على التأمين الصحي أو للحصول على مساعدة بشأن التكاليف. إذا كنت أنت أو أحد من تساعدهم لديكم أسئلة، فلك الحق في الحصول على مساعدة ومعلومات بلغتك وبدون تكلفة. للتحدث مع أحد المترجمين الفوريين، اتصل برقم 1-800-991-5840

Chinese Traditional

注意：本通知可能含有與您的申請或保險有關的重要資訊。在本通知中尋找重要的日期。您可能需要在某個截止日期前採取行動，以保持您的健康保險或獲得費用方面的幫助。如果您或者您正幫助的人有疑問，您有權利以您的語言免費獲得提供的幫助與資訊。致電口譯員，請撥打1-800-991-5840。

German

Achtung: Diese Mitteilung kann wichtige Informationen über Ihren Antrag oder die Versicherungsdeckung beinhalten. Beachten Sie wichtige Fristen in dieser Mitteilung. Sie müssen unter Umständen Maßnahmen innerhalb bestimmter Fristen ergreifen, um Ihren Krankenversicherungsschutz zu erhalten oder eine Kostenerstattung zu erhalten. Wenn Sie oder jemand, dem Sie helfen, Fragen hat, können Sie kostenlos Hilfe und Informationen in Ihrer Sprache erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte 1-800-991-5840 an.

Spanish (Mexico)
ATENCIÓN: Este aviso puede contener información importante sobre su solicitud o cobertura. Ponga atención a las fechas clave en este aviso. Puede ser que usted necesite realizar algunas acciones para determinadas fechas y así mantener su cobertura de salud o para obtener ayuda con los costos. Si usted o alguien a quien usted ayuda tiene alguna pregunta, tiene el derecho de recibir información y ayuda en su propio idioma sin costo. Para hablar con un intérprete, llame al 1-800-991-5840.

Farsi
توجه این اعلامیه ممکن است اطلاعات مهمی درباره درخواست یا طرح پوشش بیمه‌تان داشته باشد. تاریخ های اصلی را در این اعلامیه جستجو کنید. ممکن است لازم باشد تا موعد مقرری اقدام کنید تا پوشش بیمه درمانیتان حفظ شود یا هزینه های درمانی را دریافت کنید. اگر شما یا فردی دیگر که به او کمک می کنید، سؤالی دارید، از این حق برخوردار هستید تا راهنمایی و اطلاعات را به صورت رایگان به زبان خودتان دریافت کنید. برای صحبت کردن با یک مترجم، با شماره 1-800-991-5840 تماس بگیرید.

French (Europe)
ATTENTION : Cet avis peut contenir des informations importantes concernant votre demande ou votre garantie. Prêtez attention aux dates clés indiquées. Il vous faudra peut-être prendre des mesures avant une certaine date pour pouvoir conserver votre assurance santé ou bénéficier d'aides au paiement. Si vous ou une personne que vous aidez avez des questions, vous pouvez obtenir gratuitement de l'assistance et des informations dans votre langue. Pour parler à un interprète, appelez le 1-800-991-5840.

Japanese
ご注意：本通知書には、患者さんの申請や保険について重大な情報が含まれている可能性があります。本通知書の日付をご覧ください。医療保険を利用したり、費用についてサポートを受けるには、本通知書に従って特定の期限までに手続きしてください。患者さん、または付き添いの方が質問がある場合は、母国語で無料で支援を受けたり、情報を受け取る権利があります。通訳と話したい場合は、1-800-991-5840. まで電話をおかけください。

Karen
ဟ်သူဉ်ဟ်သး–တၢ်ဘိးဘဉ်သ့ဉ်ညါၦံး ဘဉ်သ့ဉ်သ့ဉ် ကဆိဉ်ဒီးတ၊်ဂ့၊်တ၊်ကျိၤလ၊ အရ့ဒိဉ်ဘဉ်ယး နလံာ်ပတံထိဉ်တ၊် မ့တမ့၊် တ၊်အ့ဉ်ကိၤသးန့ဉ်လိၤ.
ကွ၊်ယ့ မ့၊်နံၤမ့၊်သီအရ့ဒိဉ်လ၊ လံာ်ဘိးဘဉ်သ့ဉ်ညါၦံးအပူၤတက့၊်.
ဘဉ်သ့ဉ်သ့ဉ် နကဘဉ် ဟံးဂ့၊်ဝိလ၊ မ့၊်နံၤလၢခံကတ၊်လ၊ တ၊်ဟ်ပနိဉ်နှ၊်နၤ လၢနကဟ့ဉ်နတ၊်အိဉ်ဆူဉ်အိဉ်ချ့ တ၊်ဘူးတ၊်လဲတဖဉ် မ့တမ့၊် မၤန့၊်တ၊်မၤစၢၤလ၊ တ၊်ပ့ၤလိၤလဲတဖဉ်နှဉ်လီၤ.
နၤ မ့တမ့၊် ပှၤတဂၤဂၤလ၊ နမၤစၢၤမ့၊်အိဉ်ဒီးတ၊်သံကွ၊်အယိ. နအိဉ်ဒီးတ၊်ခွဲးတ၊်ယာ်လ၊ ကမၤန့၊်တ၊်မၤစၢၤဒီးတ၊်ဂ့၊်တ၊်ကျိၤလ၊ နကျိာ်လ၊ တလၫ်ဘူဉ်လၫ်စ့ၤဘဉ်နှဉ်လီၤ.
လၢနကကတိၤတ၊်ဒီး ပှၤကျိးထံတ၊်အဂိၢ်, ကိး1-800-991-5840.တက့၊်.

Korean
주의: 본고지에는해당신청서또는적용범위에대한중요한정보가있을수있습니다.
본고지의주요날짜를찾으십시오.해당건강보험을유지하거나비용을지원받는특정기한까지조치를취하셔야합니다.본인자신이나본인이돕고있는누군가가질문이있다면무료로모국어로된도움과정보를얻을수있는권리가있습니다.통역사와통화하려면1-800-991-5840. 번으로전화하십시오.

Kurdish
ئاگاداری
ڕەنگە ئەم ئاگادارییە زانیاری گرنگی تیدا بێت دەربارەی داواکاری یان ڕووماڵکردنەکەت.بەدوای بەرواره سەرەکییەکانی ناو ئەم ئاگادارییە بگەڕێ.لەوانەیە پێویست بکات لە هەندێک دوا وادە کردارێک بکەیت بۆ ئەوەی ڕووماڵی تەندروستیت بەردەوام بێت یان یارمەتی بۆ تێچووەکانت دەست بخەیت.ئەگەر تۆ یان کەسێک کە تۆ یارمەتی دەدەیت پرسیاری هەیە، تۆ مافی دەسکەوتنی یارمەتی و زانیاریت بە زمانی خۆت بێ بەرامبەر هەیە.بۆ قسەکردن لەگەڵ وەرگێرێک، پەیوەندی بە 18009915840. بکە.

Lao
ສິ່ງທີ່ຄວນເອົາໃຈໃສ່: ແຈ້ງການສະບັບນີ້ ອາດຈະມີຂໍ້ມູນທີ່ສຳຄັນກ່ຽວກັບການສະໝັກ ຫຼື ການຄຸ້ມຄອງສຸຂະພາບຂອງທ່ານ.
ຈົ່ງຊອກຫາວັນທີທີ່ສຳຄັນໃນແຈ້ງການສະບັບນີ້. ທ່ານອາດຈະຕ້ອງດຳເນີນການໃນຂອບເຂດເວລາໃດໜຶ່ງ
ເພື່ອຮັກສາການຄຸ້ມຄອງດ້ານສຸຂະພາບຂອງທ່ານ ຫຼື ໄດ້ຮັບການຊ່ວຍເຫຼືອທາງດ້ານງົບປະມານ. ຖ້າການ ຫຼືບຸກຄົນທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອຢູ່ນັ້ນ ມີຄຳຖາມ,ທ່ານມີສິດໄດ້ຮັບການຊ່ວຍເຫຼືອ ແລະ ໄດ້ຮັບຂໍ້ມູນທີ່ເປັນພາສາຂອງທ່ານ ໂດຍບໍ່ເສຍຄ່າໃຊ້ຈ່າຍ. ຕ້ອງການລົມກັບນາຍແປພາສາ, ຈົ່ງໂທຫາເບີ 1-800-991-5840.

Nepali
ध्यानाकर्षण: यो सूचनामा तपाईको निवेदन वा कभरेजको बारेमा महत्त्वपूर्ण जानकारी हुनसक्छ। यो सूचनामा मुख्य मितिहरू हेर्नुहोस्। तपाईको स्वास्थ्य कभरेज वा लागतमा मद्दत प्राप्त गर्न तपाईले निश्चित समयसीमा भित्र कारबाही लिनुपर्ने हुनसक्छ। तपाईं वा तपाईले सहायता गरेका कसैसँग जिज्ञासाहरू छन् भने तपाईंसँग आफ्नो भाषामा नि:शुल्क सहायता र जानकारी प्राप्त गर्ने अधिकार छ। दोभाषेसँग कुरा गर्न 1-800-991-5840.मा कल गर्नुहोस्।

Oromo
HUBAACHIISA: Beeksisi kun odeeffannoo barbaachisaa waa'ee iyyata keetii yookaan waa'ee tajaajiloota qabaachuu mala. Beeksisa kana irraa guyyoota barbaachisoo ta'an ilaali. Tajaajila fayyaa kee itti fufsiisuuf guyyoota murtaa'an irratti tarkaanfiin ati fudhattu yookaan kaffaltiidhaan gargaarsi ati argattu jiraachu mala. Yoo ati ykn namni ati gargaartu, gaaffii qabaattan, gatii malee gargaarsaa fi oddeeffanno afaan dandeessaaniin argachuun mirga keessaani. Warra afaan hikkaaniif lakkoofsa kanaan bilbilaa 1-800-991-5840.

Russian
ВНИМАНИЕ! В данном уведомлении может содержаться важная информация о вашей заявке или страховке. В нем также указаны ключевые даты. Вам может потребоваться выполнить некоторые действия к определенному сроку для сохранения вашей медицинской страховки или получения помощи в оплате расходов. Если у вас или у человека, которому вы помогаете, возникнут вопросы, вы имеете право получить помощь и информацию на своем языке бесплатно. Чтобы поговорить с переводчиком, позвоните по номеру 1-800-991-5840.

Vietnamese
CHÚ Ý: Thông báo này có thể chứa thông tin quan trọng về đơn đăng ký hoặc bảo hiểm của quý vị. Tìm những ngày chính trong thông báo này. Quý vị có thể cần hành động trước một số thời hạn để duy trì bảo hiểm sức khỏe của mình hoặc được giúp đỡ có tính phí. Nếu quý vị hoặc người quý vị đang giúp đỡ, có thắc mắc, quý vị có quyền lấy thông tin và được trợ giúp bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi số 1-800-991-5840.

Member discounts

Blue365® is a national program that offers members health and wellness discounts and savings. Members can explore special offerings from leading national companies in these categories:

- Apparel and footwear
- Fitness
- Hearing and vision
- Home and family
- Nutrition
- Personal care
- Travel

➔ Visit **NebraskaBlue.com/Blue365** to learn more.

Customer service and support

BCBSNE member services

➔ Phone: **877-721-2583**
➔ Website: **NebraskaBlue.com/Contact**

Locate providers nationwide:

➔ Phone: **877-721-2583**
➔ Website: **NebraskaBlue.com/DoctorFinder**

Locate pharmacies nationwide

➔ Phone: **877-800-0746**
➔ Website: **NebraskaBlue.com/MyPrime**

Access additional plan information

➔ Website: **EHAPlan.org**

The Blue365 program is brought to you by the Blue Cross Blue Shield Association.

This brochure provides you with an overview of the Blue Cross and Blue Shield of Nebraska health and dental coverage offered to Direct Bill members of Educators Health Alliance (EHA). This is not a contract. It is intended as a general overview only. It does not contain all the details of this coverage. For more complete information about your plan, including benefits, exclusions and contract limitations, please refer to the certificate of coverage or 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.