BlueCross BlueShield Nebraska | HeartlandBlue

Health Plans for Individuals and Families

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 right here in Nebraska.

Essential Health Benefits

Our health plans are available both on and off the federal government's Health Insurance Marketplace® (Marketplace). These plans comply with the Affordable Care Act requirements and include the following 10 Essential Health Benefits.

1. Outpatient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Pediatric services, including dental and vision
10. Preventive and wellness services and chronic disease management

Let's get started

Finding a health insurance plan doesn't have to be complicated. Let us show you how. Follow these simple steps to find the best plan for you and your family.

1

REVIEW NETWORKS

Understand the provider networks available in your area.

2

COMPARE PLAN OPTIONS

Look closely at the plans to see which one is right for you.

3

LEARN ABOUT PAYMENT OPTIONS

Advanced Premium Tax Credits and Cost-sharing reduction options may be available to you.

4

EXPLORE MEMBER RESOURCES

Discount programs, telehealth, tools to help manage your expenses and more.

Whether you'd like assistance or prefer to do it on your own, applying for coverage is easy.

- → Call one of our licensed sales reps at **844-665-1121**
- → Visit **NebraskaBlue.com/HeartlandBlue**
- → Apply through your insurance broker

No matter how you apply, you will be able to see if you qualify for premium assistance or extra savings.

REVIEW NETWORKS

Exclusive Provider Organization

Nebraska HeartlandBlue plans are considered Exclusive Provider Organization (EPO) plans. This means that services are covered only if you use doctors, hospitals and other health care providers in your network (except in an emergency). The chart below outlines which networks are available in each county, depending on the plan option chosen. Refer to the plan options section starting on page 8 for additional details on each plan available. **Only emergency services and urgent care services are covered outside the state of Nebraska.**

	NETWORK BLUE HB Made up of 98% of Nebraska's non-governmental acute care hospitals[1], NEtwork BLUE HB includes Nebraska Methodist Health System, Nebraska Medicine, CHI Health, and more.		**PREMIER SELECT BLUECHOICE HB** The Premier Select BlueChoice HB network features Nebraska Methodist Hospital System, Nebraska Medicine, Children's Hospital & Medical Center and Bryan Health.		**BLUEPRINT HEALTH HB** The Blueprint Health HB network features CHI Health, Creighton University System, Nebraska Spine Hospital LLC, Boys Town National Research Hospital, Children's Hospital & Medical Center and more.	
	See if your doctors are in network with NEtwork BLUE HB: **NebraskaBlue.com/NEtworkBLUEHB.**		See if your doctors are in network with Premier Select BlueChoice HB: **NebraskaBlue.com/PremierSelectBlueChoiceHB.**		See if your doctors are in network with Blueprint Health HB: **NebraskaBlue.com/BlueprintHealthHB.**	
County	**Standard Plans**	**Non-Standard Plans[2]**	**Standard Plans**	**Non-Standard Plans[2]**	**Standard Plans**	**Non-Standard Plans[2]**
Adams		✖			✖	✖
Antelope	✖	✖				
Arthur	✖	✖				
Banner	✖	✖				
Blaine	✖	✖				
Boone	✖	✖				
Box Butte	✖	✖				
Boyd	✖	✖				
Brown	✖	✖				
Buffalo		✖			✖	✖
Burt		✖	✖		✖	
Butler	✖	✖				
Cass		✖	✖		✖	
Cedar	✖	✖				
Chase	✖	✖				

[1]According to BCBSNE statistics, June 27, 2023.

[2]NEtwork BLUE HB network is not available for the Bronze health Savings account-eligible high deductible health plan in the following counties: Adams, Buffalo, Burt, Cass, Dodge, Douglas, Fillmore, Gage, Hall, Jefferson, Johnson, Kearney, Lancaster, Nemaha, Otoe, Pawnee, Phelps, Richardson, Saline, Sarpy, Saunders, Seward, Thayer, Thurston, Washington and York.

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County	Standard Plans	Non-Standard Plans[2]	Standard Plans	Non-Standard Plans[2]	Standard Plans	Non-Standard Plans[2]
Cherry	✖	✖				
Cheyenne	✖	✖				
Clay	✖	✖				
Colfax	✖	✖				
Cuming	✖	✖				
Custer	✖	✖				
Dakota	✖	✖				
Dawes	✖	✖				
Dawson	✖	✖				
Deuel	✖	✖				
Dixon	✖	✖				
Dodge		✖	✖		✖	
Douglas		✖	✖		✖	
Dundy	✖	✖				
Fillmore		✖	✖		✖	
Franklin	✖	✖				
Frontier	✖	✖				
Furnas	✖	✖				
Gage		✖	✖		✖	
Garden	✖	✖				
Garfield	✖	✖				
Gosper	✖	✖				
Grant	✖	✖				
Greeley	✖	✖				
Hall		✖			✖	✖
Hamilton	✖	✖				
Harlan	✖	✖				
Hayes	✖	✖				
Hitchcock	✖	✖				
Holt	✖	✖				
Hooker	✖	✖				
Howard	✖	✖				
Jefferson		✖	✖		✖	
Johnson		✖	✖		✖	
Kearney		✖			✖	✖
Keith	✖	✖				
Keya Paha	✖	✖				
Kimball	✖	✖				
Knox	✖	✖				

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County	Standard Plans	Non-Standard Plans[2]	Standard Plans	Non-Standard Plans[2]	Standard Plans	Non-Standard Plans[2]
Lancaster		✖	✖		✖	
Lincoln	✖	✖				
Logan	✖	✖				
Loup	✖	✖				
Madison	✖	✖				
McPherson	✖	✖				
Merrick	✖	✖				
Morrill	✖	✖				
Nance	✖	✖				
Nemaha		✖	✖		✖	
Nuckolls	✖	✖				
Otoe		✖	✖		✖	
Pawnee		✖	✖		✖	
Perkins	✖	✖				
Phelps		✖			✖	✖
Pierce	✖	✖				
Platte	✖	✖				
Polk	✖	✖				
Red Willow	✖	✖				
Richardson		✖	✖		✖	
Rock	✖	✖				
Saline		✖	✖		✖	
Sarpy		✖	✖		✖	
Saunders		✖	✖		✖	
Scotts Bluff	✖	✖				
Seward		✖	✖		✖	
Sheridan	✖	✖				
Sherman	✖	✖				
Sioux	✖	✖				
Stanton	✖	✖				
Thayer		✖	✖		✖	
Thomas	✖	✖				
Thurston		✖	✖		✖	
Valley	✖	✖				
Washington		✖	✖		✖	
Wayne	✖	✖				
Webster	✖	✖				
Wheeler	✖	✖				
York		✖	✖		✖	

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Traveling outside of Nebraska?

Services received from health care providers outside the state of Nebraska are not covered except for emergency services and urgent care facility services. If you're traveling outside of Nebraska, you still have access to your plan's telehealth benefits.

BCBSNE offers telehealth services through Amwell, so you can access a nationwide network of U.S. board-certified physicians, available for live visits over the computer, tablet or phone, whenever you need them. Telehealth visits cost less than an emergency room, urgent care or even in-office doctor visits. See page 16 for more information.

2 COMPARE PLAN OPTIONS

Find the Plan that Fits Your Budget and Needs

Now that you know what network options are available, you'll want to choose the plan that fits your needs. All our plans meet the requirements mandated by the Affordable Care Act (ACA), which means they meet cost-sharing limits and cover all essential health benefits, including pediatric dental and vision.

ACA plans are grouped into different categories, often called "metallic levels." These categories indicate how costs (coinsurance) are split between you and your insurance plan. BCBSNE offers plans in the Bronze, Silver and Gold categories. All Nebraska HeartlandBlue plans are available on and off the Individual Market Exchange and are available in every county in Nebraska. All plans are also offered as child-only policies.

› BRONZE PLANS

Bronze plans usually have the lowest monthly premiums, but the highest cost when you receive care.

› SILVER PLANS

Silver plans typically fall in the middle: You pay moderate monthly premiums and moderate costs when you need care.

› GOLD PLANS

Gold plans usually have higher monthly premiums but lower costs when you get care.

› STANDARD PLANS

Standard plans offer a uniform cost-sharing structure across all metallic levels. This allows you to easily compare plans across carriers and shop for coverage. CMS guidelines require all participating carriers to offer standard plans among their plan offerings.

Bronze Plans

	HSA Eligible 6500	0% Coinsurance 9450	Standard Expanded 7500
	In-Network	In-Network	In-Network
Deductible (Embedded*)			
Individual	$6,500	$9,450	$7,500
Family	$13,000	$18,900	$15,000
Coinsurance (Amount Member Pays)			
	20%	0%	50%
Out-of-Pocket Maximum (Embedded*, includes deductible, coinsurance and copays if applicable)			
Individual	$8,050	$9,450	$9,400
Family	$16,100	$18,900	$18,800
Preventive Care			
Preventive Care Services	0%	0%	0%
Physician Office			
Primary Care Physician Office Visit	Deductible & Coinsurance	Deductible & Coinsurance	$50
Specialist Office Visits	Deductible & Coinsurance	Deductible & Coinsurance	$100
Telehealth	Deductible & Coinsurance	$0	$0
OT, PT, Speech Therapy	Deductible & Coinsurance	Deductible & Coinsurance	$50
Pregnancy and Maternity Services			
Pre/Postnatal Care and Delivery	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Emergency Care			
Urgent Care Facility Visit	Deductible & Coinsurance	Deductible & Coinsurance	$75
Emergency Care	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Inpatient Hospital	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Ambulance Services	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Mental Illness and/or Substance Dependence and Abuse Services			
Inpatient	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Outpatient Office Visit	Deductible & Coinsurance	Deductible & Coinsurance	$50
Pharmacy Benefits			
Preferred Generic	20% after Deductible	Deductible & Coinsurance	$25
Non-Preferred Generic	30% after Deductible	Deductible & Coinsurance	N/A
Preferred Brand	50% after Deductible	Deductible & Coinsurance	$50 copay after deductible
Non-Preferred Brand	55% after Deductible	Deductible & Coinsurance	$100 copay after deductible
Preferred Specialty	60% after Deductible	Deductible & Coinsurance	$500 copay after deductible
Non-Preferred Specialty	70% after Deductible	Deductible & Coinsurance	N/A

Health Savings Account (HSA) Eligible Plans

The Bronze HSA Eligible 6500 plan is a qualified high-deductible health plan which means you can pair it with a health savings account (HSA) to save and pay for qualified health care expenses. An HSA is an alternative way to pay for your qualified health care expenses and save for future qualified health care expenses on a tax-free basis. Funds in an HSA roll over each year, and the interest earned on the assets in your account are tax free. There are limits to the amount that can be contributed to your HSA as well as what you can use your HSA funds for. These limits depend on a variety of factors, and they typically increase each year. Visit IRS.gov for more information.

* See page 32 for embedded definition.

Silver Plans

	$0 Primary Care Physician Office Visit 5000	$0 Mental Health Office Visit 6000	Standard Copay 5900
	In-Network	In-Network	In-Network
Deductible (Embedded*)			
Individual	$5,000	$6,000	$5,900
Family	$10,000	$12,000	$11,800
Coinsurance (Amount Member Pays)			
	50%	50%	40%
Out-of-Pocket Maximum (Embedded*, includes deductible, coinsurance and copays if applicable)			
Individual	$8,950	$7,900	$9,100
Family	$17,900	$15,800	$18,200
Preventive Care			
Preventive Care Services	0%	0%	0%
Physician Office			
Primary Care Physician Office Visit	$0	$40	$40
Specialist Office Visits	Deductible & Coinsurance	Deductible & Coinsurance	$80
Telehealth	$0	$0	$0
OT, PT, Speech Therapy	Deductible & Coinsurance	Deductible & Coinsurance	$40
Pregnancy and Maternity Services			
Pre/Postnatal Care and Delivery	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Emergency Care			
Urgent Care Facility Visit	$50	$50	$60
Emergency Care	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Inpatient Hospital	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Ambulance Services	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Mental Illness and/or Substance Dependence and Abuse Services			
Inpatient	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Outpatient Office Visit	$0	$0	$40
Pharmacy Benefits			
Preferred Generic	$5	$5	$20
Non-Preferred Generic	$20	$20	N/A
Preferred Brand	$150	$150	$40
Non-Preferred Brand	55% after Deductible	55% after Deductible	$80 copay after deductible
Preferred Specialty	60% after Deductible	60% after Deductible	$350 copay after deductible
Non-Preferred Specialty	70% after Deductible	70% after Deductible	N/A

These plans are eligible for Cost-Sharing Reduction. See page 11 for details.

* See page 32 for embedded definition.

Gold Plans

	$0 Primary Care Physician Office Visit 1500	$0 Deductible 9450	Standard Copay 1500
	In-Network	In-Network	In-Network
Deductible (Embedded*)			
Individual	$1,500	$0	$1,500
Family	$3,000	$0	$3,000
Coinsurance (Amount Member Pays)			
	30%	35%	25%
Out-of-Pocket Maximum (Embedded*, includes deductible, coinsurance and copays if applicable)			
Individual	$7,500	$9,450	$8,700
Family	$15,000	$18,900	$17,400
Preventive Care			
Preventive Care Services	0%	0%	0%
Physician Office			
Primary Care Physician Office Visit	$0	Deductible & Coinsurance	$30
Specialist Office Visits	Deductible & Coinsurance	Deductible & Coinsurance	$60
Telehealth	$0	$0	$0
OT, PT, Speech Therapy	Deductible & Coinsurance	Deductible & Coinsurance	$30
Pregnancy and Maternity Services			
Pre/Postnatal Care and Delivery	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Emergency Care			
Urgent Care Facility Visit	$50	Deductible & Coinsurance	$45
Emergency Care	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Inpatient Hospital	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Ambulance Services	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Mental Illness and/or Substance Dependence and Abuse Services			
Inpatient	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Outpatient Office Visit	$0	Deductible & Coinsurance	$30
Pharmacy Benefits			
Preferred Generic	$3	$3	$15
Non-Preferred Generic	$10	$10	N/A
Preferred Brand	$100	$100	$30
Non-Preferred Brand	55% after deductible	55% after deductible	$60
Preferred Specialty	60% after deductible	60% after deductible	$250
Non-Preferred Specialty	70% after deductible	70% after deductible	N/A

* See page 32 for embedded definition.

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, LLC.

Pharmacy Networks

Nebraska HeartlandBlue plans provide prescription drug benefits for prescriptions filled at in-network pharmacies. You can also use Amazon Pharmacy home-delivery service for more than a 30-day supply of your maintenance medications. Nebraska HeartlandBlue plans use Network J.

Pharmacy Network J

In-Network

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

Out-of-Network

- CVS/Target

This is a partial list and is subject to change at any time without notice. For a complete list visit **NebraskaBlue.com/Pharmacy**.

Prescription Drug List

Each Nebraska HeartlandBlue plan includes a list of covered medications, also called a prescription drug list (PDL). The PDL for our **Standard** plans is PDL69. All other plans offer PDL68. To search the list or download a copy, visit **NebraskaBlue.com/DrugList**.

Retail Pharmacies

Take your prescription to an in-network pharmacy and show the pharmacist your member ID card; you 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, you will be responsible for the difference in cost, plus the applicable copay or coinsurance amount.

MedsYourWay™ – Retail

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. Take your prescriptions to an in-network pharmacy and show the pharmacist your BCBSNE member ID card. You will pay the applicable copay, deductible or coinsurance amount or the discount card price, whichever is lower.

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

Pharmacy home-delivery services are offered exclusively through Amazon Pharmacy which delivers a breakthrough, integrated home-delivery shopping experience for you.

You will be shown the lowest cost options, whether that is your copay/coinsurance or the MedsYourWay discount card price. You may use home delivery services for your 90-day supply of maintenance medications. You will be responsible for paying the applicable cost-share amount for each 30-day supply.

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.

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.

Prescription Drug Tiers

Prescription drugs are divided into tiers. The cost for each 30-day supply of a covered prescription drug depends on the tier in which the medication is listed.

Nebraska HeartlandBlue **Standard** plans offer four prescription drug tiers

TIER 1
GENERIC

Commonly prescribed generic drugs.

TIER 2
PREFERRED BRAND

Brand-name drugs that do not have a generic equivalent.

TIER 3
NON-PREFERRED BRAND

Higher-priced brand-name drugs. Often have a generic equivalent.

TIER 4
SPECIALTY

Drugs used to treat complex conditions such as cancer. These drugs can be generic or brand name.

All other plans offer six prescription drug tiers

TIER 1
PREFERRED GENERIC

Commonly prescribed generic drugs.

TIER 2
NON-PREFERRED GENERIC

Higher-priced generic drugs that cost a little more than Tier 1.

TIER 3
PREFERRED BRAND

Brand-name drugs that do not have a generic equivalent.

TIER 4
NON-PREFERRED BRAND

Higher-priced brand-name drugs. Often have a generic equivalent.

TIER 5
PREFERRED SPECIALTY

Lower-cost specialty drugs. Used to treat complex conditions such as cancer.

TIER 6
NON-PREFERRED SPECIALTY

The most expensive drugs on the drug list which can be generic or brand name.

$ LOWEST COST ⟵ ⟶ HIGHEST COST $$

3

PAYING FOR YOUR COVERAGE

Don't let premium costs keep you from giving your family the health coverage they deserve. Many individuals can qualify for an advanced premium tax credit to lower monthly premiums and even extra savings with cost-sharing reduction.

Advance Premium Tax Credits

The Advanced Premium Tax Credit (APTC) is a credit that can be used to lower your monthly premium on plans purchased through the Marketplace. This tax credit is based on your estimated household income and will be calculated when you fill out your application for coverage.

Cost-Sharing Reduction

In addition to APTC, you can also see if you qualify for a cost-sharing reduction (CSR), also called "extra savings." These extra savings allow you to save additional money on your out-of-pocket costs when receiving medical services.

Only plans in the Silver category are eligible for a CSR; the savings amount depends on your household income. These savings include:

- Lower deductibles
- Lower coinsurance and/or copays
- Lower out-of-pocket maximums

Additional benefits and protections are available for American Indians and Alaska natives.

To learn more, visit **Healthcare.gov**.

4

EXPLORE MEMBER RESOURCES

Take a peek at some of the resources available to BCBSNE members.

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

You may use any in-network provider that offers telehealth services. BCBSNE offers telehealth services through Amwell®, the industry's leading telehealth solution. With telehealth services, you can access a nationwide network of U.S. board-certified physicians, available for live visits over a computer, tablet or phone, typically 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

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

Medical Services

Telehealth through Amwell offers medical services to treat common conditions including:

- Sinus infection
- Cold
- Flu
- Fever
- Rash
- Abdominal pain
- Pinkeye
- Ear infection

You are not required to use Amwell for telehealth. You may use any in-network provider that offers telehealth services.

Blue365®

Blue365 is just one more advantage of being a BCBSNE member. With this free program, you and your family can save money on health care products and services.

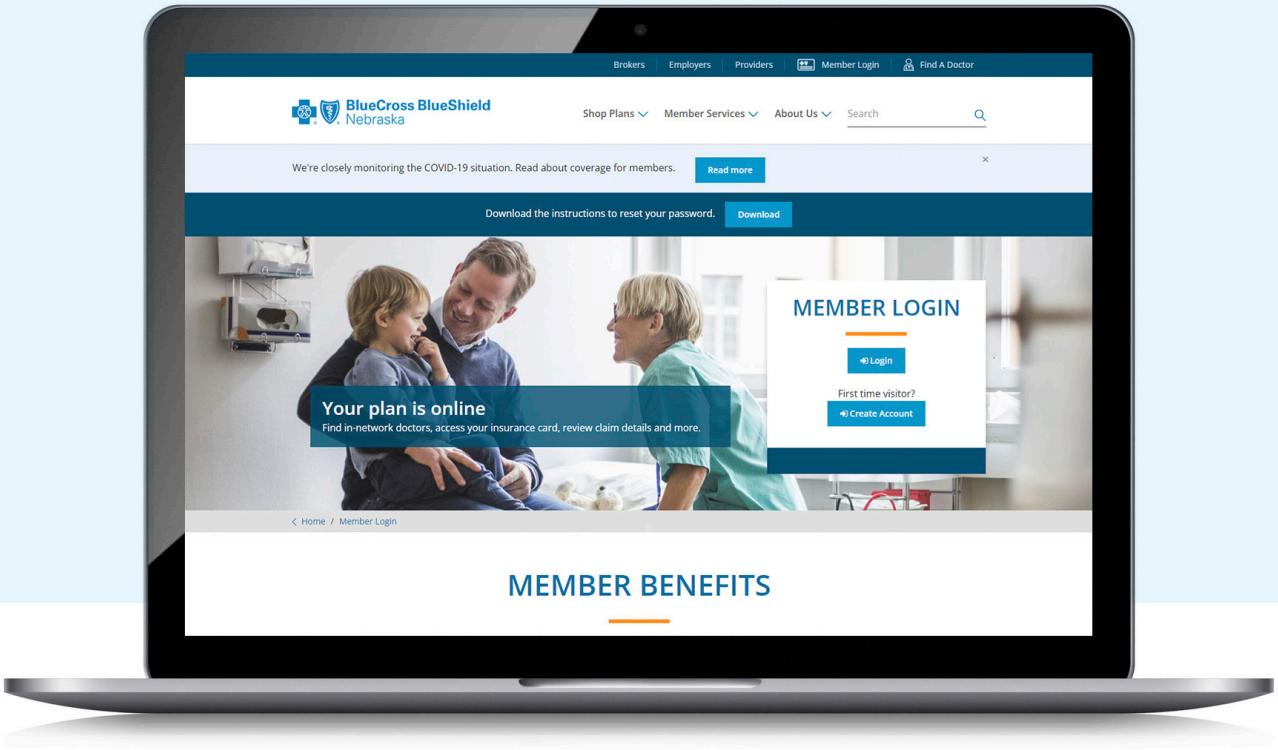
You'll see a full range of savings from top national and local retailers. Some discounts include:

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

There are no claims to file and no referrals or prior authorizations needed. After you've registered you can also sign up to receive weekly deals sent directly to your email.

Visit **NebraskaBlue.com/Blue365** to take advantage of these exclusive deals.

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



myNebraskaBlue.com

It only takes a few minutes to gain access to a wealth of online tools that offer you more control over your health plan and personal wellness. After signing up at myNebraskaBlue.com, you will instantly be able to access details about your insurance plan and track your spending.

With myNebraskaBlue, members can:

- Access claims details and status
- Find an in-network doctor or facility
- Track your health care spending
- View deductible and out-of-pocket limits
- Access pharmacy benefits
- Go paperless and order ID cards
- Manage your account - update your income level, report household changes
- Update billing information
- Access your member rewards program

Earn over $175 in Rewards!

Wellness Program

Get rewarded for making healthy choices

The Blue Cross and Blue Shield of Nebraska wellness program, powered by Vitality® provides tools and motivation to help you make healthy choices and forge your path to well-being.

Sign up through your **myNebraskaBlue.com** account and start earning rewards for focusing on your wellness! Once you're signed up, you can download the Vitality Today app to use the program while you're out and about.

As part of the Nebraska HeartlandBlue health plans, you will have free access to the Vitality platform. Vitality is a holistic, wellness-based program that rewards you for the everyday steps you take to live a longer and healthier life. You can earn over $175 in gift cards for the things you are already doing as well as adopting behaviors to help you live your best life.

Reach Goals Your Way

Everyone's wellness needs are different, which is why you can engage points in a variety of ways. Activities include taking self-paced online nutrition courses, tracking your workouts, completing preventive health exams and more.

Vitality is an independent company providing wellness services for Blue Cross and Blue Shield of Nebraska.

Care Management Programs

Included for free with your health plan, you have access to a team of health care professionals who can help maximize your benefits. They'll ensure you get the right care, at the right time, in the right place, no matter your goals.

DIABETES REVERSAL AND MANAGEMENT

Virta Type 2 Diabetes Reversal Program

Virta is a provider-led program that uses nutritional ketosis to naturally lower blood sugar and turn the body into a fat-burning machine. There is no surgery, exercise, or calorie counting. Virta provides an easy-to-use mobile and desktop app to get the help and support you need. The Virta program can be done from anywhere.

> Since, starting Virta I have lost 70 pounds, and my doctor has taken me off four of my medications.
>
> – Blue Cross and Blue Shield of Nebraska member

With Virta's personalized treatment plan, each member gets medical supervision from a physician-led care team, a one-on-one health coach, diabetes testing supplies, educational tools like videos and recipes, and a private online support community.

Nurse-Supported Prediabetes and Diabetes Education and Support

This diabetes program, supported by our nurse diabetes educators, is personalized to you and your family's specific needs.

Our nurses can help you:

- Lose weight and increase activity
- Lower your glucose and A1C levels
- Reduce or eliminate the need for diabetes medication
- Understand how to get the most of your health plan benefits
- Feel like yourself again – enjoy more stress-free time with family and friends

> Great news…A1C is 6.9. Yay! I am encouraged and it feels good that my work is showing up in measurable ways!
>
> – Blue Cross and Blue Shield of Nebraska member

NURSE-SUPPORTED CARE

If you need assistance with smoking cessation, managing chronic conditions or other challenges, we're here to help. With this program, you'll work with a nurse health coach who will offer personalized attention, customized to meet your individual wellness goals.

Virta is an independent company that provides diabetes management services to Blue Cross and Blue Shield of Nebraska.

CASE MANAGEMENT

Whether you were recently hospitalized, getting cancer treatment, or just need a little extra help with your health, our nurse care managers work one-on-one with you to get you the care you need.

PREGNANCY CARE

Whether you have a high-risk or healthy pregnancy, our labor and delivery nurses can help answer your questions and provide education, encouragement and support throughout your pregnancy. As part of the program, you will have access to a pregnancy tracking app designed to guide you through the exciting time and offers assistance maintaining a healthy pregnancy. In the app, you can chat with a nurse, receive appointment reminders and track medications.

MENTAL HEALTH

As part of our commitment to a holistic approach to mental health, you have access to resources that will enhance your health and well-being. Whether you want guidance for practicing self-care, need immediate crisis support or something in between, we are here to help.

At no cost to you, a team of nurses that collaborate and coordinate care for you and your family's mental and behavioral health needs:

- Navigate the mental and behavioral health system to find the right care and resources through your health plan benefits, group benefits like Employee Assistance Programs and other community resources
- Use a holistic approach to care – nurses can help with lifestyle changes, stress management techniques and coping strategies along with addressing any other health conditions like diabetes, heart and lung diseases, and many more
- Assesses social determinants of health to ensure you can get the care you need when you need it
- Advocates for you and works with your primary care physician

Eligibility and Enrollment Guidelines

Application for coverage is limited to initial or annual enrollment through an Open Enrollment Period or a Special Enrollment Period as stated below. Upon acceptance by BCBSNE of an application and payment of applicable premiums, coverage shall commence as follows:

Open Enrollment

The annual open enrollment period is Nov. 1 through Dec. 15. If you elect coverage during this time, you coverage will start on Jan. 1 of the upcoming year. Typically, the Open Enrollment period is extended to Jan. 15, if you elect coverage between Dec. 16 and Jan. 15, your coverage will start on Feb. 1.

Special Enrollment

If you have not previously enrolled for coverage, you may be able to enroll during a Special Enrollment Period (SEP). A Special Enrollment Period of 60 days is available if you have a qualifying life event. Including, but not limited to:

- **Loss of health coverage**
  - Losing existing health coverage, including job-based, individual and student plans
  - Losing eligibility for Medicare, Medicaid or CHIP
  - Turning 26 and losing coverage through a parent's plan
- **Changes in household**
  - Getting married or divorced
  - Having a baby or adopting a child
  - Death in the family
- **Changes in residence**
  - Moving to a different ZIP code or county
  - A student moving to or from the place they attend school
  - A seasonal worker moving to or from the place they both live and work
  - Moving to or from a shelter or other transitional housing
- **Other qualifying events**
  - Changes in your income that affect the coverage you qualify for
  - Gaining membership in a federally recognized tribe or status as an Alaska Native Claims Settlement Act (ANCSA) Corporation shareholder
  - Becoming a U.S. citizen
  - Leaving incarceration (jail or prison)
  - AmeriCorps members starting or ending their service
  - Please refer to CMS for a full listing qualifying events for on-exchange coverage. For off-exchange coverage, please discuss with your insurance broker or call 844-665-1121 to speak to one of our insurance experts.
  - Refer to Healthcare.gov for additional qualifying events.

DEPENDENT COVERAGE

Coverage is available for dependents, including your spouse and children up to age 26.

If you, as the policyholder are court-ordered to provide health coverage for stepchildren or other dependents who are not your natural-born or adopted children, a copy of the court order should be provided. Additionally, a signed dependency statement establishing the relationship between adult and child may be required in some cases.

Newborn Children

Coverage may begin at birth for your newborn child for 31 days free of charge. To add your child please visit **myNebraskaBlue.com** or call member services within 60 days of the date of birth. For single memberships, the coverage will change to a family membership as of the date of birth.

Adopted Children

Coverage for an adopted child will be effective on the date the child is placed with you for adoption or the date a court order grants custody to you, whichever is earlier. You must enroll the child within 60 days of the placement/custody order.

Grandchildren

Your grandchild(ren) are considered eligible dependents as long as they live with you (the subscriber) in a regular parent-child relationship and you provide financial support. The grandchild cannot receive any support or maintenance from the parent and you must be a court-appointed guardian. If the grandchild's parent is a covered dependent at the time of birth, you may add the grandchild for the first 31 days. After that, the grandchild must meet the above-referenced eligibility definition and provide documentation showing legal guardianship to continue the coverage.

Legal Guardianships

Guardianships are handled on a case-by-case basis and are subject to management review. The subscriber must be a court-appointed legal guardian; this does not include a foster child.

Other Caregiver Situations

Foster children, aged parents, brothers and sisters, etc., are not eligible even if they are eligible to be claimed for income tax purposes.

Disabled Dependents and Extension of Dependent Coverage

After the age of 25, a covered child will still be considered eligible for coverage if he or she is physically or mentally disabled and is dependent on you (the subscriber) for support and maintenance. Legislative Bill 551 (LB551) and Michelle's Law may apply to extend coverage beyond the age of 26 to the age of 30.

Call the member services number on the back of your member ID card to get these forms or visit **NebraskaBlue.com/Forms**.

If a child is institutionalized because of a disability, and if the cost of his/her maintenance is provided by public welfare, the child does not qualify as a dependent under the health insurance policy.

Child Only

Child-only coverage is available for children through the age of 19 as a single policy; child-only enrollment is only available during open enrollment or as a special enrollment period following effective date rules.

OVERVIEW OF AFFORDABLE CARE ACT

Essential Health Benefits

Individual health insurance policies sold beginning Jan. 1, 2014, must offer at least 10 essential health benefits. These essential health benefits, include:

1. Outpatient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Pediatric services, including dental and vision
10. Preventive and wellness services and chronic disease management

FREE-LOOK PROVISION

Once you have been accepted for coverage, we will issue a schedule of benefits (SOB), member ID cards and other fulfillment materials. You have 10 business days from the SOB mail date to contact us to cancel coverage and receive a full refund. This provision does not allow for changing an effective date. You may view your policy documents at **SBC.NebraskaBlue.com**.

PAYMENT OPTIONS

You may choose to have your monthly premium automatically withdrawn from your bank account or be billed direct on a monthly billing cycle. You may update your payment options through your myNebraskaBlue online account.

A grace period for late premium payment is outlined in the policy contracts.

If there are insufficient funds in your bank account on the regularly scheduled withdrawal date, a second withdrawal attempt will be made one to two days later. If there are still insufficient funds, the following month's debit will represent two months' premium unless it is your first payment, then, your coverage will terminate and you will have to go through the reinstatement process if eligible.

TERMINATIONS

You may terminate your coverage by notifying us in writing. If you enrolled in coverage through the Marketplace, you must terminate your coverage through the Marketplace.

Following receipt of your notification, your coverage will terminate on either the earlier of the end of the month in which the notice is received or the end of the period for which premiums have been paid.

For Marketplace coverage, your coverage will terminate on the date specified by the Marketplace. If you specify an earlier termination date when You send the notice of termination, the earlier date will be effective. Coverage may not, however, be terminated on a date earlier than our receipt of notification. In the event of termination by you, we will return the prorated unearned premium to you. Termination will not affect any claim for services provided prior to the date of termination.

Retroactive Terminations and Refunds

We will only allow a termination date prior to the date of notification if the termination is due to the death of the subscriber. This would need to be done by calling CMS.

Reformation or Rescission of Membership

If you or someone acting on your behalf commits an act of fraud or makes an intentional misrepresentation of material fact involving the application for coverage, or benefits payable under this coverage, we may make a premium adjustment or rescind the coverage.

The right of reformation applies to someone who is issued a contract at non-tobacco user rates when it is determined that the approval of such rate was based upon a material misrepresentation of the applicant's tobacco use. Documentation of tobacco use discovered in submitted claims will also be considered documented tobacco use and premiums will be adjusted accordingly. The tobacco surcharge is 10% starting at age 21.

The company limits its right of reformation or rescission to the first two years of coverage except for non-disclosed tobacco use or in cases where tobacco use starts or resumes.

A change in tobacco status can only be requested during Open Enrollment or during a Special Enrollment event.

Benefits and Responsibilities

General Information

Applications for coverage are subject to our approval.

Rate Renewal

Premium rates will be reviewed during the renewal period and adjusted each year. BCBSNE policies are rated by age, geographical area and tobacco use. We will notify you at least 30 days in advance of any premium change.

Types of Enrollment Available

Single Membership: Covers you only; this includes child-only policies.

Family Membership: Covers you and your eligible dependents. This may include your spouse and/or eligible dependent children to age 26.

Physically and mentally disabled children may be eligible for continuous coverage after age 26 if application is made within 31 days of the child's 26th birthday.

Child-Only Membership: Covers a child through age 19 as a single policy; child-only enrollment is only available during open enrollment or as a special enrollment period following effective date rules.

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.

Outpatient Hospital Benefits

Benefits for the covered services listed under Inpatient Hospital Benefits are also available (subject to certain limitations) when 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.

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 Visit Copays

When you go to a network primary care physician or specialist, you pay the policy's designated copay for an office visit. All other covered services received will be subject to the plans deductible and coinsurance.

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, family practice or mental health. All other types of physicians are considered specialists.

Benefits for Maternity and Newborn

Maternity coverage is included in Nebraska HeartlandBlue and is available to you, as well as covered spouses and dependent daughters. Benefits are available for the newborn for 31 days from the date of birth. To continue the newborn's coverage beyond this time period, you must request to add the newborn to the policy within the 60-day Special Enrollment Period.

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 Patient Protection and Affordable Care Act (PPACA) and will not be subject to cost-sharing requirements, such as copay, 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.
- Diagnostic services and surgery related to temporomandibular jaw joint (TMJ).

Benefits for Organ and Tissue Transplantation

Benefits are available for services associated with medically necessary organ and tissue transplantation, 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 Pediatric Dental Services

Pediatric dental services are available to members under the age of 19. Covered members will receive in-network benefits whenever they use dentists in our dental network.

Benefits for Pediatric Vision Services

Coverage for pediatric vision services is available for covered persons up to age 19.

Pediatric vision exclusions:

- Laser vision correction
- Visual therapy
- Replacement of lost or stolen eyewear
- Non-prescription and deluxe eyeglasses (athletic, safety and sunglasses)
- Vision prosthetic devices and related services
- Purchase of insurance on eyewear
- Color contact lenses

Pediatric Dental Covered Services	In Network	Out of Network
Type A Services Preventive and diagnostic dentistry	Deductible and Coinsurance	Not Covered
Type B Services Maintenance and simple restorative dentistry	Deductible and Coinsurance	Not Covered
Type C Services Complex restorative dentistry	Deductible and Coinsurance	Not Covered
Type D Services Orthodontic dentistry medical necessity required limited to metal braces only (after a 24-month waiting period)	Deductible and 70% Coinsurance	Not Covered

Pediatric Vision Covered Services	In Network	Out of Network
Vision Examination (including refraction and dilation, up to one exam per calendar year)	Deductible and Coinsurance	Not Covered
Eyeglass Frames/Lenses or Contacts (limited to one set of frames and eyeglass lenses per calendar year, or contact lenses per calendar year)	Deductible and 50% Coinsurance	Not Covered
Medically Necessary Contact Lenses* (in lieu of eyeglasses, includes evaluation and fitting)	Deductible and 50% Coinsurance	Not Covered

* If use of medically necessary contact lenses will result in significantly better visual and/or improved binocular function. Refer to contract for list of specific diseases.

NOTE: Contact lenses, including the evaluation and fitting requires Certification in excess of $600.

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.

Other Covered Services

(Please note: Limitations and exclusions apply.)

- Ambulance Services
- Diabetes outpatient self-management training and patient management from an approved provider
- Physical, occupational or speech therapy services, chiropractic or osteopathic physiotherapy
- Habilitative Services: Combined limit of 45 sessions per calendar year
- Rehabilitative Services: Combined limit of 45 sessions per calendar year
- Chiropractic or osteopathic manipulative treatments or adjustments (combined limit of 20 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 Nebraska HeartlandBlue health policies. For a complete listing, please refer to the contract.

No benefits are available for the following except for covered services provided as part of the preventive services benefit.

Services not covered by this contract:

- External and surgically implantable devices to improve hearing, including audient bone conductors, and hearing aids and their fitting
- Eye exercises or visual training
- Routine eye exam for members age 19 or older
- Eyeglasses or contact lenses for members age 19 and older
- Infertility treatment and related services, including artificial insemination, embryo transfer procedures, drug and/or hormonal therapy, reversal of voluntary sterilization, ultrasounds, lab work and other testing done in conjunction with fertility treatment
- 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

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 an 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 Only emergency services will be covered when an out-of-network or out-of-state facility is used.

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.

You are 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.

Glossary

Agent/Broker

A person or business who can help you determine your health care coverage needs and apply for coverage. They're also licensed and regulated by states and typically get payments, or commissions, from health insurers for enrolling a consumer into an issuer's plans. Some brokers may only be able to sell plans from specific health insurers.

Allowable Amount/Charge

An amount we use to calculate our payment of covered services. This amount will be based on the contracted amount for in-network providers or the out-of-network allowance and is the maximum amount that an in-network provider can charge for a covered service.

Bronze Health Plan

One of four plan categories (also known as "metallic levels") in the Marketplace. Bronze plans usually have the lowest monthly premiums but the highest costs when you get care.

Coinsurance

The percentage of the bill you pay for covered services after your deductible has been met.

Copay

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

Cost Share (sharing)

The share of costs covered by your health insurance plan that you pay out of pocket. This term generally includes deductibles, coinsurance, copays or similar charges, but it doesn't include premiums, balance billing amounts for out-of-network providers or the cost of noncovered services.

Cost Sharing Reduction (CSR)

A discount that lowers the amount you have to pay for deductibles, copays and coinsurance. In the Marketplace, cost-sharing reductions are often called "extra savings." If you qualify, you must enroll in a plan in the Silver category to get the extra savings.

When you fill out a Marketplace application, you'll find out if you qualify for premium tax credits and extra savings. You can use a premium tax credit for a plan in any metal category. But if you are eligible for extra savings, too, you'll get those savings only if you pick a Silver plan.

If you qualify for cost-sharing reductions, you also have a lower out-of-pocket maximum — the total amount you'd have to pay for covered medical services per year. After you reach your out-of-pocket maximum, your insurance plan covers 100% of all covered services.

If you're a member of a federally recognized tribe or an Alaska Native Claims Settlement Act (ANCSA) Corporation shareholder, you may qualify for additional cost-sharing reductions.

Deductible

The fixed dollar amount you pay for covered health services each plan/policy year before your insurance begins to pay.

Embedded

If you have an embedded deductible and out-of-pocket maximum your 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.

Emergency Care Services

Any covered services received in a hospital emergency room setting.

Essential Health Benefits (EHB)

A set of 10 categories of services health insurance plans must cover under the Affordable Care Act. These include doctors' services, inpatient and outpatient hospital care, prescription drug coverage, pregnancy and childbirth, mental health services and more. Some plans cover more services.

Exchange

Another term for the Marketplace, a service available in every state that helps individuals, families and small businesses shop for and enroll in affordable health insurance. The Marketplace is accessible through websites, call centers and in-person assistance.

Excluded or Noncovered Services

Services that your health insurance plan doesn't cover.

Exclusive Provider Organization (EPO)

A plan where services are covered only if you use doctors, hospitals and other health care providers in the plan's network (except in an emergency or as otherwise required by law). Outside of an emergency, there are no benefits for services received from out-of-network providers.

Gold Health Plan

One of four health plan categories (or "metallic levels") in the Marketplace. Gold plans usually have higher monthly premiums but lower costs when you get care.

Grace Period

A short period after your monthly health insurance payment is due. If you haven't made your payment, you may do so during the grace period and avoid losing your health coverage.

Health Insurance Marketplace®

A service, operated by the U.S. federal government, that helps people shop for and enroll in health insurance.

Health Reimbursement Arrangement (HRA)

Health Reimbursement Arrangements (HRA) are employer-funded accounts from which employees are reimbursed tax-free for qualified medical expenses up to a fixed dollar amount per year. Unused amounts may be rolled over to be used in subsequent years. The employer funds and owns the arrangement. Health Reimbursement Arrangements are sometimes called Health Reimbursement Accounts.

Health Savings Account (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.

In-network Providers

A provider contracted by your insurance company to accept an agreed-upon payment for covered services.

Open Enrollment Period (OEP)

The window of time you can purchase or renew your health insurance

Out-of-network Provider

A term for providers that aren't contracting with your insurance plan. Your out-of-pocket costs will tend to be more expensive if you go to an out-of-network provider.

Out-of-pocket Maximum

Your expenses for medical care that aren't reimbursed by your plan, including deductibles, coinsurance and copays for covered services.

Premium

The amount you're charged each month for your health insurance plan.

Prescription Drug List (PDL)/Formulary

A list of drugs covered by your prescription drug plan. Coverage of these drugs is subject to your benefit plan's design, and the list is subject to change.

Preventive Services

Routine health care that includes screenings and check-ups to prevent illness, disease or other health problems.

Primary Care Physician (PCP)

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.

Qualified High-Deductible Health Plan (HDHP)/ Health Savings Account (HSA)-eligible plan

A health plan that is health savings account (HSA)-eligible has a higher deductible than non-eligible plans. The premium is typically lower, but you will pay more upfront for medical costs (deductible) before your insurance plan starts to share in the costs (coinsurance). These plans can be combined with an HSA, allowing you to save and pay for certain medical expenses tax free.

Qualifying Life Event

A change in your life situation that makes you eligible for a special enrollment period (SEP) to enroll for coverage outside the standard open enrollment period (OEP). Qualifying life events include, but are not limited to, loss of health coverage, changes in family/household or changes in residence.

Silver Health Plan

One of four categories of Marketplace plans (sometimes called "metallic levels"). Silver plans fall about in the middle: You pay moderate monthly premiums and moderate costs when you need care.

Special Enrollment Period

The time outside of the open enrollment period (OEP) when you can enroll or make changes to your health plan if you have a qualifying life event (losing other health coverage, having a baby, getting married, moving, etc.).

Specialist

A physician who has a majority of his or her practice in fields other than internal or general medicine, obstetrics/gynecology, pediatrics or family practice.

Telehealth

A consultation with a health care provider in a remote setting (as opposed to an in-office, in-person visit), facilitated by video chat or phone. Many in-network providers offer their own telehealth options.

Notes

Ready to apply?

- Call one of our licensed sales reps at **844-665-1121**
- Visit **NebraskaBlue.com/HeartlandBlue**
- Apply through your insurance broker

No matter how you apply, you will be able to see if you qualify for premium assistance or extra savings.

BlueCross BlueShield Nebraska

NebraskaBlue.com

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