# PremierBlue

## Schedule of Benefits Summary

Group Name: League Insurance Government Health Team

Effective Date: July 01, 2024

| Payment for Services | In-network Provider | Out-of-network Provider |
|---|---|---|
| Covered Services are reimbursed based on the Allowable Charge. Blue Cross and Blue Shield of Nebraska In-network Providers have agreed to accept the benefit payment as payment in full, not including Deductible, Coinsurance and/or Copayment amounts and any charges for non-covered Services, which are the Covered Person's responsibility. That means In-network providers, under the terms of their contract with Blue Cross and Blue Shield, can't bill for amounts over the Contracted Amount. In some situations, Out-of-network Providers can bill for amounts over the Out-of-network Allowance. | | |
| **In-network Provider:** The provider network is shown on your I.D. card. For help in locating In-network Providers, visit NebraskaBlue.com/Find-a-Doctor. | | |
| **Deductible**<br>(the amount the Covered Person pays each Calendar Year for Covered Services before the Coinsurance is payable)<br>• Individual<br>• Family (Embedded*) | <br><br>$1,000<br>$2,000 | <br><br>$2,000<br>$4,000 |
| **Coinsurance**<br>(the percentage amount the Covered Person must pay for most Covered Services after the Deductible has been met)<br>• Covered Person Pays<br>• Plan Pays | <br><br>20%<br>80% | <br><br>40%<br>60% |
| **Out-of-pocket Limit**<br>(Includes Deductible, Coinsurance and Copays)<br>• Individual<br>• Family (Embedded*) | <br><br>$2,000<br>$4,000 | <br><br>$4,000<br>$8,000 |
| 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:**<br>• Physician Office • Telehealth/Virtual Care • Urgent Care Facility<br>• Prescription Drugs<br>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.** | | |

| Covered Services – Illness or Injury | In-network Provider | Out-of-network Provider |
|---|---|---|
| **Physician Office Services** | | |
| • Primary Care Physician Office Visit | $30 Copay | Deductible and Coinsurance |
| • Specialist Physician Office Visit | $45 Copay | Deductible and Coinsurance |
| • Physician Office Services provided in the office (with or without an office visit) | Applicable office visit copay | 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.<br>***Specialist Physician*** is a physician who is not a Primary Care Physician.<br>***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.<br>***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.<br>***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**<br>• Medical<br>• Mental Health | $10 Copay<br>See Mental Health and/or Substance Use Disorder Services | Not Covered<br>Not Covered |
| **Convenient Care/Retail Clinics (Quick Care)** | Same as a Primary Care Physician | Deductible and Coinsurance |
| **Urgent Care Facility Services** (a single copay applies to each urgent care visit) | $60 Copay | Deductible and Coinsurance |
| **Emergency Room Services** (services received in a Hospital emergency room setting)<br>• Facility<br>• Professional Services | <br>Deductible and Coinsurance<br>Deductible and Coinsurance | <br>In-network level of benefits<br>In-network level of benefits |
| **Outpatient Hospital or Facility Services**<br>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**<br>Charges for room and board, diagnostic testing, rehabilitation and other ancillary services provided on an inpatient basis | Deductible and Coinsurance | Deductible and Coinsurance |
| **Orthopedic Specialty Hospital or Facility Services** | Deductible and Coinsurance | Deductible and Coinsurance |
| **NOTE:** Deductibles and Coinsurance may be waived if Covered Services are provided at a designated Preferred Center. See NebraskaBlue.com/PreferredCenters for a list of Covered Services and designated hospitals. | | |

| Preventive Services | In-network Provider | Out-of-network Provider |
|---|---|---|
| **Preventive Services** | | |
| • Affordable Care Act (ACA) required preventive services (may be subject to limits that include, but are not limited to, age, gender, and frequency) | Plan Pays 100% | Deductible and Coinsurance |
| • ACA required covered preventive services (outside of limits) | Plan Pays 100% | Deductible and Coinsurance |
| • 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 exams | Plan Pays 100% | Deductible and Coinsurance |
| - All other laboratory tests; radiology, cardiac stress tests; EKG; pulmonary function and other screenings and services | Same as any other illness | Same as any other illness |
| **Immunizations** | | |
| • Pediatric (up to age 7) | Plan Pays 100% | Coinsurance |
| • Age 7 and older | Plan Pays 100% | Deductible and Coinsurance |
| • Related to an illness | Same as any other illness | Same as any other illness |
| **Colorectal Cancer Screenings** (starting at age 45) | | |
| • Colonoscopy Screening | | |
| - Diagnostic or Preventive Screening (one every five years) | Plan Pays 100% | Deductible and Coinsurance |
| - Screenings outside the age or frequency limit | Same as any other illness | Deductible and Coinsurance |
| • Sigmoidoscopy/Proctoscopy Screening | | |
| - Preventive Screening (one every five years) | Plan Pays 100% | Deductible and Coinsurance |
| - Screenings outside the age or frequency limit | Same as any other illness | Deductible and Coinsurance |
| • Barium enema, Fecal occult blood tests, FIT DNA, CT of the Colon and other tests as determined under ACA Preventive Services | | |
| - Preventive Screenings | Plan Pays 100% | Deductible and Coinsurance |
| - Diagnostic Screenings | Same as any other illness | 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 | Plan Pays 100% | Deductible and Coinsurance |
| • Telehealth/Virtual Care Services | Plan Pays 100% | Not Covered |
| • 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 and Coinsurance | In-network level of benefits |
| • Professional Services | Deductible and Coinsurance | In-network level of benefits |

| Other Covered Services – Illness or Injury | In-network Provider | Out-of-network Provider |
|---|---|---|
| **Acupuncture** | Not Covered | Not Covered |
| **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 and Coinsurance | In-network level of benefits |
| • Air Ambulance | Deductible and Coinsurance | 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** | Deductible and Coinsurance | Deductible and Coinsurance |
| **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 |
| **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 |
| **NOTE:** Benefits for specific prescription drugs are covered under the prescription drug plan and not payable under medical, other than in a hospital emergency room. A list of these specific drugs is available at NebraskaBlue.com/Pharmacy or by contacting the Member Services department. | | |
| **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.) | Deductible and Coinsurance | Deductible and Coinsurance |

| Other Covered Services – Illness or Injury | In-network Provider | Out-of-network Provider |
|---|---|---|
| **Home Health Care Services** | | |
| • Home Health Aide (limited to 60 days per Calendar Year) | Deductible and Coinsurance | Deductible and Coinsurance |
| • Home Infusion Therapy | Deductible and Coinsurance | Deductible and Coinsurance |
| • Skilled Nursing Care (limited to 8 hours per day) | Deductible and Coinsurance | Deductible and Coinsurance |
| • Respiratory Care (limited to 60 days per Calendar Year) | Deductible and Coinsurance | Deductible and Coinsurance |
| **Hospice Services** | Deductible and Coinsurance | Deductible and Coinsurance |
| **Independent Laboratory** | | |
| • Diagnostic | Plan Pays 100% | 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 | Same as any other illness |
| • Treatment to Promote Fertility | Not Covered | Not Covered |
| **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 |
| **Obesity** | | |
| • Non-Surgical Treatment | Not Covered | Not Covered |
| • Surgical Treatment | Not Covered | Not Covered |
| **Oral Surgery and Dentistry**<br>Services such as incision and drainage of abscesses and excision of tumors and cysts.<br>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** | Deductible and Coinsurance | Deductible and Coinsurance |
| **Ostomy Supplies** | Deductible and Coinsurance | Deductible and Coinsurance |
| **Physician Professional Services**<br>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) | Deductible and Coinsurance | Deductible and Coinsurance |
| • Newborn care (Newborns are covered at birth, subject to the plan's enrollment provisions) | 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. | | |

| Other Covered Services – Illness or Injury | In-network Provider | Out-of-network Provider |
|---|---|---|
| **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**<br>• Cardiac rehabilitation (limited to 18 sessions per diagnosis)<br>• Pulmonary Rehabilitation (Chronic lung disease is limited to 18 sessions per diagnosis, not to exceed 18 sessions per Calendar Year. Lung, heart-lung transplants and lung volume are limited to 18 sessions following referral and prior to surgery plus 18 sessions within six months of discharge from hospital following surgery.) | Deductible and Coinsurance<br>Deductible and Coinsurance | Deductible and Coinsurance<br>Deductible and Coinsurance |
| **Renal Dialysis** | Deductible and Coinsurance | Deductible and Coinsurance |
| **Sexual Dysfunction** | Not Covered | Not Covered |
| **Skilled Nursing Facility**<br>(limited to 60 days per Calendar Year) | 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**<br>• Physical, occupational or speech therapy services, chiropractic or osteopathic physiotherapy (combined limit to 60 sessions per Calendar Year for both rehabilitative and habilitative services)<br>• Chiropractic or osteopathic manipulative treatments or adjustments (combined limit to 30 sessions per Calendar Year) | Deductible and Coinsurance<br>Deductible and Coinsurance | Deductible and Coinsurance<br>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**<br>• Eyeglasses or Contact Lenses (Only covered if required because of a change in prescription as a result of intraocular surgery or ocular injury) must be within 12 months of surgery or injury<br>• Vision Exam<br>- Diagnostic (to diagnose an illness)<br>- Preventive (routine exam including refraction) limited to one exam per calendar year | Deductible and Coinsurance<br>See Physician Office Services<br>Not Covered | Deductible and Coinsurance<br>See Physician Office Services<br>Not Covered |
| **Wigs** | Not Covered | Not Covered |
| **All Other Covered Services** | Deductible and Coinsurance | Deductible and Coinsurance |

| Prescription Drugs | In-network Provider | Out-of-network Provider |
|---|---|---|
| ***Retail – per 30-day supply*** | | |
| • Preferred Generic Drugs | $10 Copay | 50% Coinsurance |
| • Non-Preferred Generic Drugs | $10 Copay | 50% Coinsurance |
| • Preferred Brand Name Drugs | $30 Copay | 50% Coinsurance |
| • Non-Preferred Brand Name Drugs | $50 Copay | 50% Coinsurance |
| NOTE: A 90-day supply is available at an Extended Supply Network subject to 3 copays | | |
| ***Home Delivery – per 90-day supply*** | | |
| • Preferred Generic Drugs | $30 Copay | Not Covered |
| • Non-Preferred Generic Drugs | $30 Copay | Not Covered |
| • Preferred Brand Name Drugs | $90 Copay | Not Covered |
| • Non-Preferred Brand Name Drugs | $150 Copay | Not Covered |
| ***Specialty Drugs*** (specialty drugs must be purchased through a designated specialty pharmacy) | | |
| • Preferred Specialty Drugs | $100 Copay | Not Covered |
| • Non-Preferred Specialty Drugs | $100 Copay | Not Covered |
| **Contraceptive Drugs** | | |
| • Preferred Generic Drugs | Plan Pays 100% | 50% Coinsurance |
| • Non-Preferred Generic Drugs | Same as any other Generic Drugs | Same as any other Generic Drugs |
| • Preferred Brand Name Drugs | Plan Pays 100% | 50% Coinsurance |
| • Non-Preferred Brand Name Drugs | Same as any other Non-Preferred Brand Name Drugs | Same as any other Non-Preferred Brand Name Drugs |
| **Diabetic Insulin** | | |
| • Preferred Generic Drugs | Plan Pays 100% | 50% Coinsurance |
| • Non-Preferred Generic Drugs | Same as any other Generic Drugs | Same as any other Generic Drugs |
| • Preferred Brand Name Drugs | Plan Pays 100% | 50% Coinsurance |
| • Non-Preferred Brand Name Drugs | Same as any other Non-Preferred Brand Name Drugs | Same as any other Non-Preferred Brand Name Drugs |
| **This plan uses a prescription drug list (PDL). The PDL for this plan is 40, and the Pharmacy Network is C. You can find this prescription drug list and network listing on www.NebraskaBlue.com. Or you may contact Member Services at the phone number on the back of your I.D. card.** | | |

**Please note:** This Schedule of Benefits Summary is intended to provide you with a brief overview of your benefits. It is not a contract and should not be regarded as one. For more complete information about your plan, including benefits, exclusions and 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.