BlueCross BlueShield Nebraska

BlueFreedom

Health Plans for Employer Groups With 51-150 Employees

Effective Jan.1, 2024

THERE WITH YOU

Through births and broken bones, tests and treatments, trauma and triumphs, Blue Cross and Blue Shield of Nebraska (BCBSNE) is there with you. Since 1939, we have ensured access to the providers you trust, coverage for the care you need and support from a team that's right here in Nebraska.

Why BlueFreedom?

Our BlueFreedom product offers the largest array of plan designs to meet your groups' budget and the needs of their members.

Let's get started

Select the right health plan that fits your groups budget and members' needs. Here's what you need to consider:

ACCESS TO CARE: SELECT NETWORKS AND COVERAGE

Understand provider networks, service areas and prescription drug coverage.

FLEXIBILITY: COMPARE PLAN DESIGNS

Compare plans designs for in- and out-of-network coverage, copay or coinsurance plans and Health Savings Account (HSA) eligibility.

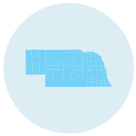
AFFORDABILITY: CONSIDER MEMBERS' COST SHARES

Compare member out-of-pocket amounts (deductibles and maximums), costs shares (copays and coinsurance) and HSA eligibility.

Consider discount programs, telehealth and tools to help manage expenses.

ACCESS TO CARE

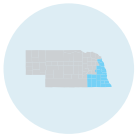
Provider Networks and Service Areas



NEtwork BLUE

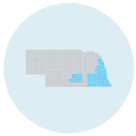
NEtwork BLUE is our statewide network, made up of 98% of Nebraska's doctors and non-governmental acute care hospitals.*

*According to BCBSNE statistics, June 21, 2022.



Premier Select BlueChoice

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



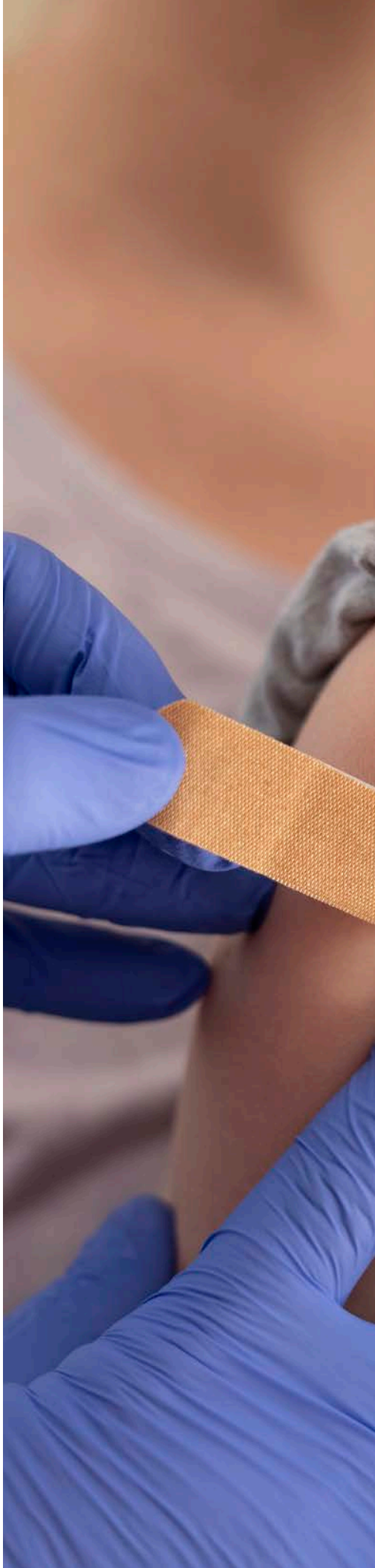
Blueprint Health

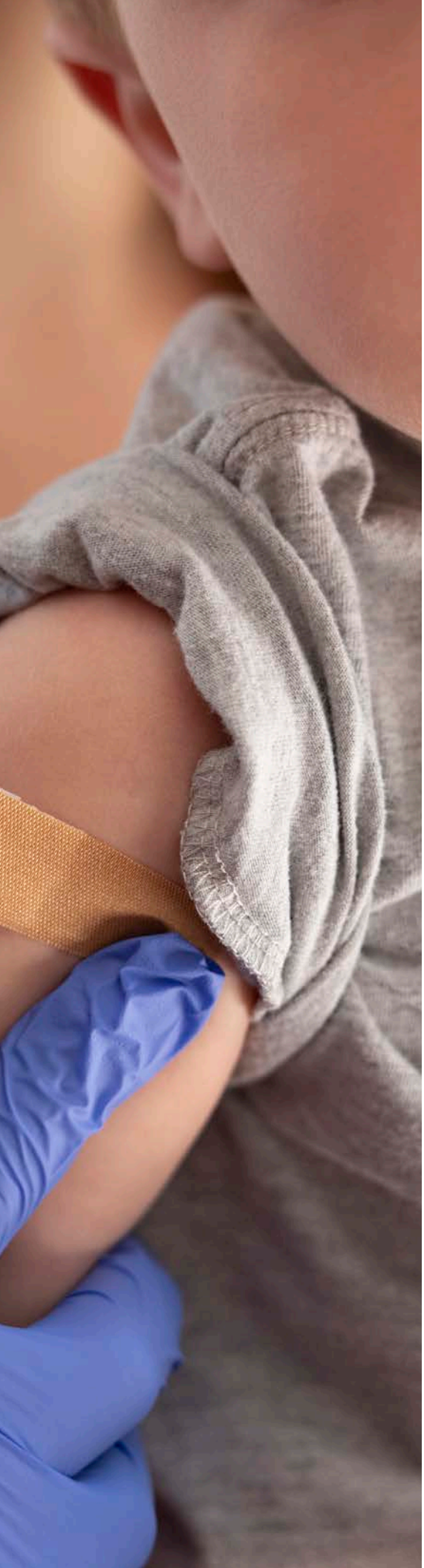
Blueprint Health is a regional network available in Omaha, Lincoln and the surrounding communities in ZIP codes starting with 680, 681, 683, 684 and 685, as well as Adams, Buffalo, Hall, Kearney and Phelps counties.** All other Nebraska providers are out of network.

To locate providers:

Members should visit **NebraskaBlue.com/Find-a-Doctor** or call the number on their member ID card.

**Plans with regional network access may only be available to certain members, depending on the ZIP code where groups are headquartered and members reside. All members in the state of Nebraska have access to NEtwork BLUE plan options.





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 around the world through the Blue Cross Blue Shield Global® Core Program.

To locate providers nationwide:

Members should visit
NebraskaBlue.com/Find-a-Doctor
or call 800-810-2583.

Telehealth – a Fast, Easy Way to See a Doctor

BCBSNE offers telehealth services through Amwell®, the industry's leading telehealth solution – serving more than 100 million people. With telehealth services, you can offer your employees access to a nationwide network of U.S. board-certified physicians, available for live visits over the computer, tablet or phone, whenever employees need them. Telehealth visits cost less than an emergency room, urgent care, or even in-office doctor visits – and they save employees 2-3 hours per consult. Best of all, employees love it. See page 24 for more details.

Amwell is an independent company that provides telehealth services for Blue Cross and Blue Shield of Nebraska.

Considering Exclusive Plan Options

Give employees a choice of plans that cover the care they need at a price they can afford.

An innovative new suite of exclusive BlueFreedom plan options, allows small and mid-sized companies to offer employees exclusive access to a trusted network of providers with lower out-of-pocket costs.

Employees appreciate the opportunity to choose their own plan, receive rich benefits and pay less when they get health care. BCBSNE works together with network providers to coordinate care, analyze shared data and manage costs. Companies benefit from more competitive medical benefit plans and the ease and accuracy of a new employee self-service enrollment portal.

	Standard Plan Options Preferred Provider Organization (PPO)		
Benefit designs	Standard in- and out-of-network benefit designs		
Network options	 **NEtwork BLUE**	 **Premier Select BlueChoice***	 **Blueprint Health***
	NEtwork BLUE access to most doctors and hospitals in Nebraska. Available to everyone in the state of Nebraska, regardless of ZIP code.	**Regional** network, anchored by these providers: • Methodist Hospital System • Nebraska Medicine • Bryan Health • Boys Town National Research Hospital • Children's Hospital & Medical Center Available in Omaha and surrounding communities, in ZIP codes starting with 680 and 681.	**Regional** network, anchored by these providers • CHI Health • Creighton University System • Nebraska Spine Hospital LLC • Boys Town National Research Hospital • Children's Hospital & Medical Center Available in Omaha, Lincoln and the surrounding communities, in ZIP codes starting with 680, 681, 683, 684 and 685, as well as Adams, Buffalo, Hall, Kearney and Phelps counties.
		*Note: If you choose a plan with **exclusive access** to one of these two regional networks, members will receive rich benefits and lower cost shares when seeing providers that are in their network, but you will pay the full cost for services if they go to a doctor or facility that's outside their network, except in an emergency situation.	
Pharmacy coverage	 Outside Nebraska, all BCBSNE members have access to a broad national network of providers, as well as doctors and hospitals around the world.		
	Network C Prescription Drug List (PDL) 40		
Getting care	In- and out-of-network benefits available, including a standard deductible		
Enrollment process	Employees work with the benefits administrator to enroll		
Plan type options	Eighteen (18) copay and eight (8) HSA-eligible options, from which groups select three (3) to offer employees		

Standard Plan Options

	Option 8		Option 15		Option 18	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Deductible						
Individual	$500	$1,000	$750	$1,500	$1,000	$2,000
Family	$1,000	$2,000	$1,500	$3,000	$2,000	$4,000
Type of Deductible	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded
Coinsurance (Amount Member Pays)						
Hospital/Medical/Surgical/Other	20%	40%	20%	40%	20%	40%
Out-of-Pocket Limit (Includes Deductible, Coinsurance and Copays)						
Individual	$2,000	$4,000	$2,750	$5,500	$2,000	$4,000
Family	$4,000	$8,000	$5,500	$11,000	$4,000	$8,000
Type of Out-of-Pocket Limit	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded
Preventive Care						
Preventive Care Services	0%	Deductible & Coinsurance	0%	Deductible & Coinsurance	0%	Deductible & Coinsurance
Physician Office						
Primary Care Physician Office	$25 copay	Deductible & Coinsurance	$25 Copay	Deductible & Coinsurance	$30 Copay	Deductible & Coinsurance
Specialist Physician Office	$40 copay	Deductible & Coinsurance	$40 Copay	Deductible & Coinsurance	$45 Copay	Deductible & Coinsurance
Telehealth	$10 copay	Not Covered	$10 Copay	Not Covered	$10 Copay	Not Covered
Emergency Care						
Urgent Care Facility Services	$50 Copay	Deductible & Coinsurance	$60 Copay	Deductible & Coinsurance	$60 Copay	Deductible & Coinsurance
Emergency Care Services	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits
Ambulance Services	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits
Mental Illness and/or Substance Dependence and Abuse Services						
Inpatient	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Outpatient	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Office Services	Plan Pays 100%	Deductible & Coinsurance	Plan Pays 100%	Deductible & Coinsurance	Plan Pays 100%	Deductible & Coinsurance
Emergency Care Services	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits
Telehealth	Plan Pays 100%	Not Covered	Plan Pays 100%	Not Covered	Plan Pays 100%	Not Covered

Standard Plan Options

	Option 20		Option 25		Option 28	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Deductible						
Individual	$1,000	$2,000	$1,500	$3,000	$1,500	$3,000
Family	$2,000	$4,000	$3,000	$6,000	$3,000	$6,000
Type of Deductible	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded
Coinsurance (Amount Member Pays)						
Hospital/Medical/Surgical/Other	20%	40%	20%	40%	20%	40%
Out-of-Pocket Limit (Includes Deductible, Coinsurance and Copays)						
Individual	$3,000	$6,000	$3,000	$6,000	$4,500	$9,000
Family	$6,000	$12,000	$6,000	$12,000	$9,000	$18,000
Type of Out-of-Pocket Limit	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded
Preventive Care						
Preventive Care Services	0%	Deductible & Coinsurance	0%	Deductible & Coinsurance	0%	Deductible & Coinsurance
Physician Office						
Primary Care Physician Office	$25 Copay	Deductible & Coinsurance	$20 Copay	Deductible & Coinsurance	$30 Copay	Deductible & Coinsurance
Specialist Physician Office	$40 Copay	Deductible & Coinsurance	$40 Copay	Deductible & Coinsurance	$45 Copay	Deductible & Coinsurance
Telehealth	$10 Copay	Not Covered	$10 Copay	Not Covered	$10 Copay	Not Covered
Emergency Care						
Urgent Care Facility Services	$50 Copay	Deductible & Coinsurance	$60 Copay	Deductible & Coinsurance	$60 Copay	Deductible & Coinsurance
Emergency Care Services	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits
Ambulance Services	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits
Mental Illness and/or Substance Dependence and Abuse Services						
Inpatient	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Outpatient	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Office Services	Plan Pays 100%	Deductible & Coinsurance	Plan Pays 100%	Deductible & Coinsurance	Plan Pays 100%	Deductible & Coinsurance
Emergency Care Services	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits
Telehealth	Plan Pays 100%	Not Covered	Plan Pays 100%	Not Covered	Plan Pays 100%	Not Covered

Standard Plan Options

	Option 29		Option 31		Option 34	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Deductible						
Individual	$1,500	$3,000	$2,000	$4,000	$2,000	$4,000
Family	$3,000	$6,000	$4,000	$8,000	$4,000	$8,000
Type of Deductible	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded
Coinsurance (Amount Member Pays)						
Hospital/Medical/Surgical/Other	30%	50%	20%	40%	30%	50%
Out-of-Pocket Limit (Includes Deductible, Coinsurance and Copays)						
Individual	$4,500	$9,000	$4,000	$8,000	$5,000	$10,000
Family	$9,000	$18,000	$8,000	$16,000	$10,000	$20,000
Type of Out-of-Pocket Limit	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded
Preventive Care						
Preventive Care Services	0%	Deductible & Coinsurance	0%	Deductible & Coinsurance	0%	Deductible & Coinsurance
Physician Office						
Primary Care Physician Office	$40 Copay	Deductible & Coinsurance	$25 Copay	Deductible & Coinsurance	$30 Copay	Deductible & Coinsurance
Specialist Physician Office	$60 Copay	Deductible & Coinsurance	$50 Copay	Deductible & Coinsurance	$45 Copay	Deductible & Coinsurance
Telehealth	$15 Copay	Not Covered	$10 Copay	Not Covered	$10 Copay	Not Covered
Emergency Care						
Urgent Care Facility Services	$75 Copay	Deductible & Coinsurance	$75 Copay	Deductible & Coinsurance	$75 Copay	Deductible & Coinsurance
Emergency Care Services	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits
Ambulance Services	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits
Mental Illness and/or Substance Dependence and Abuse Services						
Inpatient	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Outpatient	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Office Services	Plan Pays 100%	Deductible & Coinsurance	Plan Pays 100%	Deductible & Coinsurance	Plan Pays 100%	Deductible & Coinsurance
Emergency Care Services	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits
Telehealth	Plan Pays 100%	Not Covered	Plan Pays 100%	Not Covered	Plan Pays 100%	Not Covered

Standard Plan Options

	Option 35		Option 39		Option 41	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Deductible						
Individual	$2,500	$5,000	$2,500	$5,000	$3,000	$6,000
Family	$5,000	$10,000	$5,000	$10,000	$6,000	$12,000
Type of Deductible	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded
Coinsurance (Amount Member Pays)						
Hospital/Medical/Surgical/Other	0%	20%	30%	50%	20%	40%
Out-of-Pocket Limit (Includes Deductible, Coinsurance and Copays)						
Individual	$3,500	$9,000	$5,500	$11,000	$5,500	$11,000
Family	$7,000	$18,000	$11,000	$22,000	$11,000	$22,000
Type of Out-of-Pocket Limit	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded
Preventive Care						
Preventive Care Services	0%	Deductible & Coinsurance	0%	Deductible & Coinsurance	0%	Deductible & Coinsurance
Physician Office						
Primary Care Physician Office	$25 Copay	Deductible & Coinsurance	$30 Copay	Deductible & Coinsurance	$30 Copay	Deductible & Coinsurance
Specialist Physician Office	$40 Copay	Deductible & Coinsurance	$50 Copay	Deductible & Coinsurance	$50 Copay	Deductible & Coinsurance
Telehealth	$10 Copay	Not Covered	$10 Copay	Not Covered	$10 Copay	Not Covered
Emergency Care						
Urgent Care Facility Services	$60 Copay	Deductible & Coinsurance	$75 Copay	Deductible & Coinsurance	$75 Copay	Deductible & Coinsurance
Emergency Care Services	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits
Ambulance Services	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits
Mental Illness and/or Substance Dependence and Abuse Services						
Inpatient	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Outpatient	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Office Services	Plan Pays 100%	Deductible & Coinsurance	Plan Pays 100%	Deductible & Coinsurance	Plan Pays 100%	Deductible & Coinsurance
Emergency Care Services	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits
Telehealth	Plan Pays 100%	Not Covered	Plan Pays 100%	Not Covered	Plan Pays 100%	Not Covered

Standard Plan Options

	Option 42		Option 44		Option 65	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Deductible						
Individual	$3,000	$6,000	$5,000	$10,000	$1,000	$2,000
Family	$6,000	$12,000	$10,000	$20,000	$2,000	$4,000
Type of Deductible	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded
Coinsurance (Amount Member Pays)						
Hospital/Medical/Surgical/Other	30%	50%	0%	20%	50%	50%
Out-of-Pocket Limit (Includes Deductible, Coinsurance and Copays)						
Individual	$6,000	$12,000	$6,350	$14,000	$4,000	$8,000
Family	$12,000	$24,000	$12,700	$28,000	$8,000	$16,000
Type of Out-of-Pocket Limit	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded
Preventive Care						
Preventive Care Services	0%	Deductible & Coinsurance	0%	Deductible & Coinsurance	0%	Deductible & Coinsurance
Physician Office						
Primary Care Physician Office	$30 Copay	Deductible & Coinsurance	$30 Copay	Deductible & Coinsurance	$30 Copay	Deductible & Coinsurance
Specialist Physician Office	$50 Copay	Deductible & Coinsurance	$50 Copay	Deductible & Coinsurance	$50 Copay	Deductible & Coinsurance
Telehealth	$10 Copay	Not Covered	$10 Copay	Not Covered	$10 Copay	Not Covered
Emergency Care						
Urgent Care Facility Services	$75 Copay	Deductible & Coinsurance	$75 Copay	Deductible & Coinsurance	$75 Copay	Deductible & Coinsurance
Emergency Care Services	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits
Ambulance Services	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits
Mental Illness and/or Substance Dependence and Abuse Services						
Inpatient	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Outpatient	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Office Services	Plan Pays 100%	Deductible & Coinsurance	Plan Pays 100%	Deductible & Coinsurance	Plan Pays 100%	Deductible & Coinsurance
Emergency Care Services	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits
Telehealth	Plan Pays 100%	Not Covered	Plan Pays 100%	Not Covered	Plan Pays 100%	Not Covered

Standard Plan Options

	Option 68		Option 69		Option 71	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Deductible						
Individual	$2,500	$5,000	$4,000	$8,000	$6,000	$12,000
Family	$5,000	$10,000	$8,000	$16,000	$12,000	$24,000
Type of Deductible	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded
Coinsurance (Amount Member Pays)						
Hospital/Medical/Surgical/Other	50%	50%	50%	50%	20%	50%
Out-of-Pocket Limit (Includes Deductible, Coinsurance and Copays)						
Individual	$7,000	$14,000	$8,000	$16,000	$8,700	$16,000
Family	$14,000	$28,000	$16,000	$32,000	$17,400	$48,000
Type of Out-of-Pocket Limit	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded
Preventive Care						
Preventive Care Services	0%	Deductible & Coinsurance	0%	Deductible & Coinsurance	0%	Deductible & Coinsurance
Physician Office						
Primary Care Physician Office	$25 Copay	Deductible & Coinsurance	$25 Copay	Deductible & Coinsurance	$40 Copay	Deductible & Coinsurance
Specialist Physician Office	$100 Copay	Deductible & Coinsurance	$100 Copay	Deductible & Coinsurance	$60 Copay	Deductible & Coinsurance
Telehealth	$10 Copay	Not Covered	$10 Copay	Not Covered	$15 Copay	Not Covered
Emergency Care						
Urgent Care Facility Services	$50 Copay	Deductible & Coinsurance	$75 Copay	Deductible & Coinsurance	$75 Copay	Deductible & Coinsurance
Emergency Care Services	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits
Ambulance Services	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits
Mental Illness and/or Substance Dependence and Abuse Services						
Inpatient	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Outpatient	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Office Services	Plan Pays 100%	Deductible & Coinsurance	Plan Pays 100%	Deductible & Coinsurance	Plan Pays 100%	Deductible & Coinsurance
Emergency Care Services	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits
Telehealth	Plan Pays 100%	Not Covered	Plan Pays 100%	Not Covered	Plan Pays 100%	Not Covered

Standard Plan Options - HSA-Eligible

	Option 49		Option 52		Option 54	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Deductible						
Individual	$2,000	$4,000	$2,500	$5,000	$2,500	$5,000
Family	$4,000	$8,000	$5,000	$10,000	$5,000	$10,000
Type of Deductible	Aggregate	Aggregate	Aggregate	Aggregate	Aggregate	Aggregate
Coinsurance (Amount Member Pays)						
Hospital/Medical/Surgical/Other	0%	20%	0%	20%	20%	40%
Out-of-Pocket Limit (Includes Deductible, Coinsurance and Copays)						
Individual	$2,000	$8,000	$2,500	$9,000	$3,675	$9,000
Family	$4,000	$16,000	$5,000	$18,000	$7,350	$18,000
Type of Out-of-Pocket Limit	Aggregate	Aggregate	Aggregate	Aggregate	Aggregate	Aggregate
Preventive Care						
Preventive Care Services	0%	Deductible & Coinsurance	0%	Deductible & Coinsurance	0%	Deductible & Coinsurance
Physician Office						
Primary Care Physician Office	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Specialist Physician Office	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Telehealth	Deductible & Coinsurance	Not Covered	Deductible & Coinsurance	Not Covered	Deductible & Coinsurance	Not Covered
Emergency Care						
Urgent Care Facility Services	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Emergency Care Services	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits
Ambulance Services	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits
Mental Illness and/or Substance Dependence and Abuse Services						
Inpatient	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Outpatient	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Office Services	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Emergency Care Services	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits
Telehealth	Deductible & Coinsurance	Not Covered	Deductible & Coinsurance	Not Covered	Deductible & Coinsurance	Not Covered

Standard Plan Options - HSA-Eligible

	Option 55		Option 57		Option 58	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Deductible						
Individual	$3,000	$6,000	$3,500	$7,000	$3,500	$7,000
Family	$6,000	$12,000	$7,000	$14,000	$7,000	$14,000
Type of Deductible	Aggregate	Aggregate	Embedded	Embedded	Embedded	Embedded
Coinsurance (Amount Member Pays)						
Hospital/Medical/Surgical/Other	0%	20%	0%	20%	20%	40%
Out-of-Pocket Limit (Includes Deductible, Coinsurance and Copays)						
Individual	$3,000	$10,000	$3,500	$11,000	$5,500	$11,000
Family	$6,000	$20,000	$7,000	$22,000	$11,000	$22,000
Type of Out-of-Pocket Limit	Aggregate	Aggregate	Embedded	Embedded	Embedded	Embedded
Preventive Care						
Preventive Care Services	0%	Deductible & Coinsurance	0%	Deductible & Coinsurance	0%	Deductible & Coinsurance
Physician Office						
Primary Care Physician Office	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Specialist Physician Office	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Telehealth	Deductible & Coinsurance	Not Covered	Deductible & Coinsurance	Not Covered	Deductible & Coinsurance	Not Covered
Emergency Care						
Urgent Care Facility Services	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Emergency Care Services	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits
Ambulance Services	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits
Mental Illness and/or Substance Dependence and Abuse Services						
Inpatient	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Outpatient	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Office Services	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Emergency Care Services	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits
Telehealth	Deductible & Coinsurance	Not Covered	Deductible & Coinsurance	Not Covered	Deductible & Coinsurance	Not Covered

Standard Plan Options - HSA-Eligible

	Option 60		Option 66		Option 72	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Deductible						
Individual	$5,000	$10,000	$7,000	$14,000	$6,000	$12,000
Family	$10,000	$20,000	$14,000	$28,000	$12,000	$24,000
Type of Deductible	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded
Coinsurance (Amount Member Pays)						
Hospital/Medical/Surgical/Other	0%	20%	0%	50%	0%	50%
Out-of-Pocket Limit (Includes Deductible, Coinsurance and Copays)						
Individual	$5,000	$14,000	$7,000	$28,000	$6,000	$24,000
Family	$10,000	$28,000	$14,000	$56,000	$12,000	$48,000
Type of Out-of-Pocket Limit	Embedded	Embedded	Embedded	Embedded	Embedded	Embedded
Preventive Care						
Preventive Care Services	0%	Deductible & Coinsurance	0%	Deductible & Coinsurance	$0	Deductible & Coinsurance
Physician Office						
Primary Care Physician Office	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Specialist Physician Office	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Telehealth	Deductible & Coinsurance	Not Covered	Deductible & Coinsurance	Not Covered	Deductible & Coinsurance	Not Covered
Emergency Care						
Urgent Care Facility Services	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Emergency Care Services	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits
Ambulance Services	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits
Mental Illness and/or Substance Dependence and Abuse Services						
Inpatient	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Outpatient	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Office Services	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Emergency Care Services	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits	Deductible & Coinsurance	In-network Level of Benefits
Telehealth	Deductible & Coinsurance	Not Covered	Deductible & Coinsurance	Not Covered	Deductible & Coinsurance	Not Covered

Standard Plan Options - HSA-Eligible

	Option 73	
	In Network	Out of Network
Deductible		
Individual	$6,500	$13,000
Family	$13,000	$26,000
Type of Deductible	Embedded	Embedded
Coinsurance (Amount Member Pays)		
Hospital/Medical/Surgical/Other	20%	50%
Out-of-Pocket Limit (Includes Deductible, Coinsurance and Copays)		
Individual	$7,050	$26,000
Family	$14,100	$52,000
Type of Out-of-Pocket Limit	Embedded	Embedded
Preventive Care		
Preventive Care Services	$0	Deductible & Coinsurance
Physician Office		
Primary Care Physician Office	Deductible & Coinsurance	Deductible & Coinsurance
Specialist Physician Office	Deductible & Coinsurance	Deductible & Coinsurance
Telehealth	Deductible & Coinsurance	Not Covered
Emergency Care		
Urgent Care Facility Services	Deductible & Coinsurance	Deductible & Coinsurance
Emergency Care Services	Deductible & Coinsurance	In-network Level of Benefits
Ambulance Services	Deductible & Coinsurance	In-network Level of Benefits
Mental Illness and/or Substance Dependence and Abuse Services		
Inpatient	Deductible & Coinsurance	Deductible & Coinsurance
Outpatient	Deductible & Coinsurance	Deductible & Coinsurance
Office Services	Deductible & Coinsurance	Deductible & Coinsurance
Emergency Care Services	Deductible & Coinsurance	In-network Level of Benefits
Telehealth	Deductible & Coinsurance	Not Covered

Prescription Drug Coverage

Prescription Drug Coverage

Prescription drug coverage is available to BCBSNE members through our Rx Nebraska Prescription Drug Program with our pharmacy benefit manager, Prime Therapeutics®. All BlueFreedom plans will use Pharmacy Network C (out-of-network benefits may apply based on plan selection). All BlueFreedom plans use Prescription Drug List 40 (PDL 40). To search the list or download a copy, visit **NebraskaBlue.com/DrugList.**

Pharmacy Networks

BCBSNE members will pay less out-of-pocket on prescriptions filled with in-network pharmacies. Members may also use home delivery service to order up to a 90-day supply of maintenance medications at one time (if allowed by the prescription).

In-Network

- Costco
- Walgreens
- Walmart/ Sam's Clubs
- Hy-Vee
- Baker's
- U Save
- Super Saver

Out-of-Network

- CVS

The list is only a sample, not a complete list of providers. For a complete list visit **NebraskaBlue.com/Pharmacy**.

Retail Pharmacies

Members should take their prescriptions to an in-network pharmacy and show the pharmacist their BCBSNE member ID card. The member will pay the applicable copay, deductible or coinsurance amount.

Please note: Whenever appropriate, generic drugs will be used to fill prescriptions. If a brand name drug is preferred when a generic equivalent is available, the member will be responsible for the difference in cost, plus the applicable copay or coinsurance amount.

MedsYourWay™ – Retail

Effective Jan. 1, 2023, MedsYourWay - Retail simplifies the brick-and-mortar shopping experience by automatically comparing plan-covered benefit prices to discount card prices at the pharmacy, without needing to present a separate discount card.

Members should take their prescription to an in-network pharmacy and show the pharmacist their BCBSNE member ID card. The member will pay the applicable copay, deductible or coinsurance amount.

$0 Member Cost Shares on Insulin

BCBSNE provides insulin (on PDL 40) at no cost to members to help drive down diabetes-related health care cost and improve medication adherence. All BlueFreedom plans will cover generic and preferred brand-name insulin at 100%.

Prescription Drug Tiers

Prescription drugs are divided into four tiers. The cost for a covered prescription drug depends on the tier in which the medication is listed.

1	2	3	4
TIER 1	TIER 2	TIER 3	TIER 4
Generic Drugs	**Preferred Brand**	**Non-Preferred Brand**	**Specialty Drugs**

$ LOWEST COST ⟷ HIGHEST COST $$

Prime Therapeutics LLC is an independent company providing pharmacy benefit management services for Blue Cross and Blue Shield of Nebraska.

MedsYourWay is a trademark of Prime Therapeutics. Savings may differ depending on current benefit design. Prime Therapeutics is contracted to provide pharmacy benefits to Blue Cross and Blue Shield of Nebraska, an independent licensee of the Blue Cross Blue Shield Association.

Amazon Pharmacy for Home Delivery with MedsYourWay™ Drug Discount Card Pricing

Effective Jan. 1, 2023, pharmacy home delivery services will be offered exclusively through Amazon Pharmacy which delivers a breakthrough, integrated home-delivery shopping experience for our members. Members will be shown the lowest cost options, whether that is their copay/coinsurance or the MedsYourWay discount card price; depending on the pharmacy benefit plan, cost of the medication may count towards the member's out of pocket.

BCBSNE members may use home delivery services for their 90-day supply of maintenance medications. Members will be responsible for paying the applicable copay amount for each 30-day supply.

Extended Supply Network Pharmacy Benefit

Our Extended Supply Network (ESN) pharmacy benefit allows members to get a 90-day supply of medications at one time (if allowed by their prescription).* Non-ESN retail pharmacies are limited to a 30-day supply. Members may view a list of ESN retail pharmacies online or by calling Member Services.

Specialty Pharmacy

Effective Jan. 1, 2023, for specialty drugs to be considered in network, those drugs must be purchased through a designated specialty pharmacy. If a member uses retail or home-delivery pharmacy, benefits will be denied. In-network specialty pharmacies include Accredo, Option Care™ and Nebraska Medicine pharmacies.

Preauthorization

As part of our efforts to address the serious issue of escalating costs and to continue to provide members with access to quality and cost-effective pharmacy care, we require benefits for certain prescription products to be preauthorized. For a list of products requiring preauthorization, visit **NebraskaBlue.com/DrugList**.

FlexAccess™ – A new Specialty Copay Solution

FlexAccess will be implemented on Jan. 1, 2023 (not available for HSA-eligible plan designs). FlexAccess delivers a member-centric experience with greater savings opportunities and expanded pharmacy options. This program opens the door to reducing costs for specialty and HIV medications beyond the traditional, one specialty pharmacy option. By leveraging more pharmacies and HIV treatments, we expand the savings by maximizing pharmaceutical assistance programs, reducing the cost burden of specialty and HIV medications for our members.

No changes to the specialty pharmacy benefit are required or recommended. Our specialty pharmacy network benefits will not change, and we are not opening up the specialty network or recommending any network changes with this program.

COST SAVINGS

Members pay less when they choose generic medications from our drug list. Members should talk to their doctor about what is right for them.

EASY ACCESS

Members can use their benefits at many pharmacies by showing their member ID card. Find participating pharmacies at **NebraskaBlue.com/Pharmacy**.

CONVENIENCE

Make fewer trips to the pharmacy for drugs taken on a regular basis. Members may have up to a 90-day supply delivered directly to them through Amazon Pharmacy.

ONLINE RESOURCES

Members can search the drug list, find a pharmacy, view their claims and get an estimate of their cost for a medication 24/7 by logging in to **myNebraskaBlue.com**.

*Except for specialty drugs.

Option Care is an independent company offering prescription drug benefits on behalf of Blue Cross and Blue Shield of Nebraska, an independent licensee of the Blue Cross Blue Shield Association.

Accredo, a trademark of Express Scripts Strategic Development, Inc., is a specialty pharmacy contracted to provide services for Blue Cross and Blue Shield of Nebraska. Express Scripts® Pharmacy, a trademark of Express Scripts Strategic Development, Inc., is contracted to provide mail pharmacy services for Blue Cross and Blue Shield of Nebraska.

Amazon Pharmacy does not dispense controlled substances. Amazon Pharmacy is an independent company that provides pharmacy home delivery services for Blue Cross and Blue Shield of Nebraska.

FlexAccess is a trademark of Prime Therapeutics. Savings may differ depending on current benefit design. Prime Therapeutics is contracted to provide pharmacy benefits to Blue Cross and Blue Shield of Nebraska, an independent licensee of the Blue Cross Blue Shield Association.

Prescription Drug Coverage Options

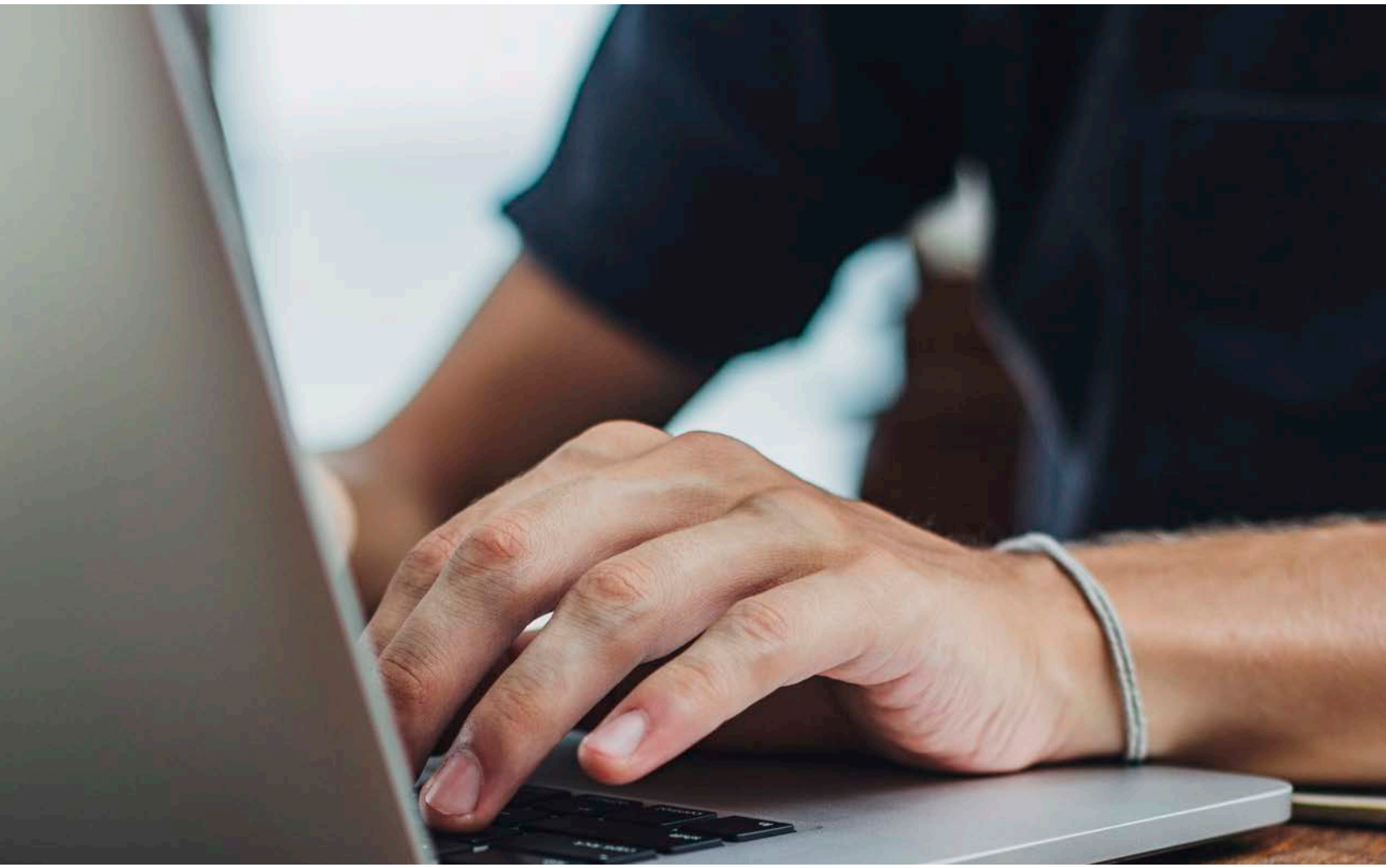
Out-of-pocket amounts per 30-day supply

	Option 1		Option 6	
	In Network	Out of Network	In Network	Out of Network
Pharmacy Benefits[1]				
Generic Drugs	$10 Copay	50% Coinsurance	$15 Copay	50% Coinsurance
Preferred Brand Name Drugs	$30 Copay	50% Coinsurance	$45 Copay	50% Coinsurance
Non-Preferred Brand Name Drugs	$50 Copay	50% Coinsurance	$80 Copay	50% Coinsurance
Specialty Drugs[2]	$100 Copay	50% Coinsurance	$250 Copay	50% Coinsurance

1 Under the QHDHP options, prescription drug benefits must be subject to plan deductible and coinsurance amounts.

2 Specialty drugs must be purchased through a designated specialty pharmacy.

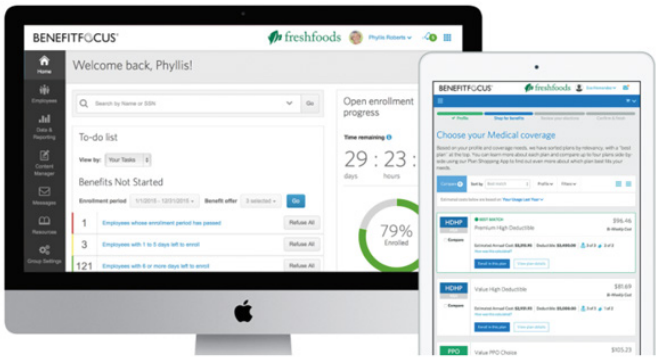
MEMBER RESOURCES



Regardless of the plan design, network coverage or option, members have resources available so they get the right care at the right place, access their benefits and claims information and other resources so they get the most of their benefits. BCBSNE will provide groups with materials that will help educate members on the resources available. These materials can be used during open enrollment and throughout the year.

Member Enrollment Platform (Exclusive plan options only)

For the exclusive plan options, groups can offer employees the opportunity to manage their own benefit selections through a self-service online platform. This eliminates paper forms, alleviates extra work for you and your customers and makes it simple for employees to understand their options.



Telehealth from Amwell
A fast, easy way to see a doctor

BCBSNE offers telehealth services through Amwell, the industry's leading telehealth solution. With telehealth services, you can offer your employees access to a nationwide network of U.S. board-certified physicians, available for live visits over the computer, tablet or phone, in less than 10 minutes. Amwell visits often cost less than an emergency room, urgent care, or even in-office doctor visits.

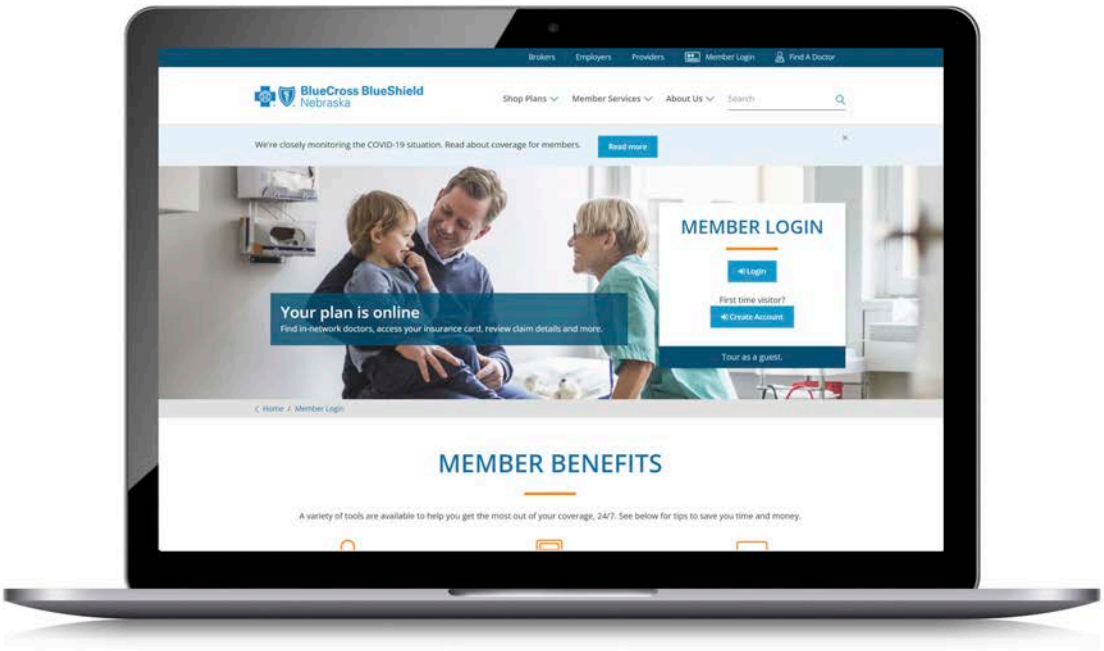
Behavioral Health Services Available

With telehealth behavioral health services, Amwell's licensed therapists are available by appointment from 7 a.m. to 11 p.m. local time, seven days per week to provide treatment for the following conditions:

- Anxiety
- Depression
- Attention deficit hyperactivity disorder (ADHD)
- Obsessive-compulsive disorder (OCD)
- Trauma/post-traumatic stress disorder (PTSD)
- Bereavement
- Panic attacks
- Stress
- And more

Note: Member communication materials are available

Amwell is an independent company that provides telehealth services for Blue Cross and Blue Shield of Nebraska.



myNebraskaBlue.com

It only takes a couple of minutes for BCBSNE members to gain access to a wealth of online tools that give them more control over their health plan and personal wellness. After signing up at myNebraskaBlue.com, members will instantly access details about their insurance plan and be able to track their spending.

With myNebraskaBlue, members can:

- Access claims details and status
- Find an in-network doctor or facility
- Track their health care spending
- View deductible and out-of-pocket limits
- Access pharmacy benefits
- Manage their account by going paperless or ordering additional ID cards

To learn more, visit **myNebraskaBlue.com**. You may view the tool as a guest by selecting "Guest" on the **myNebraskaBlue.com** home page.

Prescription Resources with MyPrime®

BCBSNE contracts with Prime Therapeutics to provide group pharmacy benefits. Members may view information about their pharmacy benefits by logging in to **myNebraskaBlue.com**. Members select Pharmacy Benefits and they will be directed to the **MyPrime.com**. This website is loaded with interactive tools to help members manage their prescription drugs.

With MyPrime, members can find:

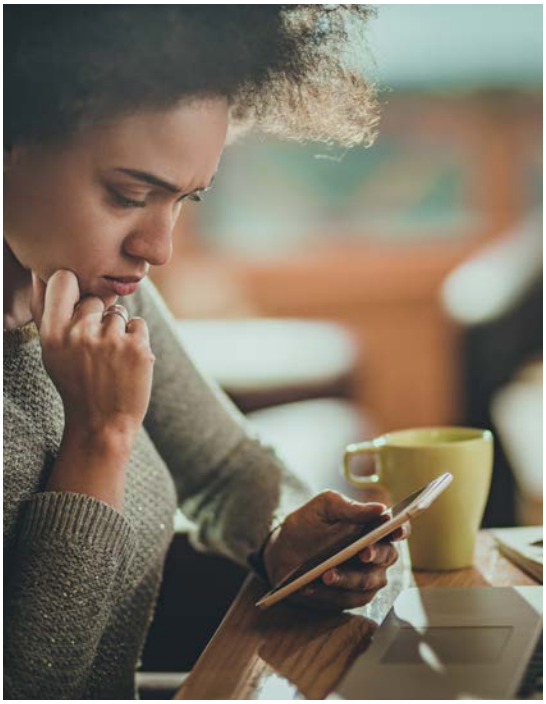
- Prescription benefits
- Drug claim history
- Prescription drug list
- Pharmacy locator
- Drug cost calculator
- Comparison of drug costs

Wellness Services

Our wellness and lifestyle program offers:

- Consultative services and resources to help businesses activate wellbeing initiatives
- Educational information targeting healthier lifestyles
- Personal health assessment tools
- Self-service tools such as calculators and challenges

To check out all the valuable health and wellness resources, visit **NebraskaBlue.com/Wellness.**



Care Management Programs

As part of your health plan, members have access to free resources, including our mobile health app, that can make it easier to manage your care. The free resources include:

- Health Coaching: Work with a nurse health coach to get help with stress, smoking cessation, chronic conditions and other challenges.
- Diabetes Management: Our diabetes educators will create a plan to help members better manage their diabetes and related issues.
- Pregnancy Care: Whether members have a high-risk or healthy pregnancy, our labor and delivery nurses can help members' answer questions and provide support between doctor appointments.

We now offer our Virta type 2 diabetes reversal program to all members at no cost.

To learn more, visit **NebraskaBlue.com/GettingCare**.

Blue365®
Because health is a big deal℠

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.

Participation in the Pregnancy Care Program does not affect members' health plan coverage for maternity/pregnancy care or entitle members to benefits not otherwise payable under the BCBSNE plan. Wellframe is an independent company that provides mobile enabled care management services for Blue Cross and Blue Shield of Nebraska. Wellframe is responsible for its services. Virta is an independent company that provides diabetes management solutions for Blue Cross and Blue Shield of Nebraska.

GLOSSARY

Embedded

If a member has an embedded deductible and out-of-pocket maximum their family members may combine their covered expenses to satisfy the required family deductible or out-of-pocket maximum; however, no one family member contributes more than their individual deductible or out-of-pocket maximum amount to satisfy the family deductible or out-of-pocket maximum.

Aggregate

If a member has an aggregate deductible and/or out-of-pocket maximum, their entire family deductible must be met before the health insurance plan begins to pay for services.

Deductible

The fixed dollar amount a member pays for covered health services each plan/policy year before the health insurance plan begins to pay.

Coinsurance

The percentage of the bill members pay for covered services after their deductible has been met.

Copay

A fixed amount members pay when they get a covered health service. For example, a doctor's office visit.

HSA

A tax-advantaged savings account that can be funded by individuals whose only health care coverage is a high-deductible health plan (HDHP). An HSA is an alternative way to pay for qualified health care expenses and save for future qualified health care expenses on a tax-free basis. Expenses such as out-of-pocket costs for office visits, prescription drugs, dental expenses and laboratory tests may be paid from an HSA.

BENEFITS AND RESPONSIBILITIES

General Information

Applications for coverage are subject to our approval.

Premier Select BlueChoice is available only to groups that are headquartered in the Omaha/Lincoln and surrounding communities in ZIP codes starting with 680, 681, 683, 684 and 685.

For exclusive plans, this network is only available to groups and members in Omaha and surrounding communities in ZIP codes starting with 680 and 681.

Blueprint Health is available only to groups that are headquartered in the 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. This applies to Exclusive Plan Options as well.

Network Blue is available to all groups and members that reside in Nebraska. It is also the only network options available to employees/subscribers that may reside outside of the state.

Types of Enrollment

Single Membership: Covers the employee only.

Employee and Spouse Membership: Covers the employee and spouse.

Employee and Child(ren) Membership: Covers the employee and eligible dependent children to age 26, but does not provide coverage to a spouse.

Family Membership: Covers the employee and spouse, as well as eligible dependent children to age 26.

Allowable Charge

Claim amounts are based on the allowable charge for a covered service. Generally, the allowable charge for services by in-network providers will be the contracted amount with BCBSNE. The allowable charge for services by non-contracting providers is the amount we determine for out-of-network. Members are responsible for the charges in excess of the allowable charge for services provided by a non-contracted provider.

Out-of-pocket Limit

(includes deductible, coinsurance and copayment amounts for medical and pharmacy services)

The policy has a yearly out-of-pocket limit, which is the total amount of cost-sharing members are required to pay toward the cost of their health care. After their annual out-of-pocket limit is reached, the member's plan pays covered services at 100% for the rest of the calendar year. In-network and out-of-network deductible and out-of-pocket limits are separate and do not cross accumulate. The out-of-pocket limit does not include charges for noncovered services, penalties or premium amounts.

Inpatient Hospital Benefits

(including long-term acute care)

Benefits are available for (but not limited to):

- Semi-private room; cardiac and intensive care units; treatment rooms and equipment
- Anesthesia
- FDA-approved drugs, intravenous solutions and vaccines administered in the hospital
- Physical, occupational and speech therapy
- Radiology, pathology and radiation therapy
- Respiratory care
- Inpatient physical rehabilitation, subject to certain requirements*
- Up to 60 days per calendar year in a skilled nursing facility when ordered by a physician*

* Requires benefit certification. For more information, see page 35.

Outpatient Hospital Benefits

Benefits for the covered services listed under "Inpatient Hospital Benefits" are also available (subject to certain limitations) when they are received in a hospital outpatient department, emergency room or ambulatory surgical facility. Benefits for outpatient cardiac and pulmonary rehabilitation are available, subject to medical criteria.

Orthopedic Specialty Hospital or Facility Services

Benefits are available in which deductible and coinsurance may be waived if Covered Services are provided at a designated Preferred Center. See **NebraskaBlue.com** for a list of Covered Services and designated hospitals.

Benefits for Physician's Services

Benefits are available for (but not limited to):

- Allergy serums and injections of allergy extracts
- Anesthesia services
- Consultation services
- Tissue examinations
- Physician home and outpatient visits
- Radiation therapy and chemotherapy
- Radiology, pathology and other diagnostic services
- Surgery and surgical assistance (for specified procedures)
- FDA-approved drugs
- Inpatient hospital visits

Primary Care Physician and Specialist Office Services Copays

When a member goes to a network primary care physician or specialist, he or she pays the plan's designated copay for office visit services.* Only covered services and supplies obtained in the physician's office will be payable under the office services copay benefit. For office visits to out-of-network primary care physicians and specialists, benefits for covered services will be subject to the plan's applicable deductible and coinsurance amounts.

Covered services include:

- Physician office visits and consultations
- X-ray, lab and pathology services
- Supplies used to treat the patient during the office visit (excluding home medical equipment)
- Drugs administered during an office visit
- Hearing and vision exams (non-routine)
- Allergy testing and injections

For purposes of this coverage, a "primary care physician" is a physician who has a majority of his or her practice in the fields of internal or general medicine, obstetrics/gynecology, general pediatrics or family practice. All other types of physicians are considered specialists.

*The primary care physician/specialist office services copay benefit is not available under all BlueFreedom options. Benefits for all covered services are subject to deductible and coinsurance amounts for plans that do not include the primary care physician/specialist office services copay.

Benefits for Hearing Aids

Benefits are available for hearing aids for members up to age 19. Limitations and exclusions apply.

Benefits for Maternity and Newborn

Maternity coverage is available to employees, as well as covered spouses and dependent daughters. If the employee is covered under a single membership, benefits are available for the newborn for 31 days from the date of birth. To continue the newborn's coverage beyond this time period, the employee must request a change to family membership within those 31 days and pay the additional premium.

Benefits are available for screening tests (including newborn/infant hearing) and physician services for routine exams of a newborn well infant while the baby is confined. All covered charges incurred by a newborn from birth will be subject to the baby's calendar year deductible.

Obstetrical benefits include prenatal and postnatal care.

Benefits For Mental Illness and Substance Dependence or Services

Benefits will be provided for covered services for the treatment of mental illness and substance dependence and abuse. Covered services include inpatient and outpatient services, including but not limited to:

- Psychological therapy and/or substance dependence and abuse counseling by approved providers.
- Office visits.
- Specified outpatient programs.
- Emergency care services.

Certain exclusions/limitations may apply.

Benefits for Preventive Services

Benefits will be provided for in-network preventive services as required by the Affordable Care Act (ACA) and will not be subject to cost-sharing requirements, such as copayment, coinsurance or deductible. A listing of these services is available upon request.

In addition to those preventive services required by the ACA, benefits will be provided for other preventive services, including:

- Specific laboratory/pathology services.
- Hearing screenings and examinations.
- Prostate cancer screenings (PSA).

Benefits for Oral Surgery

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

- Removal of tumors and cysts
- Nonsurgical treatment of infections
- Treatment of jaw joint dislocation/fracture due to an accident. Services must occur within 12 months of an injury not related to eating, biting or chewing
- Services, supplies or appliances for dental treatment of natural healthy teeth required as the direct result of an accidental Injury. Benefits for such services are limited, however, to covered services provided within 12 months of the date of Injury. Benefits are not available for orthodontics or dental implants. Benefits shall not be provided for services when the Injury occurs as the result of eating, biting or chewing.
- Medically necessary hospitalization and general anesthesia in order for the covered person to safely receive dental care, including covered persons who are under eight years of age or developmentally disabled.
- Diagnostic services and surgery related to TMJ (temporomandibular jaw joint).

Benefits for Organ and Tissue Transplants

Benefits are available for services associated with medically necessary organ and tissue transplants, including (but not limited to) liver; heart; single and double lung; lobar lung; heart-lung; heart valve (heterograft); kidney; kidney-pancreas; pancreas; bone graft; cornea; parathyroid; small intestine; small intestine and liver; small intestine and multiple viscera.

Benefits are also available for bone marrow transplants, including, but not limited to, autologous and allogeneic stem cell transplants.

Transplant procedures require certification by BCBSNE and are subject to medical policy criteria.

Benefits for Home Skilled Nursing Care, Home Health Aide, Hospice Services and Respiratory Care

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

- **Skilled nursing care:** Benefits are available for medically necessary physician-ordered care by a registered or licensed practical nurse for up to eight hours per day.
- **Home health aide:** When services are related to active medical treatment, benefits include personal services such as bathing, feeding and performing necessary household duties for a homebound patient.
- **Hospice services:** Benefits include Medicare-certified hospice services for a terminally ill patient, including home health aide and hospice nursing services, respite care, medical social worker visits, crisis care and bereavement counseling.
- **Respiratory Care:** Benefits are available for respiratory care services in the home, including airway maintenance, chest physiotherapy, delivery of medications, oxygen therapy, obtaining laboratory samples and pulmonary function testing. (Maximum of 60 days per calendar year)

Other Covered Services

(Please note: Limitations and exclusions apply.)

- Diabetes outpatient self-management training and patient management from an approved provider

- Physical, occupational or speech therapy services, chiropractic or osteopathic physiotherapy (combined limit of 60 sessions per calendar year)
- 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
- Services in accordance with the Women's Health and Cancer Rights Act, which requires that insurance companies that provide medical and surgical benefits for mastectomies also provide benefits for breast reconstruction, prostheses and treatment for physical complications

Refer to the contract for a complete listing.

Exclusions and Limitations

This document contains only a partial list of the limitations and exclusions that apply to BlueFreedom health plan coverage. For a complete listing, please refer to the contract.

No benefits are available for the following:

- Eyeglasses, contact lenses, eye exercises or visual training
- Hearing aids and their fitting
- Blood, plasma, or services by or for blood donors
- Artificial insemination; invitro fertilization; fertility treatment, and related testing
- Massage therapy and/or services provided by a massage therapist
- 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
- Removal of Skin Tags
- 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
- Routine eye exams

Certification Requirements

The purpose of certification is to determine whether a service or admission meets the medical necessity criteria of the policy.

All inpatient hospital admissions must be certified by BCBSNE. This enables us to coordinate discharge planning, case management and disease management services with the patient's providers. If the patient is hospitalized in a contracting (in-network) hospital in Nebraska, notification will be provided by the hospital.

If the patient is hospitalized in a non-contract (out-of-network) hospital in Nebraska or is admitted to an inpatient facility in another state, BCBSNE must be notified by the patient or their provider.

Certification is also required for the following care, regardless of where the care is received, in or out of network:

- Inpatient physical rehabilitation
- Long-term acute care
- Skilled nursing facility care
- Skilled nursing in the home
- Organ and tissue transplants
- Certain prescription drugs

This is not a complete list. Please refer to the contract for additional information.

The covered person is responsible for making sure that certification occurs; however a hospital or provider may initiate the certification. When possible, certification should be completed prior to receiving the services. Benefits for services that are not certified or that are not medically necessary will be denied, the member will be responsible for the charges.

For certification of benefits for an inpatient admission, call 800-247-1103 or 402-390-1870.

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