NBA BENEFIT PLANS

$3,500 High Deductible Health Plan

Schedule of Benefits Summary

Effective January 1, 2024

NBA Benefit Plans

BlueCross BlueShield Nebraska

An independent licensee of the Blue Cross and Blue Shield Association

NBA BENEFIT PLANS CONTACTS

Please note: This Schedule of Benefits Summary is intended to provide you with a brief overview of your benefits. It is not a contract and should not be regarded as one. In the event there are discrepancies between this document and the contract, the terms and the conditions of the contract will govern.

For more information about the NBA Benefit Plans and to access additional copies of the Benefits Summaries and the Benefit Coordinator login, visit **nebankers.org/benefit-plans**.

Phone: (888)-419-8322 or (402)-474-4376

For questions in their respective areas of expertise, please contact:

Karen (KC) Coufal | Vice President

- Assists members in the claim adjudication process whenever necessary and works closely with the insurance carrier personnel on enrollment changes and/or claims issues
- Emails pertinent information to members relating to carrier coverage updates
- Coordinates preparations for NBA VEBA Board meetings
- Oversees and manages activities related to the NBA Benefit Plans program
- Supervises Assistant Vice President (Jennifer) and Billing/Accounting Coordinator (James)

Jennifer Muehlhausen | Assistant Vice President-Active Enrollment

- Administrative assistance: New enrollment and enrollment changes; carrier liaison
- Enrollment and eligibility: Health, Dental, Vision, Life and Disability
- Online Portal: Assistance, training and navigation
- Life and Disability claims
- Bank Coordinator training

James Strickland | Billing/Accounting Coordinator

- Annual and monthly bank billing statements
- Accounts receivable and payable processes: Deposits, issuing checks, balancing bank statements and all month-end and year-end procedures
- Terminations and liaison with Navia on COBRA administration
- Active enrollment for the AD&D and Supplemental Benefits programs
- Back-up for active enrollment activities: Health, Dental, Life and Disability coverages

Kathy Reiss | Member Bank Education Coordinator

- NBA-member bank liaison: visits member banks across Nebraska to explain current benefits and promote additional benefits to Bank Coordinators and CEO/President
- Educate member banks about methods to maximize cost savings from NBA Benefit Plans
- Obtain feedback from Bank Coordinators and upper management on how they can be better served by the NBA Benefit Plans program

Scott Yank | Executive Vice President & CFO, NBISCO

- Oversees all operations of Nebraska Bankers Insurance & Services Corporation (NBISCO), including NBA Benefit Plans
- Oversees the financial operations of NBA and related organizations
- Ensures the compliance of NBA Benefit Plans
- Coordinates discussions between NBA Benefit Plans and NBA VEBA Board

Covered Services are reimbursed based on the allowable charge. Blue Cross and Blue Shield of Nebraska In-Network Providers have agreed to accept the benefit payment as payment in full, not including deductible and/or coinsurance amounts and any charges for non-covered services, which are the covered person's responsibility. That means that In-Network Providers, under the terms of their contract with Blue Cross and Blue Shield, can't bill for amounts over the contracted amount. In some situations, Out-of-Network Providers can bill for amounts over the out-of-network allowance.

In-Network Provider: The provider network is shown on your I.D. card. For help in locating In-Network Providers, visit **NebraskaBlue.com/Find-a-Doctor**.

Payment for Services	In-Network Provider	Out-of-Network Provider
Deductible (the amount the covered person pays each calendar year for covered services before the coinsurance is payable)		
• Individual	$3,500	$7,000
• Family (Aggregate*)	$7,000	$14,000
Coinsurance (the percentage amount the covered person must pay for most covered services after the deductible has been met)		
• Covered person pays	0%	30%
• Plan pays	100%	70%
Out-of-Pocket Limit (includes: deductible, coinsurance and copays; does not include premium, penalty and amounts not covered by the plan)		
• Individual	$3,500	$9,000
• Family	$7,000	$18,000

In-network and out-of-network deductible and out-of-pocket limits cross accumulate. All other limits (days, visits, sessions, dollar amounts, etc.) do cross accumulate between in-network and out-of-network, unless noted differently.

Day, session or visit limits for certain services shown on this summary are not applicable to mental illness and/or substance dependence and abuse.

Once the annual out-of-pocket limit is reached, most covered services are payable by the plan at 100% for the rest of the calendar year.

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

Copayment(s) [copay(s)] apply to:
- This plan has no medical or prescription drug copays.

Services may require preauthorization. Failure to obtain preauthorization will result in a denial of benefits.

Covered Services – Illness or Injury	In-Network Provider	Out-of-Network Provider
Physician Office • Primary care physician office visit • Specialist physician office visit • Physician office services provided in the office (with or without an office visit)	Deductible Deductible Deductible	Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance
• Allergy injections and serum	Deductible	Deductible and Coinsurance
• Other injections	Deductible	Deductible and Coinsurance
Convenient Care/Retail Clinics (Quick Care)	Same as a primary care physician	Deductible and Coinsurance
Urgent Care Facility Services	Deductible	Deductible and Coinsurance
Telehealth/Virtual Care Services • Medical • Mental health	Deductible See mental health and/or substance use disorder services	Not covered Not covered
Emergency Room Services (services received in a hospital emergency room setting) • Facility • Professional Services	Deductible Deductible	In-network level of benefits In-network level of benefits
Outpatient Hospital or Facility Services Services such as surgery, laboratory and radiology, cardiac and pulmonary rehabilitation, observation stays, and other services provided on an outpatient basis	Deductible	Deductible and Coinsurance
Inpatient Hospital or Facility Services Charges for room and board, diagnostic testing, rehabilitation and other ancillary services provided on an inpatient basis	Deductible	Deductible and Coinsurance
Orthopedic Specialty Hospital or Facility Services	Deductible	Deductible and Coinsurance
NOTE: Coinsurance may be waived if covered services are provided at a designated preferred Center. See **NebraskaBlue.com/PreferredCenters** for a list of covered services and designated hospitals.		

Primary care physician is a physician who has a majority of his or her practice in internal or general medicine, obstetrics/gynecology, general pediatrics or family practice. A **physician assistant** is covered in the same manner as a primary care physician.

Specialist physician is a physician who is not a primary care physician.

Office visit benefits for primary care and specialist physician office visits include office visits (including the initial visit to diagnose pregnancy) and consultations.

Physician office services include but are not limited to: office visits, X-ray, laboratory and pathology services; allergy testing, injections and serums; supplies and/or drugs administered during the office visit; hearing exams or eye exams due to illness or injury excluding refractions.

Other covered services not part of the physician office benefit (refer to the appropriate category for benefit information) include: Advanced diagnostic imaging (CT, MRI, MRA, MRS, PET and SPECT scans and other nuclear medicine); pregnancy services, preventative services; radiation therapy and chemotherapy; surgery and anesthesia; therapy and manipulations; durable medical equipment; sleep studies; biofeedback; mental health and substance use disorders.

Preventative Services	In-Network Provider	Out-of-Network Provider
Preventative Services • Affordable Care Act (ACA) required preventative services may be subject to limits that include, but are not limited to, age, gender and frequency) • ACA required covered preventative services (outside of limits) • Other covered preventative services not required by ACA, such as: o Laboratory tests as specified by Us, including urinalysis and complete blood count; general health panel; metabolic panel; prostate cancer screening (PSA) and hearing exams o All other laboratory tests; radiology, cardiac stress tests; EKG; pulmonary function and other screenings and services	Plan pays 100% Plan pays 100% Plan pays 100% Plan pays 100%	Plan pays 100% Plan pays 100% Plan pays 100% Plan pays 100%
Immunizations • Pediatric (up to age 7) • Age 7 and older • Related to an illness	Plan pays 100% Plan pays 100% Same as any other illness	Plan pays 100% Plan pays 100% Same as any other illness
Colorectal Cancer Screenings (starting at age 45) • Colonoscopy screening o Diagnostic or preventative screening (one every five years) o Screenings outside the age or frequency limit • Sigmoidoscopy/Proctoscopy screening o Preventative Screening (one every five years) o Screenings outside the age or frequency limit • Barium enema, fecal occult blood tests, FIT DNA, CT of the colon and other tests as determined under ACA Preventative Services o Preventative services o Diagnostic screenings	Plan pays 100% Same as any other illness Plan pays 100% Same as any other illness Plan pays 100% Same as any other illness	Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance
NOTE: Related services will pay in the same manner as the colorectal cancer screening when performed on the same date of service. Screening limits accumulate based on a calendar year.		

Mental Illness and/or Substance Dependence and Abuse Covered Services	In-Network Provider	Out-of-Network Provider
Inpatient Services	Deductible	Deductible and Coinsurance
Outpatient Services • Office services • Telehealth/virtual care services • All other outpatient items & services	 Deductible Deductible Deductible	 Deductible and Coinsurance Not covered Deductible and Coinsurance
Office services include office visits, medication checks, psychological therapy and/or substance use disorder counseling, x-rays, laboratory tests, supplies and/or drugs administered during the office visit. **Other covered services not part of the office benefit service are covered under all other outpatient items & services.** This includes but is not limited to: psychological evaluations, assessments, testing, physical therapy, occupational therapy, speech therapy or any other covered mental health and/or substance use disorder services.		
Emergency Care Services (services received in a hospital emergency room setting) • Facility • Professional services	 Deductible Deductible	 In-network level of benefits In-network level of benefits

Other Covered Services – Illness or Injury	In-Network Provider	Out-of-Network Provider
Acupuncture	Not covered	Not covered
Advanced Diagnostic Imaging (CT, MRI, MRA, MRS, PET & SPECT scans and other nuclear medicine)	Deductible	Deductible and Coinsurance
Ambulance (to the nearest facility for appropriate care) • Ground ambulance • Air ambulance	 Deductible Deductible	 In-network level of benefits In-network level of benefits
Autism Spectrum Disorder • Testing and diagnosis • Treatment	 Same as mental health Same as mental health	 Same as mental health Same as mental health
Biofeedback	Deductible	Deductible and Coinsurance
Dermatological Services	Same as any other illness	Same as any other illness
Diabetic Services Services include education, self-management training, podiatric appliances and equipment	Deductible	Deductible and Coinsurance
Durable Medical Equipment and Supplies (including Prosthetics) (rental or purchase, whichever is least costly; rental shall not exceed the cost of purchasing)	Deductible	Deductible and Coinsurance
Hearing Services • Bone anchored hearing aids • Cochlear implants • Hearing aids (up to age 19, limited to $3,000 every 48 months)	 Deductible Deductible Deductible	 Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance
Home Health Care Services • Home health aide (limited to 60 days per calendar year) • Home infusion therapy • Skilled nursing care (limited to 8 hours per day) • Respiratory care (limited to 60 days per calendar year)	 Deductible Deductible Deductible Deductible	 Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance
Hospice Services	Deductible	Deductible and Coinsurance
Independent Laboratory • Diagnostic • Preventative	 Deductible Same as preventative services in-network level of benefits	 In-network level of benefits Same as preventative services in-network level of benefits
Infertility • Services to diagnose • Treatment to promote fertility	 Same as any other illness Not covered	 Same as any other illness Not covered

Other Covered Services – Illness or Injury	In-Network Provider	Out-of-Network Provider
Nicotine Addiction • Medical services and therapy • Nicotine addiction classes & alternative therapy, such as acupuncture	Same as substance use disorder services Not covered	Same as substance use disorder services Not covered
Obesity • Non-surgical treatment • Surgical treatment	Not covered Deductible	Not covered Deductible and Coinsurance
Oral Surgery and Dentistry Services such as: impacted wisdom teeth; incision and drainage of abscesses; excision of tumors and cysts; and bone grafts to the jaw IV sedation for oral surgery and to remove impacted teeth. Dental treatment when due to an accidental injury to naturally healthy teeth (treatment related to accidents must be provided within 12 months of the date of injury)	Deductible	Deductible and Coinsurance
Organ and Tissue Transplantation	Deductible	Deductible and Coinsurance
Ostomy Supplies	Deductible	Deductible and Coinsurance
Physician Professional Services Inpatient and outpatient services, such as: surgery, surgical assistant, anesthesia, inpatient hospital visits and other non-surgical services	Deductible	Deductible and Coinsurance
Pregnancy, Maternity and Newborn Care • Pregnancy and maternity (payment for prenatal and postnatal care is included in the payment for the delivery) • Newborn care (Newborns are covered at birth, subject to the plan's enrollment provisions.)	Deductible Deductible	Deductible and Coinsurance Deductible and Coinsurance
NOTE: The plan pays 100% for the initial postpartum depression screening up to one year following a pregnancy or childbirth.		
Radiation Therapy and Chemotherapy	Deductible	Deductible and Coinsurance
Radiology (X-ray) Services and other Diagnostic Test	Deductible	Deductible and Coinsurance
Rehabilitation Services – Inpatient Facility	Deductible	Deductible and Coinsurance

Other Covered Services – Illness or Injury	In-Network Provider	Out-of-Network Provider
Rehabilitation Services • Cardiac rehabilitation (limited to 18 sessions per diagnosis) • Pulmonary rehabilitation (Chronic lung disease is limited to 18 sessions per diagnosis, not to exceed 18 sessions per calendar year. Lung, heart-lung transplants and lung volume are limited to 18 sessions following renewal and prior to surgery plus 18 sessions within six months of discharge from hospital following surgery.)	Deductible Deductible	Deductible and Coinsurance Deductible and Coinsurance
Renal Dialysis	Deductible	Deductible and Coinsurance
Sexual Dysfunction	Deductible	Deductible and Coinsurance
Skilled Nursing Facility (limited to 60 days per calendar year)	Deductible	Deductible and Coinsurance
Sleep Studies	Deductible	Deductible and Coinsurance
Temporomandibular and Craniomandibular Joint Disorder	Deductible	Deductible and Coinsurance
Therapy & Manipulations • Physical, occupational or speech therapy services, chiropractic or osteopathic physiotherapy (combined limit to 60 sessions per calendar year) • Chiropractic or osteopathic manipulative treatments or adjustments (combined limit to 30 sessions per calendar year)	Deductible Deductible	Deductible and Coinsurance Deductible and Coinsurance
NOTE: Treatment limits stated for physical therapy, occupational therapy and speech therapy services are not applicable to treatment provided for mental health or substance use disorders. Evaluations are covered and do not apply to the combined calendar year limit.		
Vision Services • Eyeglasses or contact lenses (only covered if required because of a change in prescription as a result of intraocular surgery or ocular injury) must be within 12 months of surgery or injury • Vision Exam o Diagnostic (to diagnose an illness) o Preventative (routine exam including refraction) limited to one exam per calendar year	Deductible See physician office services Not covered	Deductible and Coinsurance See physician office services Not covered
Voluntary Abortions	Not covered (Unless necessary to safeguard the life of the woman, or that the unborn child's viability was threatened by continuation of the pregnancy)	
Wigs	Not covered	Not covered
All Other Covered Services	Deductible and Coinsurance	Deductible and Coinsurance

Prescription Drugs	In-Network Provider	Out-of-Network Provider
Retail – per 30-day supply • Preferred generic drugs (including non-formulary contraceptives)	Deductible	Deductible and 50% Coinsurance
• Non-preferred generic drugs	Deductible	Deductible and 50% Coinsurance
• Preferred brand name drugs	Deductible	Deductible and 50% Coinsurance
• Non-preferred brand name drugs	Deductible	Deductible and 50% Coinsurance
Home Delivery – per 30-day supply • Preferred generic drugs (including non-preferred contraceptives)	Deductible	Not covered
• Non-preferred generic drugs	Deductible	Not covered
• Preferred brand name drugs	Deductible	Not covered
• Non-preferred brand name drugs	Deductible	Not covered
Specialty Drugs (specialty drugs must be purchased through a designated pharmacy after one fill)		
• Preferred specialty	Deductible	Not covered
• Non-preferred specialty	Deductible	Not covered
Contraceptive Drugs • Preferred generic • Preferred brand name • Non-preferred generic • Non-preferred brand name	Plan pays 100% Plan pays 100% Same as any other generic drugs Same as any other non-preferred brand name drugs	50% Coinsurance 50% Coinsurance
Diabetic Insulin • Preferred generic • Preferred brand name • Non-preferred generic • Non-preferred brand name	Plan pays 100% Plan pays 100% Same as any other generic drugs Same as any other non-preferred brand name drugs	50% Coinsurance 50% Coinsurance
Infant Formulas*	Deductible	50% Coinsurance
Infertility (FDA approved prescription drugs to promote fertility)	Not covered	Not covered
Nicotine Addiction (FDA approved prescription drugs and over-the-counter nicotine addiction drugs and deterrents)	Plan Pays 100%	50% Coinsurance
Obesity (FDA approved prescription drugs)	Not covered	Not covered
This plan uses a prescription drug list (PDL). The PDL for this plan is PDL20, and the pharmacy network is Network C. You can find this prescription drug list and network listing on NebraskaBlue.com/Pharmacy. Or you may contact Member Services at the phone number on the back of your I.D. card.		

***Infant Formulas:** Infant Formulas are a category of drugs that are limited to: Neocate, Elecare, Cyclinex-1, Cyclinex 2, Pro Phree and Vivonex. Benefits are payable for these drugs. See the summary above.

ADDITIONAL BCBS RESOURCES

To access NBA Benefit Plans Blue Cross and Blue Shield (BCBS) forms, as well as additional resources and information, please visit:

nebankers.org/benefit-plans

From there, click on “BCBS Links” under the “Other Information” heading. Additional BCBS-member tools can be found in the myNebraskaBlue Online Resource Center.

In the BCBS Resource Center, you can:

- Find in-network providers and estimate costs of care
  - Search for doctors, hospitals and dentists
  - Locate in-network pharmacies and search covered medications
  - Estimate costs of medical services
- View your benefits details
  - Review your benefits, copays, coinsurance and out-of-pocket costs
  - Download your mobile or printable ID card
  - Manage medications and see prescription claim history
  - Set up home delivery for prescriptions
- View current costs and claims
  - Review your claims history and track claims status
  - Review your Explanation of Benefits (EOB) documents
  - Authorize access to others
  - Sign up for email notifications