BlueEssentials

BlueCross BlueShield Nebraska

BENEFITS BROCHURE

Health Plans for Individuals and Families

BRONZE | SILVER | GOLD | CATASTROPHIC | COST SHARE REDUCTION*

**The BlueEssentials Silver and Gold options are not available in the following counties: Burt, Cass, Dodge, Douglas, Otoe, Sarpy, Saunders and Washington*

Count On Us to Be There

Blue Cross and Blue Shield of Nebraska

For over 75 years, Blue Cross and Blue Shield of Nebraska has been an important part of Nebraskans' lives. We provide health insurance coverage or benefits administration to nearly 700,000 people. We're a Nebraska-based company with our main office in Omaha and a satellite location in Lincoln.

What you Need to Know About Health Care Reform

BlueEssentials health insurance plans from Blue Cross and Blue Shield of Nebraska are compatible with The Affordable Care Act (ACA). One of the most significant changes implemented by ACA is that every health insurance plan for individuals and families will include **10 Essential Health Benefits** as defined by the federal government.

As a result of the Affordable Care Act:

- You may be eligible to get lower costs on your monthly health insurance premiums. Find out if you're eligible by applying online at healthcare.gov.
- Guaranteed coverage – Pre-existing conditions will be covered with no waiting periods. You can no longer be denied coverage or charged more due to pre-existing health conditions, including a pregnancy or disability.
- Most people are required to have health coverage. If they don't, they may have to pay a tax penalty.
- Open enrollment for ACA plans begins November 1, 2016. Coverage begins as early as January 1, 2016.

10 ESSENTIAL BENEFITS

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

Health Insurance Coverage Levels

To make it easier for you to compare health insurance plans, the government has set certain cost-sharing levels for individual health insurance plans and named each level in the following way:

COST-SHARING	BRONZE	SILVER	GOLD
Health insurance pays about this percentage of the insured's medical costs	60%	70%	80%
You are expected to pay this percentage through deductibles, copays and other cost-sharing features	40%	30%	20%

Another plan, called a Catastrophic plan, covers essential health benefits but has high deductibles. Only adults under 30 and individuals exempted from the individual mandate because they cannot find affordable insurance are allowed to purchase catastrophic plans. Catastrophic plans do not qualify for government cost assistance.

Native Americans and Alaskan Natives

If you are an eligible Native American or Alaskan Native as determined by the Health Insurance Marketplace (Exchange), you may be entitled to receive services from qualified Indian Health Care providers at no cost.

To learn more about eligibility, visit healthcare.gov. To apply, visit nebraskablue.com beginning November 1, 2015.

You should read your contract carefully.

This outline of coverage provides you with an overview of the Blue Cross and Blue Shield of Nebraska BlueEssentials health plan. This is not your contract. Only the actual benefit provisions in your contract determine your benefits. The contract itself sets forth in detail the rights and obligations of both you and Blue Cross and Blue Shield of Nebraska. In the event that there are discrepancies with the information in this document, the terms and conditions of the contract will govern.

For more complete information about your plan, including benefits, exclusions and limitations, please refer to the BlueEssentials contract.

About Enrollment Periods

These health insurance plans may be purchased:

- during the open enrollment period from November 1, 2015 through January 31, 2016
- during a special enrollment period after January 31, 2016 if you have a qualifying life event. An example of a qualifying life event is a change in your family size (for example, if you marry, divorce, have a baby, or become pregnant).

BlueEssentials is available both on and off the federal government's Health Insurance Marketplace.

BlueEssentials Health Plans

BlueEssentials health plans outlined here are designed to provide you with coverage for hospital, medical and surgical expenses incurred as the result of a covered illness or injury. Coverage includes the 10 essential health benefits required by federal health care law, including required preventive services.

The BlueEssentials Silver and Gold options are not available in the following counties: Burt, Cass, Dodge, Douglas, Otoe, Sarpy, Saunders and Washington.

About High-Deductible Health Plans (HDHPs)

Some BlueEssentials health plans are available as High-Deductible Health Plans (HDHPs). HDHPs work in combination with a health savings account (HSA) to help you save and pay for your health care and experience some tax benefits.

An HSA allows you to pay for qualified medical expenses such as your out-of-pocket costs for office visits, prescription drugs, dental expenses and laboratory tests on a tax-free basis. Contributions to an HSA are tax deductible and can earn tax-free interest. You decide how and when to use your HSA funds. For example, you may use your HSA to pay for your health care until you meet your health plan deductible or you may save the funds for future medical expenses. HSA distributions for non-medical expenses are subject to income tax.

- Many financial institutions, including banks, savings and loans and credit unions, offer HSAs.
- In general, any individual who is covered under a "high deductible health plan" is eligible to establish an HSA.
- You are not eligible for an HSA if you are covered by another health plan that is not a high-deductible plan or you are entitled to Medicare, or if you are a dependent on someone else's tax return.

Provider Networks

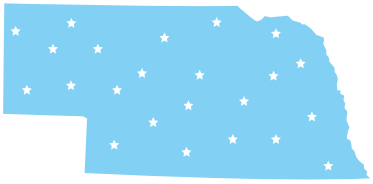
Statewide, Nationwide and Around the World

To locate NEtwork BLUE providers in Nebraska:

- Visit nebraskablue.com
- Or call the Member Services number on the back of your I.D. card.

To locate BlueCard PPO providers nationwide:

- Visit nebraskablue.com
- Or call (800) 810-2583



NEtwork BLUE

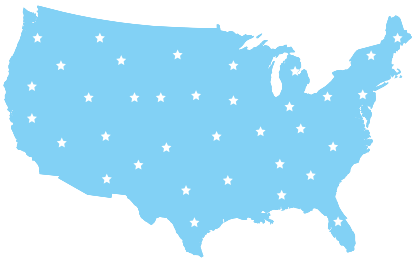
6,000+ Doctors across the state

3,000+ In-network doctors in Omaha

95 Hospitals and medical facilities in Nebraska

BlueCard® Program: Your National PPO Network

Access to benefits nationwide – all you have to do is use hospitals and doctors in the local Blue Cross Blue Shield Plan's PPO provider network.



BlueCard® Worldwide Program

Outside of the U.S., you have access to doctors and hospitals in nearly 200 countries and territories around the world.

BlueEssentials Plan Options

	BlueEssentials 4500 Bronze		BlueEssentials 3500 HSA Bronze		BlueEssentials 6450 HSA Bronze	
	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
Deductible						
Individual	$4,500	$9,000	$3,500	$7,000	$6,450	$12,900
Family	$9,000	$18,000	$7,000	$14,000	$12,900	$25,800
Type of Deductible	Embedded		Embedded		Embedded	
Coinsurance						
Hospital/medical/surgical/other	50%	50%	50%	50%	0%	0%
Out of Pocket Limit (includes deductible, coinsurance and copays)						
Individual	$6,850	$13,700	$6,450	$12,900	$6,450	$12,900
Family	$13,700	$27,400	$12,900	$25,800	$12,900	$25,800
Type of Out of Pocket Limit	Embedded		Embedded		Embedded	
Preventive Care						
Preventive Care Services	Plan pays 100%	Deductible and Coinsurance	Plan pays 100%	Deductible and Coinsurance	Plan pays 100%	Deductible
Physician Office						
Primary Care Physician Office	$60 office visit copay (2 per person per year then deductible and coinsurance)	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible	Deductible
Specialist Physician Office	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible	Deductible
Telehealth	$15 copay	Not covered	Deductible and Coinsurance	Not covered	Deductible	Not covered
Pregnancy and Maternity Services						
Pre/Post Natal Care and Delivery	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible	Deductible
Emergency Care						
Urgent Care Facility	$100 copay	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible	Deductible
Hospital Emergency Room	$300 copay + Deductible and Coinsurance◆	$300 copay + In-Network Deductible and Coinsurance◆	Deductible and Coinsurance	In-Network Deductible and Coinsurance	Deductible	In-Network Deductible
Inpatient Hospital	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible	Deductible
$250 of first Dollar Accident-related care, per person	Plan pays 100%	Plan pays 100%	Deductible and Coinsurance	Deductible and Coinsurance	Deductible	Deductible
Ambulance Services	Deductible and Coinsurance	In-Network Deductible and Coinsurance	Deductible and Coinsurance	In-Network Deductible and Coinsurance	Deductible	In-Network Deductible
Mental Illness and/or Substance Dependence and Abuse Services						
Inpatient	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible	Deductible
Outpatient	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible	Deductible
Office Services	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible	Deductible
Prescription Drugs						
Generic Drugs Tier 1 (lowest-cost generics)	Deductible and Coinsurance	In-Network Deductible and Coinsurance + 25% penalty	Deductible and Coinsurance	In-Network Deductible and Coinsurance + 25% penalty	Deductible	In-Network Deductible + 25% penalty
Generic Drugs Tier 2 (all other generics)	Deductible and Coinsurance	In-Network Deductible and Coinsurance + 25% penalty	Deductible and Coinsurance	In-Network Deductible and Coinsurance + 25% penalty	Deductible	In-Network Deductible + 25% penalty
Formulary Brand-name Drugs	Deductible and Coinsurance	In-Network Deductible and Coinsurance + 25% penalty	Deductible and Coinsurance	In-Network Deductible and Coinsurance + 25% penalty	Deductible	In-Network Deductible + 25% penalty
Non-Formulary Brand-name Drugs	Deductible and Coinsurance	In-Network Deductible and Coinsurance + 25% penalty	Deductible and Coinsurance	In-Network Deductible and Coinsurance + 25% penalty	Deductible	In-Network Deductible + 25% penalty
Specialty Drugs	Deductible and Coinsurance	Not covered	Deductible and Coinsurance	Not covered	Deductible	Not covered

◆ Copay waived if admitted within 24 hours for the same diagnosis

BlueEssentials Options

The BlueEssentials Silver and Gold options are not available in the following counties: Burt, Cass, Dodge, Douglas, Otoe, Sarpy, Saunders and Washington

	BlueEssentials 3000 Silver		BlueEssentials 2700 HSA Silver		BlueEssentials 1500 Gold	
	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
Deductible						
Individual	$3,000	$6,000	$2,700	$5,400	$1,500	$3,000
Family	$6,000	$12,000	$5,400	$10,800	$3,000	$6,000
Type of Deductible	Embedded		Embedded		Embedded	
Coinsurance						
Hospital/medical/surgical/other	20%	50%	20%	50%	20%	50%
Out of Pocket Limit (includes deductible, coinsurance and copays)						
Individual	$6,850	$13,700	$5,600	$11,200	$4,350	$8,700
Family	$13,700	$27,400	$11,200	$22,400	$8,700	$17,400
Type of Out of Pocket Limit	Embedded		Embedded		Embedded	
Preventive Care						
Preventive Care Services	Plan pays 100%	Deductible and Coinsurance	Plan pays 100%	Deductible and Coinsurance	Plan pays 100%	Deductible and Coinsurance
Physician Office						
Primary Care Physician Office	$30 copay	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	$20 copay	Deductible and Coinsurance
Specialist Physician Office	$60 copay	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	$30 copay	Deductible and Coinsurance
Telehealth	$15 copay	Not covered	Deductible and Coinsurance	Not covered	$10 copay	Not covered
Pregnancy and Maternity Services						
Pre/Post Natal Care and Delivery	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Emergency Care						
Urgent Care Facility	$100 copay	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	$75 copay	Deductible and Coinsurance
Hospital Emergency Room	$300 copay + Deductible and Coinsurance	$300 copay + In-Network Deductible and Coinsurance	Deductible and Coinsurance	In-Network Deductible and Coinsurance	$300 copay + Deductible and Coinsurance	$300 copay + In-Network Deductible and Coinsurance
Inpatient Hospital	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
$250 of first Dollar Accident-related care, per person	Plan pays 100%	Plan pays 100%	Deductible and Coinsurance	Deductible and Coinsurance	Plan pays 100%	Plan pays 100%
Ambulance Services	Deductible and Coinsurance	In-Network Deductible and Coinsurance	Deductible and Coinsurance	In-Network Deductible and Coinsurance	Deductible and Coinsurance	In-Network Deductible and Coinsurance
Mental Illness and/or Substance Dependence and Abuse Services						
Inpatient	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Outpatient	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Office Services	$30 copay	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	$20 copay	Deductible and Coinsurance
Prescription Drugs						
Generic Drugs Tier 1 (lowest-cost generics)	$5 copay	$5 copay + 25% penalty	Deductible and Coinsurance	In-Network Deductible and Coinsurance + 25% penalty	$5 copay	$5 copay + 25% penalty
Generic Drugs Tier 2 (all other generics)	$15 copay	$15 copay + 25% penalty	Deductible and Coinsurance	In-Network Deductible and Coinsurance + 25% penalty	$15 copay	$15 copay + 25% penalty
Formulary Brand-name Drugs	$50 copay	$50 copay + 25% penalty	Deductible and Coinsurance	In-Network Deductible and Coinsurance + 25% penalty	$50 copay	$50 copay + 25% penalty
Non-Formulary Brand-name Drugs	Deductible and Coinsurance	Deductible and Coinsurance + 25% penalty	Deductible and Coinsurance	In-Network Deductible and Coinsurance + 25% penalty	$95 copay	$95 copay + 25% penalty
Specialty Drugs	Deductible and Coinsurance	Not covered	Deductible and Coinsurance	Not covered	$285 copay	Not covered

◆ Copay waived if admitted within 24 hours for the same diagnosis

BlueEssentials Catastrophic Option

	BlueEssentials 6850 Catastrophic	
	In-network	Out-of-network
Deductible		
Individual	$6,850	$13,700
Family	$13,700	$27,400
Type of Deductible	Embedded	
Coinsurance		
Hospital/medical/surgical/other	0%	0%
Out of Pocket Limit (includes deductible, coinsurance and copays)		
Individual	$6,850	$13,700
Family	$13,700	$27,400
Type of Out of Pocket Limit	Embedded	
Preventive Care		
Preventive Care Services	Plan pays 100%	Deductible
Physician Office		
Primary Care Physician Office	$0 copay (3 per person per year, then deductible)	Deductible
Specialist Physician Office	Deductible	Deductible
Telehealth	$0 copay	Not covered
Pregnancy and Maternity Services		
Pre/Post Natal Care and Delivery	Deductible	Deductible
Emergency Care		
Urgent Care Facility	Deductible	Deductible
Hospital Emergency Room	Deductible	In-Network Deductible
Inpatient Hospital	Deductible	Deductible
$250 of first Dollar Accident-related care, per person	Plan pays 100%	Plan pays 100%
Ambulance Services	Deductible	In-Network Deductible
Mental Illness and/or Substance Dependence and Abuse Services		
Inpatient	Deductible	Deductible
Outpatient	Deductible	Deductible
Office Services	$0 copay	Deductible
Prescription Drugs		
Generic Drugs Tier 1 (lowest-cost generics)	Deductible	In-Network Deductible + 25% penalty
Generic Drugs Tier 2 (all other generics)	Deductible	In-Network Deductible + 25% penalty
Formulary Brand-name Drugs	Deductible	In-Network Deductible + 25% penalty
Non-Formulary Brand-name Drugs	Deductible	In-Network Deductible + 25% penalty
Specialty Drugs	Deductible	Not covered

Catastrophic Health Plan Option

Catastrophic plans are available only to adults under 30 and individuals exempted from the individual mandate because they cannot find affordable insurance.

The BlueEssentials 6850 Catastrophic health plan option outlined here is designed to provide you with coverage for hospital, medical and surgical expenses incurred as the result of a covered illness or injury. Coverage includes the 10 essential health benefits required by the federal health care law, including required preventive services.

BlueEssentials Cost Share Reduction Plan Options

Cost Share Reduction Plan Options

Cost share reduction plans are available only through the federally facilitated Marketplace at healthcare.gov. You must meet income requirements in order to qualify for these plans.

	BlueEssentials 3000 Silver (2250) 73%		BlueEssentials 3000 Silver (800) 87%		BlueEssentials 3000 Silver (325) 94%	
	On Marketplace		On Marketplace		On Marketplace	
	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
Deductible						
Individual	$2,250	$6,000	$800	$6,000	$325	$6,000
Family	$4,500	$12,000	$1,600	$12,000	$650	$12,000
Type of Deductible	Embedded		Embedded		Embedded	
Coinsurance						
Hospital/medical/surgical/other	20%	50%	20%	50%	10%	50%
Out of Pocket Limit (includes deductible, coinsurance and copays)						
Individual	$5,000	$13,700	$1,600	$13,700	$650	$13,700
Family	$10,000	$27,400	$3,200	$27,400	$1,300	$27,400
Type of Out of Pocket Limit	Embedded		Embedded		Embedded	
Preventive Care						
Preventive Care Services	0%	Deductible and Coinsurance	0%	Deductible and Coinsurance	0%	Deductible and Coinsurance
Physician Office						
Primary Care Physician Office	$30	Deductible and Coinsurance	$10 copay	Deductible and Coinsurance	$5 copay	Deductible and Coinsurance
Specialist Physician Office	$60	Deductible and Coinsurance	$25 copay	Deductible and Coinsurance	$10 copay	Deductible and Coinsurance
Telehealth	$10 copay	Not covered	$5 copay	Not covered	$5 copay	Not covered
Pregnancy and Maternity Services						
Pre/Post Natal Care and Delivery	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Emergency Care						
Urgent Care Facility	$100 copay	Deductible and Coinsurance	$100 copay	Deductible and Coinsurance	$100 copay	Deductible and Coinsurance
Hospital Emergency Room	$300 copay + Deductible and Coinsurance	$300 copay + Deductible and Coinsurance	$150 copay	$150 copay	$100 copay	$100 copay
Inpatient Hospital	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
$250 of first Dollar Accident-related care, per person	$250	$250	$250	$250	$250	$250
Ambulance Services	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Mental Illness and/or Substance Dependence and Abuse Services						
Inpatient	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Outpatient	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Office Services	$30 copay	Deductible and Coinsurance	$10 copay	Deductible and Coinsurance	$5 copay	Deductible and Coinsurance
Prescription Drugs						
Generic Drugs Tier 1 (lowest-cost generics)	$5 copay	$5 copay + 25% penalty	$5 copay	$5 copay + 25% penalty	$5 copay	$5 copay + 25% penalty
Generic Drugs Tier 2 (all other generics)	$15 copay	$15 copay + 25% penalty	$15 copay	$15 copay + 25% penalty	$15 copay	$15 copay + 25% penalty
Formulary Brand-name Drugs	$50 copay	$50 copay + 25% penalty	$50 copay	$50 copay + 25% penalty	$50 copay	$50 copay + 25% penalty
Non-Formulary Brand-name Drugs	Deductible and Coinsurance	Deductible and Coinsurance + 25% penalty	Deductible and Coinsurance	Deductible and Coinsurance + 25% penalty	Deductible and Coinsurance	Deductible and Coinsurance + 25% penalty
Specialty Drugs	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Not Covered

BlueEssentials Cost Share Reduction Plan Options

	HSA-Eligible		HSA-Eligible		HSA-Eligible	
	BlueEssentials 2700 Silver (1750) 73%		BlueEssentials 2700 Silver (650) 87%		BlueEssentials 2700 Silver (250) 94%	
	On Marketplace		On Marketplace		On Marketplace	
	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
Deductible						
Individual	$1,750	$5,400	$650	$5,400	$250	$5,400
Family	$3,500	$10,800	$1,300	$10,800	$500	$10,800
Type of Deductible	Embedded		Embedded		Embedded	
Coinsurance						
Hospital/medical/surgical/other	20%	50%	20%	50%	10%	50%
Out of Pocket Limit (includes deductible, coinsurance and copays)						
Individual	$5,000	$11,200	$1,300	$11,200	$600	$11,200
Family	$10,000	$22,400	$2,600	$22,400	$1,200	$22,400
Type of Out of Pocket Limit	Embedded		Embedded		Embedded	
Preventive Care						
Preventive Care Services	0%	Deductible and Coinsurance	0%	Deductible and Coinsurance	0%	Deductible and Coinsurance
Physician Office						
Primary Care Physician Office	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Specialist Physician Office	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Telehealth	Deductible and Coinsurance	Not covered	Deductible and Coinsurance	Not covered	Deductible and Coinsurance	Not covered
Pregnancy and Maternity Services						
Pre/Post Natal Care and Delivery	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Emergency Care						
Urgent Care Facility	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Hospital Emergency Room	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Inpatient Hospital	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
$250 of first Dollar Accident-related care, per person	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Ambulance Services	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Mental Illness and/or Substance Dependence and Abuse Services						
Inpatient	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Outpatient	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Office Services	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Prescription Drugs						
Generic Drugs Tier 1 (lowest-cost generics)	Deductible and Coinsurance	Deductible and Coinsurance + 25% penalty	Deductible and Coinsurance	Deductible and Coinsurance + 25% penalty	Deductible and Coinsurance	Deductible and Coinsurance + 25% penalty
Generic Drugs Tier 2 (all other generics)	Deductible and Coinsurance	Deductible and Coinsurance + 25% penalty	Deductible and Coinsurance	Deductible and Coinsurance + 25% penalty	Deductible and Coinsurance	Deductible and Coinsurance + 25% penalty
Formulary Brand-name Drugs	Deductible and Coinsurance	Deductible and Coinsurance + 25% penalty	Deductible and Coinsurance	Deductible and Coinsurance + 25% penalty	Deductible and Coinsurance	Deductible and Coinsurance + 25% penalty
Non-Formulary Brand-name Drugs	Deductible and Coinsurance	Deductible and Coinsurance + 25% penalty	Deductible and Coinsurance	Deductible and Coinsurance + 25% penalty	Deductible and Coinsurance	Deductible and Coinsurance + 25% penalty
Specialty Drugs	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Not Covered	Deductible and Coinsurance	Not Covered

Benefits and Responsibilities

BlueEssentials

General Information

Applications for coverage are subject to our approval. Coverage is available to Nebraska residents only.

The BlueEssentials Silver and Gold options are not available in the following counties: Burt, Cass, Dodge, Douglas, Otoe, Sarpy, Saunders and Washington

Rate Renewal

Premium rates will be reviewed during renewal period and adjusted each year. Blue Cross and Blue Shield of Nebraska plans are age-rated. Your rate for the entire year is based on your age as of the annual renewal date. We will notify you at least 30 days in advance of any premium change.

Types of Membership Available

SINGLE: Provides benefits for covered services provided to the primary policy holder only.

FAMILY: Provides benefits for covered services provided to the subscriber and his or her eligible dependents.

Eligible dependent children are defined as the member's dependent children through 25 years of age. Physically and mentally disabled children may be eligible for continuous coverage after age 25 if application is made within 31 days of the child's 26th birthday.

Family Premium Pricing

Family premiums will be calculated by adding together the premium for each parent, plus the premium for each covered child age 21 and older, plus the premium for each of the three oldest children under age 21.

EXAMPLE: The Smith Family

Frank, age 47
Janice, age 46
Sarah, age 24
Mandy, age 18
Tom, age 16
Rob, age 12
Jamie, age 10

Frank's premium and Janice's premium will be added together. Since Sarah is over age 21, her monthly premium will be added to the family amount. Finally, the premium for the three oldest children under 21 (Mandy, Tom and Rob) will be added to the family premium. Jamie will continue to be covered under the plan, but she won't factor into the calculation of the family's premium.

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 will generally be the lesser of the billed charge or the reasonable allowance for the service. You are responsible for the charges in excess of the contracted amount for services provided by a non-contracting provider.

Calendar Year Deductible

The deductible is the fixed dollar amount you pay for covered services each calendar year before benefits are available. There are individual and family deductibles.

Family Deductible

The family deductible is equal to two times the individual deductible, unless otherwise indicated on your plan contract. Family members may combine their covered expenses to satisfy the required deductible amount.

Coinsurance

Coinsurance is your share of the costs of a covered benefit. Coinsurance is always calculated as a percent of the allowed amount for the service. For example, if your plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20.

Copayment (Copay)

A copayment is a fixed dollar amount (for instance, $15) of the allowable charge you pay for a covered service. Copayments are separate from and do not accumulate toward the deductible.

For the BlueEssentials plan, deductibles, copays and coinsurance are shown on pages 5-9.

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 you are required to pay toward the cost of your health care. After your annual out-of-pocket limit is reached, your 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.

COMMITTED TO PROMOTING QUALITY CARE AND PATIENT SAFETY

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, please see page 16.*

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.

Outpatient pulmonary rehabilitation programs must be certified.

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

Supplemental Accident Benefit

The BlueEssentials plan pays up to $250 in benefits per person each calendar year for the care and treatment of injuries caused by an accident. Such benefits are not subject to deductible and coinsurance amounts. Covered services in excess of this benefit are subject to deductible and coinsurance amounts.

Note: The Supplemental Accident Benefit is not paid on high-deductible, HSA-eligible plans.

Physician Office Services

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

- X-ray, laboratory and pathology services performed in the physicians' office, including pap smears and mammograms due to Illness.
- Supplies used to treat the covered person during the office visit (not including durable medical equipment).
- Drugs administered by the physician during the office visit, except those drugs payable only under the Rx Nebraska Prescription Drug Program.
- Hearing exams due to Illness or Injury (non-routine/preventive).
- Eye exams due to Illness or Injury (non-routine/preventive), excluding refractions.
- Allergy testing, injections and serums.

Benefits for Pregnancy, Maternity and Newborn Care

Benefits are available for:

- Pregnancy, maternity and newborn care.
- Covered services for the newborn infant for a period of 31 days from the date of birth. To continue coverage for the child, a request must be made to enroll the child within the 60-day special enrollment period and any additional premium must be paid. The newborn infant will be subject to a separate, individual deductible for covered services.

Benefits For Mental Illness & 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 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 & Dentistry

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 Transplantion

Benefits are available for services associated with medically necessary organ and tissue transplantion, 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 Blue Cross and Blue Shield of Nebraska 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.

Benefits for Pediatric Dental Services

Pediatric dental services are available to members under the age of 19. Covered services include:

PEDIATRIC DENTAL SERVICES	IN-NETWORK	OUT-OF-NETWORK
Type A Services – Preventive and diagnostic dentistry	Deductible and Coinsurance	Deductible and Coinsurance
Type B Services – Maintenance and simple restorative dentistry	Deductible and Coinsurance	Deductible and Coinsurance
Type C Services – Complex restorative dentistry	Deductible and Coinsurance	Deductible and Coinsurance
Type D Services – Orthodontic Dentistry • 24 month wait imposed • Medical necessity required • Limited to metal braces only	Deductible, then Covered Person pays 70% Coinsurance	Deductible, then Covered Person pays 70% Coinsurance

The pediatric dental benefit offers one of the largest PPO dental networks in the nation. Covered members will receive in-network benefits whenever they use dentists in our dental network. This is a provider network of multiple Blue Cross and Blue Shield Plans that, when combined, offers members one of the largest PPO dental networks in the nation. It provides patients with lower out-of-pocket costs and broad access to participating dentists.

Find network providers in Nebraska and anywhere in the United States by visiting nebraskablue.com. Select "Find a Doctor."

Benefits for Pediatric Vision Services

Pediatric vision services are available to members under the age of 19. Covered services include:

PEDIATRIC VISION SERVICES	IN-NETWORK	OUT-OF-NETWORK
Vision Examination (including refraction and dilation, up to one exam per calendar year)	Deductible and Coinsurance	Deductible and Coinsurance
Eyeglass Frames/Lenses or Contacts (limited to one set of frames and eyeglass lenses per calendar year, or contact lenses per calendar year)	Deductible, then 50%Coinsurance	Deductible and Coinsurance
Medically Necessary Contact Lenses* (in lieu of eyeglasses, includes evaluation and fitting) NOTE: Contact lenses, including the evaluation and fitting requires Certification in excess of $600.	Deductible, then 50%Coinsurance	Deductible and Coinsurance

* *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.*

For the BlueEssentials Plus plan, deductibles and coinsurance are shown on pages 5-9.

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

The pediatric vision benefit uses NEtwork BLUE providers. For more information on NEtwork Blue, including how to locate providers, please see page 4.

Benefits for Prescription Drugs

Prescription drug coverage is available to Blue Cross and Blue Shield of Nebraska members under BlueEssentials coverage through our Rx Nebraska Prescription Drug Program.

Benefits are based on Blue Cross and Blue Shield of Nebraska's prescription drug list (formulary). A formulary is a list of prescription medications that Blue Cross and Blue Shield of Nebraska considers safe and cost effective for care. The formulary is updated regularly and communicated to physicians, pharmacists and members to encourage the use of the most cost-effective drug therapies.

To review the prescription drug list (formulary), visit nebraskablue.com. You may also call our Member Services Department at the number on the back of your Blue Cross and Blue Shield of Nebraska member ID card.

Prescription drugs are divided into the following five tiers:

Tier 1	Generic drugs – lowest-priced generics
Tier 2	Generic drugs – all other generics
Tier 3	Formulary brand-name drugs
Tier 4	Non-formulary brand-name drugs
Tier 5	Specialty drugs

Your copay for each 30-day supply of your covered prescription drug depends on the tier in which your medication is listed.

Note: Prescription drug copay amounts apply toward your out-of-pocket limit.

For the BlueEssentials plan, copays for each drug tier are shown on pages 5-9.

Retail Pharmacies

Take your prescription to a participating Rx Nebraska pharmacy and show the pharmacist your Blue Cross and Blue Shield of Nebraska I.D. card. Your copay is based on how your medication is classified (Tier 1 Generic drugs, Tier 2 Generic drugs, Formulary brand-name drugs, Non-formulary brand-name drugs or Specialty drugs).

Please note: Whenever appropriate, generic drugs will be used to fill your prescriptions. If you prefer a brand-name drug, even when a generic is appropriate, you will be responsible for the difference in cost plus the applicable copay amount.

To locate participating Rx Nebraska pharmacies nationwide, call toll-free **(877) 800-0746**.

If you have to file an Rx Nebraska claim form (for example, if you have the prescription filled at a non-participating pharmacy, or if you don't present your card at a participating pharmacy), you will be reimbursed the reasonable allowance for the drug less the applicable copayment and a 25% penalty. Copayment and penalty amounts do not apply toward the deductible or coinsurance maximum.

Mail Service

If you use the PrimeMail® Mail Service Program, you may order at one time a 90-day supply of your maintenance medication by paying the applicable copay amount for each 30-day supply.

BlueEssentials coverage includes preauthorization programs for COX-2 drugs and Proton Pump Inhibitors. These programs help Blue Cross and Blue Shield of Nebraska members manage the monetary costs involved with the use of these drugs. Please refer to your contract for more information about these programs.

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 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
- Colorectal cancer screening

Refer to your contract for a complete listing.

Exclusions and Limitations

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

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

- Services determined by us to be not medically necessary
- Blood donor services
- Pregnancy assistance treatments, including infertility treatment and related services
- Artificial insemination; in vitro fertilization, fertility treatment and monitoring
- Services provided by a massage therapist
- Nutrition care, supplies, supplements or other nutritional substances, including Neocate, Vivonex and other over-the-counter supplements
- Radial keratotomy or any other procedures/alterations of the refractive character of the cornea to correct myopia and/or astigmatism
- Services we consider to be investigative, experimental, cosmetic or obsolete
- Services, drugs, medical supplies, devices or equipment which are not cost effective compared with established alternatives or which 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 related to military service
- Services provided for, or related to, sex transformation surgery
- Pediatric dental or vision care services required by the ACA, for covered persons age 19 and over
- 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 the contracted amount
- Charges made separately for services, supplies and materials we consider to be included within the total charge payable
- Treatment and monitoring for weight reduction/obesity, including surgical procedures
- Screening eye exams, refractions, eyeglasses, contact lenses, eye exercises or visual training (unless covered services under the pediatric vision benefit)

Certification Requirements

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

All inpatient hospital admissions must be certified by Blue Cross and Blue Shield of Nebraska. 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, Blue Cross and Blue Shield of Nebraska must be notified by you or your 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 medically necessary will be denied. If you choose to have these services performed even though we are unable to certify the medical necessity of the services, you will be responsible for the charges.

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

Telehealth Services

Telehealth services allow BCBSNE members and U.S. board certified, licensed and credentialed providers to come together online for live, immediate healthcare encounters. Members can access care from the comfort and convenience of their home or workplace (where permitted by law) by using two-way video, audio, secure text chat and/or the phone.

This new service is:

- **Affordable:** Cost depends on your plan
- **Dependable:** 24/7/365 access
- **Convenient:** No appointment needed and ePrescriptions if you need one*
- **Confidential:** Private and secure, HIPAA-compliant

Available 1/1/16 or upon your group's renewal.

* Note: Telehealth is available in most states, but some states do not allow telehealth or eprescriptions. For a full list, visit: info.americanwell.com/where-can-i-see-a-doctor-online.

BCBSNE members can experience online, live interaction with providers

Discounts

Vision Care Discount*

10% Discount on routine eye exams

17.5% Discount on frames, lenses, and contacts

Hearing Care Discount*

10% Discount on routine hearing exams

10% Discount on hearing aids

Tobacco-Free Discount

To find participating providers, visit nebraskablue.com or your *my*blue account.

* Must show Blue Cross and Blue Shield of Nebraska I.D. Discount program only. No claims are filed. Participating providers must be used.

Online Member Services

Manage Your Health Care Whenever It's Convenient

At Blue Cross and Blue Shield of Nebraska, we think everyone should be able to understand their health insurance, so they can make better decisions about their health. So we created myblue – a self-service website that makes sense of your medical bills and health care spending – all in one place at mynebraskablue.com.

- Track your health care spending
- Get a secure view of your bills and benefits
- Find a doctor close to work or home
- Make smart health care decisions
- Contact Member Services online

Visit mynebraskablue.com today, and see how it can help you manage your health care dollars.

Blue365®

We understand helping you live a healthy life means more than regular doctor visits—it's helping you find time for the things that matter most. Blue365 is a national program that gives you exclusive access to discounts and savings that make it easier and more affordable to make healthy choices.

Blue365 features savings on select products and services you can use to improve and maintain your health every day.

Explore the special offerings from leading national companies in the following categories:

- Fitness
- Healthy Eating
- Personal Care

Plus, join the Blue365 e-mail list and you'll receive weekly deals on healthy products, along with discounts on health and fitness clubs, weight-loss programs, and much more. Learn more at nebraskablue.com.

MyPrime®

MyPrime, from Blue Cross and Blue Shield of Nebraska's pharmacy benefits manager, Prime Therapeutics, Inc., is loaded with valuable information and interactive tools that you can use to manage your prescription drug purchases.

At MyPrime, you can find benefit information, prescription drug information and other resources.

To access the personalized information available via MyPrime, you must be a registered Online Member Services user. Simply visit nebraskablue.com and enter your Member ID as it appears on your ID card (e.g.YEP123456789). Then sign in to our Online Member Services Website to view your personal pharmacy information.

Questions about MyPrime?
Call (877) 794-3574.

Glossary

The Affordable Care Act (ACA): Signed into law by President Obama in 2010, the Affordable Care Act puts in place comprehensive health insurance reforms and strong consumer protections that will roll out over several years. It was designed to improve quality access to healthcare and reduce costs. It also comes with some changes for individual consumers and for employers offering health insurance to their employees.

Allowable Charge: An amount we use to calculate our payment of covered services. This amount will be based on either the Contracted Amount for In-network Providers or the Out-of-network Allowance.

Coinsurance: The percentage amount the covered person must pay for covered services.

Copayment (copay): A fixed dollar amount of the allowable charge, payable by the covered person for a covered service. Copayments are separate from and do not accumulate to the deductible.

Deductible: An amount of allowable charges that must be paid by the covered person each calendar year for Covered Services before benefits are payable by the contract.

Emergency Care: Any Covered Services provided in a hospital emergency room setting.

Hospice: A program of care provided for persons diagnosed as terminally ill, and their families.

In-network Hospital, Physician or other Provider: A licensed practitioner of the healing arts, a licensed facility or other qualified provider of health care services who has contracted with us to provide services as a part of a preferred provider network in Nebraska.

Inpatient: A patient admitted to a hospital or other institutional facility for bed occupancy to receive services consisting of active medical and nursing care to treat conditions requiring continuous nursing intervention of such an intensity that it cannot be safely or effectively provided in any other setting.

Marketplace (Exchange): An exchange is an online marketplace where individuals and small businesses can compare and buy affordable health insurance plans. Exchanges will be available online beginning on November 1, 2015. Insurance plans purchased through the exchanges before December 15, 2015 will become effective beginning on January 1, 2016.

Mental Illness: A pathological state of mind producing clinically significant psychological or physiological symptoms (distress) together with impairment in one or more major areas of functioning (disability) wherein improvement can reasonably be anticipated with therapy, and which is a condition listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM IV, or any subsequent version).

Noncovered Services: Services that are not payable under the contract.

Out-of-network Provider: A provider of health care services who has not contracted with us to provide services as a part of the preferred provider network in Nebraska.

Out-of-Pocket Limit: The maximum amount of cost-sharing each covered person and/or membership unit must pay in a calendar year before benefits are payable without application of a cost-share amount. The out-of-pocket limit includes deductible, coinsurance and copayment amounts for medical and pharmacy services. The out-of-pocket limit does not include premium amounts, amounts over the allowable charge, charges for noncovered services, or penalties for failure to comply with certification requirements or as imposed under the Rx Nebraska Prescription Drug Program.

Outpatient: A person who is not admitted for Inpatient care, but is treated in the outpatient department of a hospital, in an observation room, in an ambulatory surgical facility, urgent care facility, a physician's office, or at home. Ambulance services are also considered outpatient.

Participating Provider: A licensed practitioner of the healing arts, or qualified provider of health care Services, who is a participating provider in the BlueCard Program.

Physician: Any person holding an unrestricted license and duly authorized to practice medicine and surgery and prescribe drugs.

Preferred Provider: A health care provider (hospital, physician or other health care provider) who has contracted to provide services as part of the network in Nebraska, or if in another state, who is a preferred provider with the BlueCard Program PPO network.

Premium: The amount that must be paid to the health insurance company in exchange for coverage.

Primary Care Physician: 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.

Skilled Nursing Care: A level of care that includes services that can only be performed safely and correctly by a licensed nurse (either a registered nurse or a licensed practical nurse).

Special Enrollment Period: A period of time during which an individual is allowed to enroll because of a loss of coverage, an adoption, placement for adoption, birth or marriage, without being considered a late enrollee, subject to certain criteria as further described in the contract.

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

Substance Dependence and Abuse: For purposes of the contract, this term is limited to alcoholism and drug abuse.

Urgent Care Facility: A facility, other than a hospital, that provides covered health services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen sickness, injury or the onset of acute or severe symptoms.

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