A Guide to Your HEALTH BENEFITS

Nebraska Bankers Association Voluntary Employees' Beneficiary Association
Nebraska Bankers Association VEBA Group Insurance PPO Plans
$500 Deductible

(Effective Date: 01/01/2024)

NBA Nebraska Bankers Association

98-535 1/2024

Benefit Summary

Payment for Services	In-network Provider	Out-of-network Provider
Covered Services are reimbursed based on the Allowable Charge. Blue Cross and Blue Shield of Nebraska In-network Providers have agreed to accept the benefit payment as payment in full, not including Deductible, Coinsurance and/or Copayment amounts and any charges for non-covered Services, which are the Covered Person's responsibility. That means 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.		
Deductible (the amount the Covered Person pays each Calendar Year for Covered Services before the Coinsurance is payable) • Individual • Family (Embedded*)	 $500 $1,000	 $1,000 $2,000
Coinsurance (the percentage amount the Covered Person must pay for most Covered Services after the Deductible has been met) • Covered Person Pays • Plan Pays	 25% 75%	 50% 50%
Out-of-pocket Limit (Includes Deductible, Coinsurance and Copays) • Individual • Family (Embedded*)	 $2,500 $5,000	 $5,000 $10,000
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 Health and/or Substance Use Disorders. Once the annual Out-of-pocket Limit is reached, most Covered Services are payable by the plan at 100% for the rest of the Calendar Year.		
*Embedded – If you have single coverage, you only need to satisfy the individual Deductible and Out-of-pocket Limit amounts. If you have family coverage, no one family member contributes more than the individual amount. Family members may combine their covered expenses to satisfy the required family Deductible and Out-of-pocket amounts.		
Copayment(s) (copay(s)) apply to: • Prescription Drugs The Copay amount varies by the type of Covered Services. Refer to the appropriate category for benefit information.		
Services may require Preauthorization. Failure to obtain Preauthorization will result in denial of benefits.		

Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Physician Office Services		
• Primary Care Physician Office Visit	Deductible and Coinsurance	Deductible and Coinsurance
• Specialist Physician Office Visit	Deductible and Coinsurance	Deductible and Coinsurance
• Physician Office Services provided in the office (with or without an office visit)	Deductible and Coinsurance	Deductible and Coinsurance
• Allergy Injections and Serum	Deductible and Coinsurance	Deductible and Coinsurance
• Other Injections	Deductible and Coinsurance	Deductible and Coinsurance
Primary Care Physician is a physician who has a majority of his or her practice in internal or general medicine, obstetrics/gynecology, general pediatrics or family practice. A **physician assistant** is covered in the same manner as a Primary Care Physician. ***Specialist Physician*** is a physician who is not a Primary Care Physician. ***Office Visit Benefits*** for Primary Care and Specialist Physician Office Visit include office visits (including the initial visit to diagnose pregnancy) consultations and medication checks. ***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 Services Benefit (Refer to the appropriate category for benefit information) include:*** Advanced Diagnostic Imaging (CT, MRI, MRA, MRS, PET and SPECT scans and other Nuclear Medicine); Pregnancy Services; Preventive Services; Radiation Therapy and Chemotherapy; Surgery and Anesthesia; Therapy and Manipulations; Durable Medical Equipment; Sleep Studies; Biofeedback; Mental Health and Substance Use Disorders.		
Convenient Care/Retail Clinics (Quick Care)	Same as a Primary Care Physician	Deductible and Coinsurance
Urgent Care Facility Services	Deductible and Coinsurance	Deductible and Coinsurance
Telehealth/Virtual Care Services		
• Medical	Deductible and Coinsurance	Not Covered
• Mental Health	See Mental Health and/or Substance Use Disorder Services	Not Covered
Emergency Room Services (services received in a Hospital emergency room setting)		
• Facility	Deductible and Coinsurance	In-network level of benefits
• Professional Services	Deductible and Coinsurance	In-network level of benefits
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 and Coinsurance	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 and Coinsurance	Deductible and Coinsurance
Orthopedic Specialty Hospital or Facility Services	Deductible and Coinsurance	Deductible and Coinsurance
NOTE: Deductibles and Coinsurance may be waived if Covered Services are provided at a designated Preferred Center. See NebraskaBlue.com/PreferredCenters for a list of Covered Services and designated hospitals.		

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

Mental Health and/or Substance Use Disorder Services	In-network Provider	Out-of-network Provider
Inpatient Services	Deductible and Coinsurance	Deductible and Coinsurance
Outpatient Services		
• Office Services	Deductible and Coinsurance	Deductible and Coinsurance
• Telehealth/Virtual Care Services	Deductible and Coinsurance	Not Covered
• All Other Outpatient Items & Services	Deductible and Coinsurance	Deductible and Coinsurance
Office Services include office visits, medication checks, psychological therapy and/or substance use disorder counseling, x-rays, laboratory tests, supplies and/or drugs administered during the office visit. ***Other Covered Services not part of the Office Benefit Services are covered under All Other Outpatient Items & Services.*** This includes but is not limited to: psychological evaluations, assessments, testing, physical therapy, occupational therapy, speech therapy or any other covered Mental Health and/or Substance Use Disorder services.		
Emergency Care Services (services received in a Hospital emergency room setting)		
• Facility	Deductible and Coinsurance	In-network level of benefits
• Professional Services	Deductible and Coinsurance	In-network level of benefits
Other Covered Services – Illness or Injury	**In-network Provider**	**Out-of-network Provider**
Acupuncture	Not Covered	Not Covered
Advanced Diagnostic Imaging (CT, MRI, MRA, MRS, PET & SPECT scans and other Nuclear Medicine)	Deductible and Coinsurance	Deductible and Coinsurance
Ambulance (to the nearest facility for appropriate care)		
• Ground Ambulance	Deductible and Coinsurance	In-network level of benefits
• Air Ambulance	Deductible and Coinsurance	In-network level of benefits
Autism Spectrum Disorder		
• Testing and Diagnosis	Same as mental health	Same as mental health
• Treatment	Same as mental health	Same as mental health
Biofeedback	Deductible and Coinsurance	Deductible and Coinsurance
Dermatological Services	Same as any other illness	Same as any other illness
Diabetic Services Services include education, self-management training, podiatric appliances and equipment.	Deductible and Coinsurance	Deductible and Coinsurance
Durable Medical Equipment and Supplies (including Prosthetics) (rental or purchase, whichever is least costly; rental shall not exceed the cost of purchasing)	Deductible and Coinsurance	Deductible and Coinsurance
Hearing Services		
• Bone Anchored Hearing Aids	Deductible and Coinsurance	Deductible and Coinsurance
• Cochlear Implants	Deductible and Coinsurance	Deductible and Coinsurance
• Hearing Aids (up to age 19, limited to $3,000 every 48 months.)	Deductible and Coinsurance	Deductible and Coinsurance

Other Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Home Health Care Services		
• Home Health Aide (limited to 60 days per Calendar Year)	Deductible and Coinsurance	Deductible and Coinsurance
• Home Infusion Therapy	Deductible and Coinsurance	Deductible and Coinsurance
• Skilled Nursing Care (limited to 8 hours per day)	Deductible and Coinsurance	Deductible and Coinsurance
• Respiratory Care (limited to 60 days per Calendar Year)	Deductible and Coinsurance	Deductible and Coinsurance
Hospice Services	Deductible and Coinsurance	Deductible and Coinsurance
Independent Laboratory		
• Diagnostic	Deductible and Coinsurance	In-network level of benefits
• Preventive	Same as Preventive Services In-network level of benefits	Same as Preventive Services In-network level of benefits
Infertility		
• Services to Diagnose	Same as any other illness	Same as any other illness
• Treatment to Promote Fertility	Not Covered	Not Covered
Nicotine Addiction		
• Medical Services and Therapy	Same as Substance Use Disorder Services	Same as Substance Use Disorder Services
• Nicotine addiction classes & alternative therapy, such as acupuncture	Not Covered	Not Covered
Obesity		
• Non-Surgical Treatment	Not Covered	Not Covered
• Surgical Treatment	Deductible and Coinsurance	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 and Coinsurance	Deductible and Coinsurance
Organ and Tissue Transplantation	Deductible and Coinsurance	Deductible and Coinsurance
Ostomy Supplies	Deductible and Coinsurance	Deductible and Coinsurance
Physician Professional Services Inpatient and Outpatient services, such as, surgery, surgical assistant, anesthesia, inpatient hospital visits and other non-surgical services	Deductible and Coinsurance	Deductible and Coinsurance
Pregnancy, Maternity and Newborn Care		
• Pregnancy and maternity (Payment for prenatal and postnatal care is included in the payment for the delivery)	Deductible and Coinsurance	Deductible and Coinsurance
• Newborn care (Newborns are covered at birth, subject to the plan's enrollment provisions)	Deductible and Coinsurance	Deductible and Coinsurance
NOTE: The Plan pays 100% for the initial postpartum depression screening up to one year following a pregnancy or childbirth.		

Other Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Radiation Therapy and Chemotherapy	Deductible and Coinsurance	Deductible and Coinsurance
Radiology (X-ray) Services and Other Diagnostic Tests	Deductible and Coinsurance	Deductible and Coinsurance
Rehabilitation Services – Inpatient Facility	Deductible and Coinsurance	Deductible and Coinsurance
Rehabilitation Services • 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 referral and prior to surgery plus 18 sessions within six months of discharge from hospital following surgery.)	Deductible and Coinsurance Deductible and Coinsurance	Deductible and Coinsurance Deductible and Coinsurance
Renal Dialysis	Deductible and Coinsurance	Deductible and Coinsurance
Sexual Dysfunction	Deductible and Coinsurance	Deductible and Coinsurance
Skilled Nursing Facility (limited to 60 days per Calendar Year)	Deductible and Coinsurance	Deductible and Coinsurance
Sleep Studies	Deductible and Coinsurance	Deductible and Coinsurance
Temporomandibular and Craniomandibular Joint Disorder	Deductible and Coinsurance	Deductible and Coinsurance
Therapy & Manipulations • 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 and Coinsurance Deductible and Coinsurance	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 - Diagnostic (to diagnose an illness) - Preventive (routine exam including refraction) limited to one exam per calendar year	Deductible and Coinsurance 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)	$10 Copay	50% Coinsurance
• Non-preferred Generic Drugs	50% Coinsurance, $25 min Copay, $50 max Copay	50% Coinsurance
• Preferred Brand Name Drugs	25% Coinsurance, $25 min Copay, $50 max Copay	50% Coinsurance
• Non-preferred Brand Name Drugs	50% Coinsurance, $50 min Copay, $75 max Copay	50% Coinsurance
Home Delivery – per 30-day supply		
• Preferred Generic Drugs (including non-preferred contraceptives)	$10 Copay	Not Covered
• Non-preferred Generic	50% Coinsurance, $25 min Copay, $50 max Copay	Not Covered
• Preferred Brand Name Drugs	25% Coinsurance, $25 min Copay, $50 max Copay	Not Covered
• Non-preferred Brand Name Drugs	50% Coinsurance, $50 min Copay, $75 max Copay	Not Covered
Specialty Drugs (specialty drugs must be purchased through a designated pharmacy after one fill)		
• Preferred Specialty	25% Coinsurance, $100 min Copay, $150 max Copay	Not Covered
• Non-Preferred Specialty	25% Coinsurance, $100 min Copay, $150 max Copay	Not Covered
Contraceptive Drugs		
• Preferred Generic Drugs	Plan Pays 100%	50% Coinsurance
• Non-Preferred Generic Drugs	Same as any other Generic Drugs	Same as any other Generic Drugs
• Preferred Brand Name Drugs	Plan Pays 100%	50% Coinsurance
• Non-Preferred Brand Name Drugs	Same as any other Non-Preferred Brand Name Drugs	Same as any other Non-Preferred Brand Name Drugs
Diabetic Insulin		
• Preferred Generic Drugs	Plan Pays 100%	50% Coinsurance
• Non-Preferred Generic Drugs	Same as any other Generic Drugs	Same as any other Generic Drugs
• Preferred Brand Name Drugs	Plan Pays 100%	50% Coinsurance
• Non-Preferred Brand Name Drugs	Same as any other Non-Preferred Brand Name Drugs	Same as any other Non-Preferred Brand Name Drugs
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.**		

IMPORTANT TELEPHONE NUMBERS

Member Services

Omaha and Toll-free. 1-844-286-0859

Coordination of Benefits

Omaha 402-390-1840

Toll-free 1-800-462-2924

Preauthorization

Omaha 402-390-1847

Toll-free 1-800-662-3554

Workers' Compensation

Omaha 402-398-3615

Toll-free 1-800-821-4786

Certification

Omaha 402-390-1870

Toll-free 1-800-247-1103

BlueCard Provider Information

Toll-free 1-800-810-BLUE (2583)

Website . . . . . www.bcbs.com

Network Pharmacy Locator

Toll-free 1-877-800-0746

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INTRODUCTION

This document is your Summary Plan Description (SPD).

This SPD has been written to help you understand your Group health Plan coverage. It describes the benefits, exclusions and limitations of your Plan in a general way, and is not, and should not be considered a contract.

Your Group health Plan is administered in accordance with the Administrative Services Agreement between the Group and Blue Cross and Blue Shield of Nebraska, Inc. (BCBSNE), an independent licensee of the Blue Cross and Blue Shield Association. The Administrative Services Agreement and official Plan documents control the coverage for your Group.

NOTE: BCBSNE provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims. BCBSNE liability may occur only under a stop loss provision, as set forth in a stop loss agreement with the Group.

Please share the information found in this SPD with your Eligible Dependents.

How To Use This Document

For your convenience, defined terms are capitalized throughout this document. For an explanation of a defined term, refer to the Section titled "Definitions."

Please take some time to read this document and become familiar with it. As you read this document, you will find that many sections are related to other sections of the document. You may not have all the information you need by reading just one section. We encourage you to review the benefits and limitations by reading the Benefit Summary page and the sections titled "Benefit Descriptions" and "Exclusions." **If you have a question about your coverage or a Claim, please contact BCBSNE Member Services Department.**

About Your I.D. Card

BCBSNE will issue you an identification card (I.D. card). Your I.D. number is a unique alpha numeric combination.

Present your I.D. to your health care provider when you receive Services. With your BCBSNE I.D. card, Hospitals and Physicians can identify your coverage and will usually submit Claims for you.

If you want extra cards for covered family members or need to replace a lost card, please contact BCBSNE Member Services Department, or you may access through the website, NebraskaBlue.com.

Schedule Of Benefits And Benefits Summary

Your Schedule of Benefits is a personalized document, sent by BCBSNE, that provides you with a basic description of your Plan coverage option. It also shows the membership option that applies to you.

A **Benefit Summary** is included in this SPD. It includes information concerning deductible and cost-sharing amounts, benefit limits, and other coverage details.

Your Rights And Responsibilities As A BCBSNE Member

You have the right to:

- be treated with respect and dignity;
- privacy of your personal health information that BCBSNE maintains, following state and federal laws;
- receive information about the benefits, limitations and exclusions of your health plan, including how to access the network of hospitals, physicians and other health care providers;
- work with your doctor and other health care professionals about decisions regarding your treatment;
- discuss all of your treatment options, regardless of cost or benefit coverage;
- make a complaint or file an appeal about your health plan, any care you receive or any benefit determination your health plan makes;
- make recommendations to BCBSNE about this rights and responsibilities policy; and
- give Us suggestions about how BCBSNE can better serve you and other members.

You have the responsibility to:

- read and be familiar with your health plan coverage information and what your plan covers and doesn't cover, or ask for help if you need it;
- understand how your choice of an In-network or Out-of-network Provider will impact what you pay out of your own pocket, if your plan has different In-network and Out-of-network benefits, or ask for help if you need it;
- give BCBSNE all the information needed to process your claims and provide you with the benefits you're entitled to under your plan;
- give all your health care providers the information they need to appropriately treat you; and
- advise your Group of any changes that affect you or your family, such as a birth, marriage/divorce or change of address.

About The Plan

This Group health Plan is a Preferred Provider Organization (PPO) health benefit plan. Claims administration is provided by Blue Cross and Blue Shield of Nebraska (BCBSNE).

Preferred Provider (PPO) networks have been established by BCBSNE through contracts with a panel of Hospitals, Physicians and other health care providers who have agreed to furnish medical Services to you and your family in a manner that will help manage health care costs. These providers are referred to as "In-network" or "Preferred Providers." The BCBSNE PPO provider network is identified on your I.D. card.

Blue Cross and Blue Shield Plans in other states (Host Blue) have also contracted with health care providers in their geographic areas, who are referred to as "Preferred Providers."

Use of the network is voluntary, and selection of a health care provider is always your choice. If you choose to use providers who do not participate in the BCBSNE or Host Blue network for non-emergency situations, you can expect to pay more than your applicable Deductible, Copayment and/or Coinsurance amounts. After this health plan pays its required portion of the bill, Out-of-network Providers may bill you for any amount not paid. This balance billing does not happen when you use In-network or Preferred Providers because these providers have agreed to accept a discounted payment for Services with no additional billing to you other than your applicable Deductible, Copayment and/or Coinsurance amounts. In-network Providers will also file Claims for you.

For help in locating In-network Providers, managing your personal health care benefits, as well as accessing various resources and tools, visit BCBSNE online at NebraskaBlue.com. You may also call BCBSNE Member Services using the toll-free number on your I.D. card or refer to the Important Telephone Numbers in the front of this book. If you would like a printed provider list, BCBSNE will furnish one without charge.

For help in locating a Preferred Provider in another Blue Cross and/or Blue Shield Service Area, including providers outside the U.S., you may call the special toll-free number of the Blue Cross and Blue Shield BlueCard Program (1-800-810-2583) for assistance.

Be Informed. Out-of-network Providers' charges may be higher than the benefit amount allowed by this health plan. You may contact BCBSNE Member Services Department concerning allowable benefit amounts in Nebraska for specific procedures. Your request must specify the Service or procedure, including any Service or procedure code(s) or diagnosis-related group, and the provider's estimated charge.

How The Network Works

Using In-network Providers:

- present I.D. card and pay Copayment (when applicable);
- receive highest level of benefits;
- provider files Claims for you;
- provider accepts insurance payment as payment in full (except Deductible, Copayment and/or Coinsurance amounts); and
- no balance billing.

Using Out-of-network Providers:
- you may be required to pay full cost at time of service;
- you may be reimbursed at a lower benefit level;
- you may have to file Claims; and
- you're responsible for amounts that exceed the Allowable Charge.

Remember, if more than one Physician is involved in your care, it is important for you to check the status of each provider.

Exception
Emergency Services and post stabilization Services provided at an Out-of-network health care facility, limited to a hospital emergency department, general acute hospital, satellite emergency department, or Ambulatory Surgical Facility, or by an ancillary individual Out-of-network health care professional or air ambulance, will be considered as having been provided by an In-network Provider, and the Covered Person will not be responsible for amounts over the Allowable Charge, as required by law. Benefits for Inpatient care will continue to be paid subject to the In-network cost-sharing level, as long as the Services are for an Emergency Medical Condition.

For non-emergency Services, if a Covered Person receives Services at an In-network health care facility but the Physician or other provider is Out-of-network, benefits for those Covered Services will be subject to the In-network Deductible, Coinsurance, and/or Copayment. Providers may not bill the Covered Person for charges over the Allowable Charge payable under this Plan, unless otherwise allowed by law.

If a Covered Person receives a bill from an Out-of-network Provider, and the Covered Person did not provide consent to the Out-of-network Provider to receive such Services, the Covered Person should send the bill to the Member Services Department for further review by either sending a secure e-mail through myNebraskaBlue.com or by mail at the following address:

Blue Cross and Blue Shield of Nebraska
P.O. Box 3248
Omaha, NE 68180

Out-Of-Area Services

BCBSNE has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. These relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross and Blue Shield Association ("Association"). Whenever you access health care services outside the geographic area BCBSNE serves, the claim for those services may be processed through one of these Inter-Plan Arrangements.

When you access care outside BCBSNE's service area, you will receive it from one of two kinds of providers. Most providers ("participating providers") contract with the local Blue Cross and Blue Shield Licensee in that geographic area ("Host Blue"). Some providers ("non-participating providers") don't contract with the Host Blue. We explain below how we pay both kinds of providers.

Inter-Plan Arrangements Eligibility - Claim Types — All claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for dental care benefits (except when paid as medical benefits), and any prescription drug programs or vision care benefits that may be administered by a third party contracted by BCBSNE to provide the specific services or services.

BlueCard® Program
Under the BlueCard® Program, when you receive Covered Services within the geographic area served by a Host Blue, BCBSNE will remain responsible for doing what we agreed to in our agreement with the Group. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating providers.

When you receive Covered Services outside BCBSNE's service area and the claim is processed through the BlueCard Program, the amount you pay for Covered Services is calculated based on the lower of:

- The billed charges for your Covered Services, or
- The negotiated price that the Host Blue makes available to BCBSNE.

Often, this "negotiated price" will consist of a simple discount which reflects an actual price that the Host Blue pays to your health care provider. Sometimes, it is an estimated price that takes into account special arrangements with your health care provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of health care providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price BCBSNE used for your claim because they will not be applied after a claim has already been paid.

Negotiated (non-BlueCard® Program) National Account Arrangements
With respect to one or more Host Blues, instead of using the BlueCard Program, BCBSNE may process your claims for Covered Services through Negotiated Arrangements for National Accounts.

The amount you pay for Covered Services under this arrangement will be calculated based on the lower of either billed covered charges for Covered Services or the negotiated price (refer to the description of negotiated price under BlueCard® Program) made available to BCBSNE by the Host Blue.

If reference-based benefits, which are service-specific benefit dollar limits for specific procedures, based on a Host Blue's local market rates, are made available to you, you will be responsible for the amount that the health care provider bills above the specific reference benefit limit for the given procedure. For a participating provider, that amount will be the difference between the negotiated price and the reference benefit limit. For a non--participating provider, that amount will be the difference between the provider's billed charge and the reference benefit limit. Where a reference benefit limit is greater than either a negotiated price or a provider's billed charge, you will incur no liability, other than related patient cost-sharing under the Plan.

Special Cases – Total Care

- BlueCard Program: If you receive Covered Services under a Total Care value-based program inside a Host Blue's service area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement except when a Host Blue passes these fees to BCBSNE through average pricing or fee schedule adjustments.
- Negotiated (non-BlueCard Program) Arrangements: If BCBSNE has entered into a Negotiated Arrangement with a Host Blue to provide Total Care to your Group on your behalf, BCBSNE will follow the same procedures for Total Care administration and Care Coordinator Fees noted above for the BlueCard Program.

Inter-Plan Programs – Federal/State Taxes/Surcharges/Fees
Federal or state laws or regulations may require a surcharge, tax or other fee that applies to insured accounts. If applicable, BCBSNE will include any such surcharge, tax or fee as part of the claim charge passed on to you.

Non-Participating Healthcare Providers Outside Our Service Area

Subscriber Liability Calculation — When Covered Services are provided outside of BCBSNE's service area by nonparticipating healthcare providers, the amount you pay for such Services will normally be based on either the Host Blue's nonparticipating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the nonparticipating provider bills and the payment BCBSNE will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

If you need Emergency Services, BCBSNE will cover you at the highest level that federal regulations allow. You will have to pay any Deductibles, Coinsurance, Copayments, charges for Noncovered Services, and any excess charge over the amount payable under the Contract, unless prohibited by law.

Exceptions — In certain situations, BCBSNE may use other payment bases, such as billed covered charges for Covered Services, the payment BCBSNE would make if the healthcare Services had been obtained within BCBSNE's service area, or a special negotiated payment, to determine the amount BCBSNE will pay for Services provided by nonparticipating providers. In these situations, you may be liable for the difference between the amount that the nonparticipating provider bills and the payment BCBSNE will make for the Covered Services set forth in this paragraph.

Blue Cross Blue Shield Global® Core
If you are outside the United States, (hereinafter "BlueCard service area"), you may be able to take advantage of Blue Cross Blue Shield Global Core when accessing Covered Services. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the Blue Cross Blue Shield Global Core assists you with accessing a network of inpatient, outpatient and professional providers, the network is not served by Host Blue. As such, when you receive care from providers outside the BlueCard service area, you will typically have to pay the providers and submit the claims yourself to obtain reimbursement for these services. If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, you should call the Blue Cross Blue Shield Global Core Service Center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

- Inpatient Services: In most cases, if you contact the Blue Cross Blue Shield Global Core Service Center for assistance, hospitals will not require you to pay for covered inpatient services, except for your cost-share amounts. In such cases, the hospital will submit your claim to the Service Center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for Covered Services. You must contact BCBSNE to obtain Preauthorization for non-emergency inpatient services.
- Outpatient Services: Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for Covered Services.
- Submitting a Blue Cross Blue Shield Global Core Claim: When you pay for Covered Services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global Core claim form and send the claim form with the provider's itemized bill(s) to the Service Center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from BCBSNE, the Service Center or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the Service Center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week.

How The Plan Components Work

Your Deductible, Copayment, Coinsurance (cost-sharing) and Out-of-pocket Limit for In-network and Out-of-network Providers are shown on the Benefit Summary. Following is an explanation of each of those components.

Allowable Charge — An amount BCBSNE uses to calculate the payment of Covered Services. This amount will be based on either the Contracted Amount for In-network Providers or the Out-of-network Allowance for Out-of-network Providers.

Coinsurance — This is the percentage you must pay for Covered Services, after the Deductible is applied.

Copayment (Copay) — A fixed dollar amount payable by the Covered Person for a Covered Service. Multiple Copayments may apply to one claim, depending on the Services submitted on the Claim.

Deductible* — You are responsible for your expenses until you reach the Plan's Deductible. After the Deductible is met, benefits for the rest of that Benefit Year will not be subject to any further Deductible. Copayments do not apply to the Deductible. In-network and Out-of-network Deductibles cross accumulate. Charges paid for prescription drugs with a pharmaceutical discount or drug copay card may not accumulate to the Deductible.

Out-of-pocket Limit* — This Limit is the maximum amount of cost-sharing each Covered Person or Membership Unit must pay in a Benefit Year. In-network and Out-of-network Out-of-pocket Limits cross accumulate.

Certain kinds of charges do not count toward your Out-of-pocket Limit. For example:

- charges in excess of the Allowable Charge;
- charges for Noncovered Services;
- penalty amounts for failure to comply with Preauthorization requirements;
- penalty amounts under the Prescription Drug Program;
- cost-sharing amounts for prescription drugs paid by the Covered Person with a pharmaceutical discount or copay card may not apply.

**If you have a family or multiple party membership, your plan may have either an Aggregate or an Embedded Deductible and/or Out-of-pocket Limit. The Benefit Summary will indicate whether your plan has an Aggregate or an Embedded amount. See "Definitions" in the back of this book for a description of these terms.*

If you have a Health Savings Account (HSA) eligible high Deductible health Plan, the Deductible and Out-of-pocket limit may be adjusted annually. All Copays and Coinsurance amounts will apply after the Deductible is met.

Utilization Review — Benefits are available for **Medically Necessary and Scientifically Validated Services.** Services provided by all health care providers are subject to utilization review by BCBSNE. Services will not automatically be considered Medically Necessary because they have been ordered or provided by a Physician. BCBSNE will determine whether Services provided are Medically Necessary or Scientifically Validated under the terms of the plan, and if benefits are available.

Preauthorization Requirements — Preauthorization is required for all Inpatient Hospital admissions, as well as certain surgical procedures, and specialized Services and supplies. In-network Hospitals will notify BCBSNE of an Inpatient admission. However, when you are admitted as an Inpatient to an Out-of-network Hospital, or to a Hospital outside the state of Nebraska, it is your responsibility to see that BCBSNE is notified of your admission. For more information, please refer to the section of this book titled "Preauthorization Requirements."

Expansion of Benefits —The scope of benefits may be expanded on a concurrent/prospective basis as determined by BCBSNE, to include payment for specific Services which would not ordinarily be included as Covered Services. It must appear that the use of such Services will: 1) equal or reduce costs; 2) improve the quality of medical care; and 3) be medically more appropriate than an alternate Covered Service. BCBSNE will advise the Covered Person and the provider in writing to what extent payment will be allowed for such Services. Any such expansion of the scope of benefits does not constitute an amendment to the Plan, or provide a continuing right to receive such Services.

Continuity of Care — In the event a Covered Person is receiving an active course of treatment for certain types of care from an In-network Provider on the date that Our contracting agreement with that provider is terminated, the provider will continue to render Covered Services to the Covered Person, and the contracting agreement shall continue to apply to those Covered Services after the termination takes effect, for up to 90 days or until the Covered Person is no longer a continuing care patient. The types of care that qualify and the length of time that the contracting agreement shall continue to apply are stated in the BCBSNE Provider Policies and Procedures Manual. The terms of the Provider Policies and Procedures Manual may be updated by BCBSNE from time to time.

Preauthorization Process

Preauthorization procedures are intended to determine if health care services or supplies are appropriate under the terms of the Plan.

BCBSNE requires that all Hospital stays, certain surgical procedures, and specialized Services and supplies be Preauthorized prior to receipt of such Services or supplies. It is your responsibility to see that Preauthorization occurs; however, a Hospital or Provider may initiate the Preauthorization.

Under all circumstances, the Covered Person and his or her provider bear the ultimate responsibility for the medical decisions regarding treatment. BCBSNE is not responsible for treatment or diagnosis of a Covered Person, regardless of any case preauthorization, review or management.

When BCBSNE receives a request for Preauthorization, the appropriateness of the setting and the level of medical care as well as the timing and duration of the admission is assessed by BCBSNE (or by persons designated by BCBSNE).

To initiate the Preauthorization process, BCBSNE must be contacted by you, your family member, the Physician, the Hospital or someone acting on behalf of you or your family member. Notification of the intended receipt of Services may be made by telephone or in writing. We may require that the Preauthorization include written documentation from the attending Physician, dentist or other medical provider demonstrating the Medical Necessity of the procedure or Service and the location where the Service will be provided.

In the case of an ongoing Inpatient admission, the care should continue to be Preauthorized in order to assure that it is being provided in the most appropriate setting.

Please remember that Preauthorization does not guarantee payment. All other Group health Plan provisions apply. For example: Copayments, Deductibles, Coinsurance, eligibility and exclusions.

Benefits Requiring Preauthorization

The following Services, supplies or drugs must be Preauthorized:

- Advanced Diagnostic Imaging;
- Durable Medical Equipment (DME) - subsequent purchases of DME or DME identified on the Preauthorization list;
- Genetic Testing;
- Hospice Care;
- Inpatient Hospital admissions;
- Inpatient Physical Rehabilitation;
- Long Term Acute Care at an Inpatient Facility after receiving treatment in the Hospital;
- organ and tissue transplants;
- prescription drugs (certain drugs as defined by BCBSNE);
- Skilled Nursing Care in the home;
- Skilled nursing facility care;
- Services subject to surgical, laboratory, radiology or other Preauthorization programs, as defined by BCBSNE; and
- other Services as may be specifically stated elsewhere in this booklet.

A list of Services subject to Preauthorization may be obtained at NebraskaBlue.com/PreAuth. Preauthorization requirements are subject to change.

Preauthorization Exceptions

Maternity

Federal law provides for a length of stay of up to 48 hours following a normal vaginal delivery and 96 hours following a cesarean section unless otherwise agreed to by the Covered Person and her Physician. Preauthorization is not required for an initial maternity admission. However, Preauthorization is required if the hospitalization extends beyond these times.

Emergencies

BCBSNE must be notified of an admission for an Emergency Medical Condition within 24 hours of the admission or the next business day. If Preauthorization is not received, the 24-hour period prior to the time of admission and the 24-hour period after such admission will be reviewed to determine if the Covered Person's condition and treatment would have hindered his or her ability to provide notice.

NOTE: Admission through the emergency room does not necessarily constitute an emergency admission.

Effect On Benefits

Failure to comply with the Preauthorization requirements may result in a penalty or denial of benefits and unanticipated costs associated with the incurred expenses.

Certain surgical, radiology or other Preauthorization programs require that benefit approval be obtained prior to the Service being provided, with failure to do so resulting in a denial of benefits for the Service.

If Services are not properly Preauthorized and benefits are reduced or denied, you are responsible for paying any amount due. However if the Hospital, Inpatient facility or Physician is an In-network Provider with BCBSNE, they are liable for their Services which are determined by BCBSNE to be not Medically Necessary (or for denial due to failure to Preauthorize if required), unless you have agreed in writing to be responsible for such Services, or the provider has documented in the medical record that you were notified of the Preauthorization determination. Any reductions in benefits are not considered when computing your Deductible or your Out-of-pocket Limit.

Out-of-Network or Out-of-State Providers

Covered Persons are responsible to obtain Preauthorization for all Services requiring Preauthorization received for an Out-of-network Provider or provider located outside the State of Nebraska. The responsibility for charges denied for failure to obtain Preauthorization rests with the Covered Person, unless the provider if located in Nebraska and is a Contracting Provider with BCBSNE.

Benefits are not payable for Services determined to be not Medically Necessary.

BENEFIT DESCRIPTIONS

This section provides a general overview of Covered Services. Benefits are payable subject to cost-sharing and all terms, conditions, exclusions and limitations of the Plan.

What's Covered

The following list includes examples of the Services that are covered when Medically Necessary care is provided by an Approved Provider. Additional information on many of these Services is found on the pages following this list:

- *Advanced Diagnostic Imaging;*
- *allergy testing, serum and injections;*
- *ambulance Services* (see Additional Information in this section);
- *anesthesia* (see Additional Information in this section);
- *assistant surgeon* Services for surgical procedures specifically identified by BCBSNE;
- *Autism Spectrum Disorders* (see Additional Information in this section)*;*
- *blood, blood plasma, blood derivatives or blood fractionates, including administration and processing,* unless donated and for which there is not a charge;
- *breast prostheses,* custom prostheses are limited to one per side every two years, and fiber or foam-filled prostheses are limited to one per side every six months (two standard or prefabricated per year);
- *cardiac rehabilitation* when in an accredited program and approved by BCBSNE;
- *chemotherapy;*
- *chiropractic care* (subject to scope of practice regulations)*;*
- *circumcision;*
- *clinical trials,* for approved individuals, as described in the ACA, including routine patient costs in connection with the clinical trial, consistent with Plan benefits;
- *cochlear implants and bone anchored hearing aids,* which includes the pre-implant evaluation, implant system, surgery and post-surgical fitting;
- *colorectal cancer screening and related Services;*
- *contraceptive supplies and Services* (unless otherwise covered under the Rx Nebraska Prescription Drug Program and/or not covered under the medical plan);
- *dialysis;*
- *diabetic education* when provided by a Certified Diabetes Educators or Licensed Medical Nutrition Therapist, including self-management training and patient management;
- *diabetic supplies* (which are Covered Services under the Plan, but are not covered under the RX Nebraska Prescription Drug Program);
- *Durable Medical Equipment (DME) rental or initial purchase* (whichever costs less), when prescribed by a Physician and determined by BCBSNE to be Medically Necessary (see Additional Information in this section);
- *Emergency Service;*
- *eyeglasses or contact lenses* when ordered by a Physician because of a change in prescription as a direct result of a covered intraocular surgery or ocular injury (must be within 12 months of the surgery or injury);
- *home health aide Services* (see Additional Information in this section);
- *home infusion therapy;*
- *Hospice Services* when Preauthorized by BCBSNE (see Additional Information in this section);
- *Hospital Services* such as nursing care, drugs, medicines, therapies, x-rays (radiology) and laboratory (pathology) tests;
- *immunizations;*
- *Inpatient Physician care;*
- *Inpatient Physical Rehabilitation* (see Additional Information in this section);
- *insulin pumps and other equipment for treatment of diabetes* (unless otherwise covered under the Prescription Drug Program);
- *mammography;*
- *manipulative treatment or adjustments;*
- *mastectomy bras* (limited to four per year)*;*
- *maternity care* (see Additional Information in this section);
- *Mental Health care on an Inpatient, Outpatient and Emergency Service basis* (see Additional Information in this section);

- *newborn care* (see Additional Information in this section);
- *nursing Services* in the home which require the skill, proficiency and training of a registered nurse (RN) or a licensed practical nurse (LPN) (see Additional Information in this section);
- *obesity surgery for morbid obesity;*
- *occupational therapy;*
- *oral surgery, dental treatment and TMJ Services* (see Additional Information in this section);
- *orthotics* for preventing complications associated with diabetes;
- *osteopathic care;*
- *ostomy supplies;*
- *Outpatient (ambulatory) surgery;*
- *Outpatient x-ray, radiology, laboratory and pathology charges;*
- *oxygen;*
- *pacemakers;*
- *pap smears;*
- *physical therapy;*
- *Physician visits;*
- *podiatric appliances necessary for the prevention of complications associated with diabetes;*
- *Preventive care* (see Preventive Care included in this section for additional information);
- *prosthetic devices;*
- *pulmonary rehabilitation* when in an accredited program and approved by BCBSNE;
- *radiation therapy;*
- *renal dialysis,* including charges for covered home dialysis equipment and covered disposable supplies, and dialysis training or counseling;
- *respiratory care;*
- *room and board,* including cardiac care and intensive care room for an Inpatient stay;
- short term storage and retrieval of cord blood for transplants and maternity and delivery care;
- *skilled nursing facility care;*
- *sleep studies;*
- *speech therapy;*
- *Substance Use Disorder treatment;*
- *surgical care* (the Allowable Charge includes preoperative and postoperative care, and may include reductions for procedures involving multiple Physicians or multiple or bilateral surgical procedures);
- *surgical dressings;*
- *telehealth Services* (see Additional Information in this section);
- *transplants* (see Additional Information in this section); and
- *Urgent Care Facility Services*.

COVERED SERVICES - ADDITIONAL INFORMATION

Ambulance Services

Benefits are available for ambulance Services provided to a Covered Person for:

- transportation to the nearest facility for appropriate care for an Emergency Medical Condition;
- transportation from a facility where emergent care was obtained or from an Inpatient acute care facility to the nearest facility where appropriate care can be provided, whether it is a lesser or greater level of specific care. Benefits are also available for transporting the Covered Person who is bedridden, to a facility for treatment or to his or her place of residence, subject to preauthorization and Medical Necessity;
- transporting a respirator-dependent person; and
- transportation to and from the nearest appropriate facility for testing and/or procedures that are not available at the present facility.

Benefits are not available if solely for the convenience of the patient, family or provider, or if a less intensive level of transportation is more appropriate.

Anesthesia Services

Benefits are payable for anesthesia Services by a Physician or Certified nurse anesthetist. The amount payable for the anesthesia will include the usual preoperative and postoperative visits and the necessary management of the patient, during and after the administration. Payment will not be made for supervision of the administration. Benefits are not available for local infiltration or the administration of anesthesia by the attending or assisting surgeon (except spinal, saddle or caudal blocks for Pregnancy, general anesthesia for covered oral surgery and dental procedures and IV sedation for oral surgery or to remove impacted teeth in the office or in a covered Outpatient setting).

Autism Spectrum Disorders

Benefits are available for Covered Services for the screening, diagnosis and treatment of autism spectrum disorders which may include behavioral health treatment such as applied behavior analysis. Benefits are subject to the applicable Copay, Deductible and/or Coinsurance amounts for other Mental Health Services. **Autism Spectrum Disorder Services must be Preauthorized.**

Definitions

The following definitions apply to autism spectrum disorders.

Applied behavior analysis: the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior.

Autism spectrum disorder: any of the pervasive developmental disorders or autism spectrum disorder as defined by the most recent Diagnostic and Statistical Manual of Mental Disorders.

Behavior analyst: a Certified provider, which may include a Board Certified Behavior analyst approved by the Behavioral Analyst Certification Board, as defined in BCBSNE's medical policy.

Behavioral health treatment: counseling and treatment programs, including applied behavior analysis that are:

- necessary to develop, maintain, or restore to the maximum extent practicable, the functioning of an individual; and
- provided or supervised either in person or by telehealth, by a behavior analyst certified by a national certifying organization or a Licensed Psychologist if the Services performed are within the boundaries of the psychologist's competency.

Treatment: evidence-based care, including related equipment, that is prescribed or ordered for an individual diagnosed with an autism spectrum disorder by a Licensed Physician or a Licensed Psychologist, within the scope of his or her practice, including:

- behavioral health treatment;
- pharmacy care;
- psychiatric care;
- psychological care; and
- therapeutic care.

NOTE: Except in the case of Inpatient Services, BCBSNE reserves the right to request a review of treatment of autism spectrum disorders once every six months, unless the Covered Person's Licensed Physician or Licensed Psychologist agrees to more frequent reviews.

Durable Medical Equipment (DME)

Benefits are available for rental or initial purchase (whichever costs less) for covered DME when prescribed by a Physician. Benefits for rental of DME shall not exceed the cost of purchase unless otherwise approved by BCBSNE.

Benefits will be available for subsequent purchases of covered DME when:

- there is a significant change in the Covered Person's condition;
- the Covered Person grows;
- the item cannot be repaired and/or the cost of repairs exceeds the expense of purchasing a second piece of equipment;
- the item is five or more years old (equipment may be replaced earlier if Preauthorized by BCBSNE);
- or as otherwise determined by BCBSNE to be reasonable and necessary.

In addition, reimbursement will only be made to a DME or medical supply company for Medically Necessary repair, adjustment and maintenance of purchased DME, as determined appropriate by BCBSNE. Benefits are not available for DME which is rented or purchased from, or used while confined to a Hospital, skilled nursing facility, intermediate care facility, a nursing home or other Licensed residential facility if such equipment is usually supplied by the facility.

NOTE: Oxygen and equipment for its administration, respiratory therapy, ventilation equipment, apnea monitors and continuous positive airway pressure devices (CPAP) may be subject to review of rental versus purchase by BCBSNE.

Home Health Care Services and Hospice Services

Benefits are available subject to the benefit limits outlined in the Benefit Summary for Medically Necessary home health aide, respiratory care, and Skilled Nursing Care provided in the home to a Covered Person.

Home Health Aide

Benefits are available for Physician ordered home health aide Services provided in the home by a licensed or Medicare-Certified home health agency. Covered Services include personal care Services such as:

- bathing;
- feeding; and
- household cleaning duties.

Benefits are only available for home health aide Services when they are related to active and specific medical, surgical or psychiatric treatment of the Covered Person which requires the skills of a registered nurse.

Respiratory Care

Respiratory care Services must be ordered by a Physician, be performed in the home, and must relate to active and specific medical or surgical treatment which requires the skill of a registered nurse or respiratory therapist. These Services include, but are not limited to: airway maintenance, chest physiotherapy, delivery of medications, oxygen therapy, obtaining laboratory samples and pulmonary function testing. Services must be provided by a Licensed or Medicare-Certified home health agency.

Skilled Nursing Care

Nursing care must be Physician ordered and the patient must need care which requires the skill, proficiency and training of a registered nurse (RN) or a Licensed practical nurse (LPN). **Skilled Nursing Care must be Preauthorized.**

Benefits will not be provided for:

- nursing care in excess of any benefit limit;
- nursing care which is primarily for the convenience of the patient or the patient's family;
- time spent bathing, feeding, transporting, exercising or moving the patient, giving oral medication or acting as a companion, sitter, or homemaker;

- care provided by a nurse who is an immediate relative by blood, marriage or adoption, or a member of the Covered Person's household; and
- care provided in a Hospital, a skilled nursing facility, intermediate care facility, or a sub-acute care or rehabilitation facility.

Hospice Services

Hospice is a program of care provided for a person diagnosed as terminally ill and his/her family. The Covered Person must have a life expectancy of six months or less and Services must be ordered by a Physician, and be appropriate for palliative support or management of a terminal illness. **Hospice Services must be Preauthorized.**

Benefits are available for the following Covered Services provided by a Medicare-certified Hospice:

- Hospice nursing Services provided in the home;
- Inpatient Hospice care;
- respite care, which is short-term Inpatient care necessary in order to give temporary relief to the person who regularly assists with the care at home. Respite care may be provided in the Hospice's designated Inpatient unit that is affiliated with the Hospice providing Services to the Covered Person, which may be a Skilled Nursing Facility or a Hospital;
- medical social Services, provided by a medical social worker employed by the Hospice, which are directly related to the Covered Person's medical condition;
- crisis care, which is extended Skilled Nursing Care for up to 24 hours per day in lieu of a Medically Necessary Inpatient hospitalization; and
- bereavement counseling for a covered family member of the deceased Covered Person who was the recipient of Hospice Services. The counseling Services must be provided within six month of the death.

Hospital And Facility Services

Inpatient and Long Term Acute Care

Benefits are available for Inpatient Covered Services such as room and board, treatment rooms, diagnostic Services, drugs, medicines and other ancillary Services provided by the Hospital.

If an intensive care, cardiac care or similar type room is used during a 24-hour period, only one room charge will be payable, and benefits will be based on the most intensive care provided during that period.

NOTE: If benefits are denied for Hospital room and board, all other Inpatient Services are denied.

Skilled Nursing Facility Care

Benefits are available subject to Medically Necessary criteria, and to any limit stated in the Benefit Summary. After the exhaustion of the stated limit, all Services provided in the skilled nursing facility will be denied. The care must be provided in a Licensed or Medicare-certified skilled nursing facility or in a part of Hospital with designated skilled nursing or swing beds, licensed to provide room, board, 24-hour-a-day Skilled Nursing Care and other related non-Custodial Services. The care must be ordered by a Physician and the patient must be receiving Skilled Nursing Care.

Skilled nursing facility care does not include:

- supportive Services for a stabilized condition;
- care which can be learned and given by unlicensed or uncertified medical personnel;
- routine health care Services;
- general maintenance or supervision of routine daily activities; and
- routine administration of oral or prescription drugs.

Inpatient Physical Rehabilitation
Benefits are available for Covered Hospital and Physician Services for Inpatient care when provided as part of a Physical Rehabilitation admission. In addition, Covered Services will include the following when part of the rehabilitation admission:

- recreational therapy;
- social service counseling;
- prosthetic devices and fitting; and
- psychological testing.

The facility must be accredited for Comprehensive Inpatient Rehabilitation by the Commission on the Accreditation of Rehabilitation Facilities (CARF), or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or appropriately Preauthorized by BCBSNE.

Orthopedic Specialty Benefit
Benefits for Hospital facility Covered Services may be subject to a waiver of the Deductible and Coinsurance amounts if such Covered Services are provided at a Hospital designated by BCBSNE as a "Preferred Center." A list of the Hospitals for this orthopedic specialty benefit may be found at NebraskaBlue.com/PreferredCenters. Exception: The waiver of the Deductible is not applicable to a Health Savings Account (HSA) eligible health plan. Facility participation is subject to change.

Outpatient Hospital Or Facility Services
Benefits are available for Covered Outpatient Services provided by a Hospital, Ambulatory Surgical Facility, Urgent Care Facility or other Outpatient facility. An observation stay is considered an Outpatient Service.

Emergency Rooms Are Expensive. Hospital emergency rooms are very expensive because they are specifically staffed and equipped to handle accidents, injuries and other emergencies. Using them for preventive care (or as a substitute for the family physician) can cost you time and money.

Emergency Room Care
When you receive care in the emergency room, benefits will be provided subject to the applicable Copay, Deductible and/or Coinsurance shown on the Benefit Summary. If you receive care at an Out-of-network Hospital emergency room or by an Out-of-network Provider, benefits for Covered Services may be provided at the In-network benefit level. You will still be responsible for amounts in excess of the Allowable Charge when you receive Services from an Out-of-network Provider.

If Emergency Service results in a Covered Person being admitted to the Hospital, BCBSNE must be notified of the admission in accordance with the Preauthorization requirements for emergencies. (Please refer to "Preauthorization Requirements.")

If a Copayment is applicable to the Emergency Room facility charge, it will be waived if the patient is admitted within 24 hours for the same diagnosis.

Cardiac and Pulmonary Rehabilitation Services — Outpatient
Cardiac or Pulmonary Rehabilitation is defined as the use of various modalities of treatment to improve cardiac or pulmonary function as well as tissue perfusion and oxygenation through which selected patients are restored to and maintained at either a pre-illness level of activity or a new and appropriate level of adjustment.

- **Covered Outpatient Cardiac or Pulmonary Rehabilitation.** The following Services are also covered when provided as part of an Outpatient rehabilitation program:
  - initial rehabilitation evaluation;
  - exercise sessions;
  - concurrent monitoring during the exercise session for high risk patients; and
  - Physician Services which are otherwise defined as Covered Services.

- **Cardiac Rehabilitation Criteria.** Benefits are available at any therapeutic level, up to 18 sessions per diagnosis or condition.
- **Pulmonary Rehabilitation Criteria.** Benefits are available for Services provided prior to and following a lung transplant, heart-lung transplant, lung volume reduction surgery and for severe chronic lung disease patients, as reviewed and determined by BCBSNE. Pulmonary rehabilitation Services must be under the continuing supervision of a Physician and in a Hospital environment.
- **Pulmonary Rehabilitation Limits.** Unless otherwise shown on the Benefit Summary, the following limits apply:
  - chronic lung disease patients are limited to 18 sessions (including follow-up home sessions) initially and after significant changes in clinical status. No more than 18 sessions will be covered in a calendar year;
  - lung transplant, heart-lung transplant and lung volume reduction surgery patients are limited to 18 sessions following referral and prior to surgery plus 18 sessions within six months of discharge from the hospital following surgery.

Maternity And Newborn Care

Maternity Care

Maternity benefits are available to you, a covered spouse, or an Eligible Dependent daughter unless otherwise indicated. You may contact the BCBSNE Member Services Department for verification of maternity benefits.

Benefits for covered Hospital, surgical and medical care related to Pregnancy includes all related Services for prenatal care, postnatal care, delivery, and complications of Pregnancy or interruptions of Pregnancy. Charges for pre-natal, post-natal and delivery Services are payable as a total (global) charge, per American Medical Association Current Procedural Terminology (CPT) terms, codes and related guidance. Charges for additional Services outside the total (global) maternity charge, such as radiology, pathology and other diagnostic Services are payable as for any other Service.

Benefits are also available for obstetrical care provided by and within the scope of practice of a certified nurse midwife.

Postpartum depression, psychosis or any other Mental Health diagnosis are not considered complications of Pregnancy. Benefits for these conditions are provided in the same manner as all other Mental Health Services.

Newborn Care

Benefits are available at birth for Covered Services for an eligible newborn infant. Covered Services include:

- room and board, including any ancillary Services;
- screening tests, including the initial newborn hearing exam;
- Physician Services for a newborn well infant while hospitalized, including circumcision;
- newborn screening Services for an infant born at home; and
- Medically Necessary definitive medical or surgical treatment, including the necessary care and treatment of medically diagnosed Congenital Abnormalities.

Benefits for Covered Services will be subject to the child's individual cost-sharing amounts, unless otherwise stated. For information on adding a newborn to your coverage, refer to the section titled "Eligibility and Enrollment."

Statement Of Rights Under The Newborns' And Mothers' Health Protection Act

Under federal law, benefits may not be restricted for any Hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, benefits may be paid for a shorter stay if the mother's or newborn's attending provider, after consulting with the mother, discharges the mother or newborn earlier.

Also, under federal law, an insurer may not set the level of benefits or out-of-pocket costs so that any later portion of the 48 hour (or 96 hour) stay is treated in a manner less favorable than any earlier portion of the stay. In addition, an insurer may not require the provider to obtain authorization from the insurer for prescribing a length of stay of up to 48 hours (or 96 hours).

Mental Health, Substance Use Disorder Benefits

Benefits are payable for Covered Hospital and Physician Services, including mental health Services, psychological, or alcoholism and drug counseling Services by and within the scope of practice of:

- a qualified Physician, Licensed Psychiatrist or Licensed Psychologist;
- a Licensed Special Psychologist, Licensed mental health practitioner, Licensed clinical social worker, Licensed professional counselor, marriage and family therapist; or
- auxiliary providers who are supervised, and billed for, by a qualified Physician, Licensed Psychiatrist or Licensed Psychologist or as otherwise permitted by state law.

All licensing or certification shall be by the appropriate state authority. Appropriate supervision and consultation requirements also shall be provided by state law.

Benefits are subject to the applicable Deductible, Copay and/or Coinsurance amount indicated on the Benefit summary.

Inpatient Care

Benefits for Inpatient admissions must be Preauthorized by BCBSNE.

A person shall be considered to be receiving Inpatient treatment if he or she is confined to a Hospital or a Substance Use Disorder Treatment Center that provides medical management including 24-hour nursing care. Services provided by a facility that does not meet this criteria are considered part of a Residential Treatment Program.

Facilities must be Licensed by the Department of Health and Human Services, Regulation and Licensure (or equivalent state agency), or accredited by the Joint Commission on Accreditation of Rehabilitation Facilities (CARF) or Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Residential Treatment Services

Benefits are available for Covered Services and room and board provided as part of a Residential Treatment Program, for treatment of Mental Health and Substance Use Disorder.

The Residential Treatment Program and/or facility must be Licensed, accredited or Certified to provide such Services by the appropriate state agency, or accredited by CARF or JCAHO.

Benefits are available subject to Preauthorization and BCBSNE Medical Necessity criteria.

Outpatient Care

Benefits are available for Outpatient treatment of Mental Health and Substance Use Disorder.

A person who is not admitted for Inpatient care, but is receiving treatment in the Outpatient department of a Hospital, in an observation room, in an Ambulatory Surgical Facility, Urgent Care Facility, a Physician's office, or home shall be considered to be receiving Outpatient Care.

Outpatient Covered Services include:

- psychological therapy and/or Substance Use Disorder counseling/rehabilitation provided by an Approved Provider;
- office visit or clinic visit, consultation, or emergency room visit;
- an evaluation and assessment;
- medication checks;
- an Outpatient day, or partial hospitalization program for Mental Health or a Substance Use Disorder treatment program, that offers all-inclusive Services for each Outpatient treatment day;

- ambulance Services provided for the treatment of Mental Health and Substance Use Disorder;
- laboratory and diagnostic Services; and
- psychological and neuro-psychological testing;
- individual, family and group therapy; and
- methadone maintenance programs for the treatment of opioid use disorder.

Day treatment, partial care, and Outpatient programs must be provided in a Hospital or facility which is Licensed by the Department of Health and Human Services Regulation and Licensure or accredited by the Commission on the Accreditation of Rehabilitation Facilities (CARF).

Emergency Service
Benefits are also available, subject to any applicable Emergency Service Copay, Deductible and/or Coinsurance indicated in the Benefit Summary, for any Covered Services provided in a Hospital emergency room setting for the treatment of Mental Health and Substance Use Disorder.

Oral Surgery And Dentistry
Limited benefits are available for oral surgery and dentistry.

Covered Oral Surgery And Dentistry Services
The Plan provides benefits for Medically Necessary Covered Services for the following:

- evaluation and treatment of impacted teeth;
- incision and drainage of abscesses, and other non-surgical treatment of infections (excluding periodontic or endodontic treatment of infections);
- excision of exostoses, tumors and cysts, whether or not related to the temporomandibular joint of the jaw (TMJ);
- Services for the treatment of TMJ or craniomandibular disorder;
- bone grafts to the jaw, including preparation of the mouth for dentures;
- reduction of a complete dislocation or fracture of the TMJ required as a direct result of an accident. Benefits are limited to treatment provided within 12 months of the injury;
- Services, supplies or appliances for dental treatment of natural healthy teeth required as the direct result of an accidental injury, provided that the Services will restore the Covered Person to a similar level of dental health and function that existed prior to the injury by a similar means of restoration. Benefits are limited to treatment provided within 12 months of the injury;
- osteotomy performed for a gross congenital abnormality of the jaw which can not be treated solely by orthodontic treatment or appliances; and
- dental implants when related to trauma (within one year of injury if osseous growth pattern has been completed, otherwise coverage will be extended for one year following completion of osseous growth pattern providing that coverage is still in effect at the time of treatment), cancer and other tumor, benign cysts, and for persons from puberty through age 23 with two or more adjacent congenitally missing teeth, provided that the Services will restore the Covered Person to a similar level of dental health and function that existed prior to the Injury by similar means of restoration;
- Medically necessary hospitalization and general anesthesia, as required by law, for Covered Persons under eight years of age or developmentally disabled to safely receive dental care.

Please note, damage to teeth or an injury that occurs as a result of eating, chewing or biting is not considered an "accident." Benefits are not available for Services resulting from these types of injuries.

Dental Related Facility Charges
Benefits are available for the following charges if determined by BCBSNE to be Medically Necessary when related to Covered Services for oral surgery and dentistry:

- Hospital Inpatient Services;
- Hospital Outpatient Services;
- Ambulatory facility Services.

Exclusions
Benefits are not available under this section or any other part of the Plan for the following:
- care in connection with the treatment, filling, removal, repositioning or replacement of teeth, including orthodontics or implants, except as specifically identified as covered;
- root canal therapy or care;
- preparation of the mouth for dentures, except as specifically identified as covered;
- treatment of the dental occlusion by any means or for any reason, except as specifically identified as covered;
- all other procedures involving the teeth or structures directly related to or supporting the teeth, including the gums and the alveolar processes; and
- treatment of sleep disorders by a dentist, including sleep apnea, except for the fabrication of an orthotic for treatment of a sleep disorder.

Organ And Tissue Transplants
Benefits are available to a Covered Person who is a transplant recipient for Medically Necessary Covered Services relating to or resulting from a transplant of these body organs or tissues:
- liver;
- heart;
- single and double lung;
- lobar lung;
- heart-lung,
- heart valve (heterograft);
- kidney;
- kidney-pancreas;
- pancreas;
- cornea;
- parathyroid;
- small intestine;
- small intestine and liver;
- small intestine and multiple viscera; or
- bone marrow transplants, including autologous and allogeneic stem cell transplants.

All transplant Services must be Preauthorized by BCBSNE, and meet BCBSNE established criteria and medical policies.

Donation of Organs and Tissue
Benefits are available for Services arising from an organ donation from either a live or non-living donor, including acquisition costs, when the recipient is a Covered Person. Benefits are included as part of the recipient's coverage, and are covered for the duration of the Covered Person's coverage under the Plan. Benefits for donation include Covered Services for treatment of complications resulting from the organ/tissue donation. Covered Services include:
- Hospital, medical, surgical or other Covered Services;
- Services provided for the evaluation of organs or tissue;
- Services provided for the removal of organs or tissue from nonliving donors; and
- Services provided for the transportation and storage of donated human organs or tissues.

Exclusions and Limitations
Benefits will not be provided for:
- donor charges other than those identified as covered under "Donations of Organ and Tissue;"
- purchase of organs or tissue, that are sold rather than donated to the recipient; or
- transplantation of any nonhuman organ or tissue, or the implantation of an artificial/mechanical organ into a human recipient. This does not apply to pacemakers, LVADs, or other devices specifically approved by BCBSNE.

Physician Services

Benefits are payable for Covered Services provided by a Physician, including an oral surgeon, Certified nurse midwife, Certified nurse practitioner, or a Certified Physician assistant, within the Provider's scope of practice. Covered Services include:

- Inpatient, Outpatient, office and home visits;
- surgical and assistant surgical Services;
- anesthesia;
- radiology, laboratory, pathology, and other diagnostic Services;
- radiation therapy and chemotherapy;
- FDA-approved drugs listed under the Drugs Administered in an Outpatient Setting List, IV solutions, vaccines, biologicals and medicines administered in the office;* and
- allergy serums and injections, except as specifically excluded.

Services performed in a Convenient Care/Retail Clinic or performed by a Physician assistant are covered in the same manner as a Primary Care Physician.

Physician Office Services

Benefits for the following Services provided in a Primary Care or Specialist Physician's office shall be paid subject to the cost-sharing amounts indicated in the Benefit Summary.

- **Physician Office Visit.** The Office Visit benefit includes the following Services performed in the Physician office:
  - office visit, including the initial visit to diagnose Pregnancy;
  - consultation;
  - psychological therapy and/or Substance Use Disorder counseling/rehabilitation for the treatment of Mental Health and Substance Use Disorder; and
  - medication checks.
- **Physician Office Services.** The Office Services benefit includes the following Services when performed in a Physician office:
  - diagnostic x-ray, laboratory and pathology Services performed in the Physician's office, including diagnostic pap smears and mammograms;
  - supplies used to treat the patient during the office visit;
  - covered drugs administered to the patient during the office visit;
  - hearing examination due to Illness or Injury;
  - vision examinations due to Illness or Injury; and
  - allergy testing.

Telehealth Services

Physician's Services include telehealth Services as a delivery of care method, for the diagnosis and treatment of a Covered Person's medical condition. Telehealth Services means web-based, video or telephonic visits, calls or consultations between a Covered Person and a Licensed Physician or other professional provider qualified to provide such Services.

The delivery and scope of telehealth Services are subject to applicable state and federal laws and regulations..

Telehealth Services are not applicable to or available for:

- reporting lab or other test results;
- office appointment requests;
- communication primarily educational in nature;
- billing, insurance or payment questions;
- Preauthorization procedures;

- Physician to Physician consultations;
- calls or consults by Telemedicine to another health care provider during a Covered Person's visit in a provider's office, unless otherwise covered by this Plan;
- Services, treatment or conditions outside the scope of the vendor Covered Services payable via a telehealth delivery of care method.

Telemedicine is web-based, video or telephonic visits, calls or consultations between or related to a Covered Person (with or without the Covered Person present) and a Licensed Physician and another professional provider qualified to provide such services.

Telehealth Services are subject to the cost-sharing amounts shown on the Benefit Summary. Benefits may be limited to In-network Providers only.

NOTE: If a Covered Person receives telehealth or telemedicine Services which may be covered under more than one health plan or contract, and identifies to the telehealth Services provider at the time of service that this Plan is to be used for coverage, this Plan will provide benefits as the primary coverage. When another health plan or contract is used or identified at the time of service, this Plan will become the secondary coverage pursuant to Coordination of Benefits. The Covered Person must submit a claim form and itemized statement and the other plan's Explanation of Benefits to BCBSNE reflecting the charges and cost-sharing amount paid pursuant to the other plan for benefit consideration under this Plan as the secondary coverage.

Preventive Services

Benefits are payable for Preventive Services required by the ACA, which are defined as:

- evidence-based items or Services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task force;
- with respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration;
- with respect to women, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and
- immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

The ACA-required Preventive Services may include age, gender and frequency limits. A list of these Preventive Services is available at NebraskaBlue.com/PreventiveCare, or you may contact the BCBSNE Member Services Department.

Benefits are also available as shown on the Benefit Summary for Covered Preventive Services.

Preventive Services do not generally include Services intended to treat an existing Illness or condition.

Therapy and Manipulations

The following Outpatient and/or home therapies and manipulative treatments or adjustments are covered subject to the applicable Deductible, Copay and/or Coinsurance amounts and benefit maximums shown on the Benefit Summary (Services must be ordered by a Physician):

- physical therapy by a Licensed physical therapist or Licensed physical therapist assistant who is an Approved Provider;
- occupational therapy by a Licensed occupational therapist or Licensed occupational therapist assistant under the supervision and billing of a Licensed occupational therapist;
- speech therapy provided by a Licensed speech-language pathologist or registered speech-language pathology assistant practicing under the supervision of a Licensed speech-language pathologist;
- chiropractic or osteopathic physiotherapy; and
- chiropractic or osteopathic manipulative treatments or adjustments by an Approved Provider.

Therapy Services described above include habilitative Services, which are Services designed to help a person keep, learn or improve skills and functions of daily living.

NOTE: A benefit maximum may apply to all of the above therapy and manipulation Services, or any combination of these services. Refer to the Benefit Summary for any applicable benefit maximums. Treatment limits stated for physical therapy, occupational therapy, and speech therapy are not applicable to treatment for Mental Health or Substance Use Disorder.

A session is defined as one visit. Ongoing preventive/maintenance therapy sessions (excluding habilitative Services) are not covered once the maximum therapeutic benefit has been achieved for a given condition and continued therapy no longer results in some functional or restorative improvement.

Women's Health Act

The Women's Health and Cancer Rights Act of 1998 (Women's Health Act) includes protections for patients who elect to have breast reconstruction in connection with a mastectomy.

The law requires that certain coverage be provided, and that notice be given to Covered Persons regarding coverage for this care under the Group health Plan. The Women's Health Act requires that:

A Group health Plan which provides medical and surgical benefits for mastectomies shall also provide, in the case of a Covered Person who is receiving benefits in connection with a mastectomy and elects breast reconstruction in connection with such mastectomy, coverage in a manner determined in consultation with the attending Physician and patient for:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- physical complications resulting from all stages of the mastectomy (including lymphedemas).

This Group health Plan is in compliance with the Women's Health Act, and provides benefits as required by the Act, subject to the Deductible, Copay and Coinsurance amounts applicable to other benefits under the Plan.

EXCLUSIONS — WHAT'S NOT COVERED

The Services, treatments and supplies listed in this section are not covered, except where specifically provided for under another section of this SPD, by an Amendment to this SPD, or as required by law.

Using Headings In This Section

To help you find specific exclusions more easily, headings are shown for types of Services, treatments or supplies that fall into a similar category. The actual exclusion appears under the heading.

Plan Exclusions

Benefits are not available for Services not covered by the Plan, nor for Services determined by BCBSNE to be not Medically Necessary.

Benefits are not available for the Services, treatments or supplies described in this section, even if:

- recommended or prescribed by a Physician; and/or
- it is the only treatment available for the Covered Person's condition.

Noncovered Services include, but are not limited to any Service for, or related to the following:

- **Alternative Treatments**
  - alternative therapies and programs including but not limited to;
    - massage therapy, including rolfing;
    - acupuncture;
    - aromatherapy;
    - light therapy, infrared or ultraviolet therapy;
    - naturopathy;
    - VAX-D therapy (vertebral axial decompression);
    - support therapies, including personal counseling and assertiveness training;
    - dream therapy;
    - activity therapy, including but not limited to music, dance, art, and play;
    - recreational therapy or care, unless otherwise identified as covered;
    - cruises;
    - wilderness programs;
    - adventure therapy;
    - camps, including all activities and therapies;
    - animal based therapy programs; and
    - vitamin therapy and herbal remedies.
  - Services provided by a massage therapist; and
  - Services, drugs, medical supplies, devices or equipment which are not cost effective compared to established alternatives or which are provided for the convenience or personal use of the Covered Person;
  - whirlpools, contrast baths, paraffin baths and iontophoresis.

- **Comfort Or Convenience**
  - personal expenses such as guest meals, television or beauty/barber services;
  - supplies, equipment or similar incidental charges for personal comfort or convenience, including:
    - batteries and battery chargers unless the device is covered by the Plan;
    - equipment primarily for education or a person's safety;
    - hot tubs, saunas, jacuzzis or whirlpools;
    - humidifiers;
    - medical alert systems;
    - music devices, radios or video players;
    - personal computers;
    - pillows;
    - safety equipment; and
    - strollers;
  - equipment for purifying, heating, cooling or otherwise treating air or water;
  - exercise equipment;

- building, remodeling or alteration of a residence, investigation and remediation of harmful contaminants such as lead and mold; and
- purchasing or customizing of vans or other vehicles.

- **Durable Medical Equipment (DME) And Supplies**
  - enuresis alarms and incontinence devices and supplies, even if prescribed by a Physician;
  - external defibrillators;
  - items purchased for the convenience of the Covered Person;
  - mouth guard, even if prescribed by a Physician;
  - power seat elevating systems and chairs;
  - rental or purchase from or use of DME while the patient is confined to a Hospital, skilled nursing facility, an intermediate care facility, a nursing home or any other licensed residential facility if such equipment is usually supplied by the facility;
  - repair, maintenance or adjustment of DME, except as specifically identified as covered, or provided by other than a DME or medical supply company; and
  - repair or replacement of an item of DME due to misuse, malicious damage, gross neglect or to replace lost or stolen items.
- **Experimental Or Investigative**
  - Services considered by BCBSNE to be Investigative, or for any directly related Services; or
  - Services for medical treatment and/or drugs, whether compensated or not, that are directly related to, or resulting from the Covered Person's participation in a voluntary, Investigative test or research program or study, unless authorized by BCBSNE.

- **Foot Care**
  - orthopedic shoes, except for initial purchase when permanently attached to a brace;
  - orthotics for the foot, except when such podiatric appliances are necessary for the prevention of complications associated with diabetes; or when necessary to treat a congenital anomaly, as determined by BCBSNE; or
  - treatment or removal of corns, callosities, or the cutting or trimming of nails, except as Medically Necessary.

- **Mental Health and Substance Use Disorder**
  - education, socialization, delinquency or custodial care Services for Mental Health and Substance Use Disorders
  - halfway houses, foster homes or group homes and treatment groups for Substance Use Disorder maintenance programs, unless otherwise identified as covered;
  - programs for co-dependency, employee assistance, probation, prevention, educational or self-help;
  - Inpatient confinement for environmental change or similar treatment;
  - Inpatient or Outpatient programs ordered by the Court that are determined by BCBSNE to be not Medically Necessary;
  - self-help programs that treat obesity, gambling or nicotine addiction, except when specifically identified elsewhere as a Covered Service;
  - halfway house or Substance Use Disorder maintenance programs;
  - Services by a non-Approved Mental Health Services Provider;
  - Services not within the scope of practice of the provider. (Licensing or certification is by the appropriate state authority. Supervision and consultation requirements are governed by the state law); or
  - Services, supplies, equipment, procedures, drugs or programs for treatment of nicotine addiction, except as identified as a Covered Service; and
  - stress reduction classes and pastoral counseling.

- **Nutrition**
  - dietary counseling, except as part of nutritional management for diabetes, certain conditions covered under the ACA Preventive Services and eating disorders;
  - enteral feedings, even if the sole source of nutrition; or

- nutrition care, nutritional supplements, FDA-exempt infant formulas and supplies;
- electrolytes or other nutritional substances, except as specifically identified as covered. This includes, but is not limited to, vitamins, minerals, elements, foods of any kind (including high protein and low carbohydrate foods) and other over-the-counter nutritional substances.

- **Physical Appearance**
  - Cosmetic Services, except for Covered Services:
    - required as a result of a traumatic injury;
    - to correct a Congenital Abnormality when the defect severely impairs or impedes normal essential functions; or
    - to correct a scar or deformity resulting from cancer or from non-Cosmetic surgery.

      Reconstructive surgery is available only when required to restore, reconstruct or correct any bodily function that was lost, impaired or damaged as a result of Injury or Illness.

      Benefits are not payable for treatment of complications, unless the treatment is normally covered under the Plan.

      The Cosmetic exclusion applies regardless of the underlying cause of the condition or any expectation that the Cosmetic procedure may be psychologically or developmentally beneficial to the Covered Person. Examples include but are not limited to:
      - dermabrasion;
      - liposuction;
      - breast augmentation;
      - breast reduction (unless Medically Necessary);
      - breast replacement;
      - protruding ears;
      - spider veins;
      - tattoo removal or revision; and
      - telangiectasias;
  - treatment and monitoring for obesity or weight reduction, regardless of diagnosis. Examples include:
    - health and athletic club memberships;
    - physical conditioning programs such as athletic training, body-building exercise, fitness, flexibility and diversion or general motivation; and
    - weight loss programs.

- **Providers**
  - Canceled appointment: charges for failure to cancel a scheduled appointment;
  - Claim forms/records/administrative fees or charges. This includes: charges made for filling out claim forms or furnishing any records or information; special charges such as dispensing fees; admission charges; Physician's charges for Hospital discharge Services; after-hour charges over and above the routine charge; administrative fees; technical support or utilization review charges which are normally considered to be within the charge for a Service;
  - Custodial Care, domiciliary care, rest cures, or Services provided by personal care attendants;
  - immediate family: charges for Services provided by a relative or person who is a member of the Covered Person's immediate family by blood, marriage or adoption;
  - inadequate documentation: charges received when there is inadequate documentation that a Service was provided;
  - non-approved facility: a health care facility that does not meet the licensing or Accreditation Standards required by BCBSNE;
  - non-approved Provider: charges for Services by a non-Approved provider, or provided by or under the supervision of a health care provider determined to be non-payable by BCBSNE;
  - out-of-hospital: charges made while the patient is temporarily out of the Hospital;
  - overhead expenses: charges for any office or facility overhead expenses including, but not limited to, staff charges, copying fees, facsimile fees and office supplies;

- scope of practice: charges for Services by a health care provider which are not within the scope of practice of such provider;
- Services provided in or by:
  - a Veterans Administration Hospital where the care is for a condition related to military service; or
  - any non-Participating Hospital or other institution which is owned, operated or controlled by any federal government agency, except where care is provided to nonactive duty Covered Persons in medical facilities;
- standby: Hospital or Physician charges for standby availability.

- **Reproductive Services**
  - Pregnancy assistance treatments, which include but are not limited to, infertility treatment and related Services, in addition to:
    - Assisted Reproductive Technology (ART), such as artificial insemination, sperm washing, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), and in vitro fertilization;
    - drug and/or hormonal therapy for fertility enhancement;
    - embryo transfer procedures;
    - reversal of voluntary sterilization;
    - storage and retrieval of all reproductive materials;
    - surrogate parenting, donor eggs, donor sperm and host uterus; and
    - ultrasounds, lab work and other testing in conjunction with infertility treatment (diagnostic testing done to determine the diagnosis of infertility, treatment of polycystic ovary disease, and treatment of endometriosis are not considered to be infertility treatments);
  - surrogate mother Services; and
  - voluntary abortions, unless the attending Physician certifies that the abortion was necessary to safeguard the life of the woman, or that the unborn child's viability was threatened by continuation of the Pregnancy. Services for medical complications arising from a voluntary abortion are not excluded.

- **Services Payable Under Another Plan**
  - Services available at government expense, except as follows:
    - if payment is required by state or federal law, the obligation to provide benefits will be reduced by the amount of payments the patient is eligible for under such program (except Medicaid);
    - with respect to persons entitled to Medicare Part A and eligible for Part B benefits, the obligation to provide benefits will be reduced by the amount of payment or benefits such person receives from Medicare. This provision will not apply if the patient is still actively at work or is an Eligible Dependent of a Subscriber who is actively at work and has elected this Plan as primary. Services provided for renal dialysis and kidney transplant Services will be provided pursuant to federal law; or
    - Services arising out of the course of employment, whether or not the patient fails to assert or waives his or her right to Workers' Compensation or Employers' Liability Law. This includes Services determined to be work-related under a Workers' Compensation law, or under a Workers' Compensation Managed Care Plan, but which are not payable because of noncompliance with such law or plan. Any charges incurred as a result of or in the course of employment for an employer that is not legally required to carry Workers' Compensation coverage and that does not provide Workers' Compensation coverage will be covered.

- **Travel**
  - lodging, meals and/or travel expenses incurred by the patient or the provider, even though directed by a Physician for the purpose of obtaining medical treatment, except covered ambulance Services or other expenses specifically identified as covered by the Plan.

- **Vision And Hearing**
  - eyeglasses or contact lenses, eye exercises or visual therapy or visual training (orthoptics), except when specifically identified elsewhere as a Covered Service;
  - preventive vision examinations or care, extended vision care or exam packages and screening eye examinations, including eye refractions, except when specifically identified elsewhere as a Covered Service;

- screening audiological tests (except as may be covered under Preventive Services); external and surgically implantable devices (except cochlear implants and bone anchored hearing aids as otherwise covered under this Plan) and combination external/implantable devices to improve hearing, including audiant bone conductors;
- hearing aids and their fitting, unless otherwise required by law, or as specifically covered under the Plan;
- surgical, laser or nonsurgical procedures or alterations of the refractive character of the eye including but not limited to correction of myopia, hyperopia or astigmatism. In addition, benefits are not available for:
  - charges for related Services; and
  - eyeglasses or contact lenses following the surgery.

Other Exclusions And Limitations

- Services, including related diagnostic testing, which are primarily:
  - recreational, such as music or art therapy;
  - educational, including school-based individualized education programs;
  - work-hardening therapy; vocational rehabilitation and training;
  - medical/non-medical self-care; or
  - self-help training;
- sex transformation surgery and related Services;
- interest, sales or other taxes or surcharges on Covered Services, drugs, supplies or DME, other than those surcharges or assessments made directly upon employers or third party payers;
- genetic treatment or engineering; cellular therapy, definitive drug test, gene therapy, gestational carrier, presumptive drug test and surrogate mother services, except for certain FDA-approved therapies approved by BCBSNE;
- any amount paid for eligible Claims expenses which arise out of or as caused or contributed to by war or an act of war. "War" means declared or undeclared war, whether civil or international, and any substantial armed conflict between organized forces of a military nature;
- food antigens, skin titration, cytotoxicity testing, treatment of non-specific candida sensitivity and auto-urine injections;
- snoring, the reduction or elimination of, when that is the primary purpose of treatment;
- calls or consults by telephone or other electronic means, including e-mail and video or internet transmissions, and telemedicine, except in conformance with BCBSNE policies and procedures;
- blood, blood plasma or blood derivatives or fractionates, or Services by or for blood donors, except administrative and processing charges for blood used for a Covered Person furnished to a Hospital by the American Red Cross, county blood bank, or other organization that does not charge for blood;
- Services provided to or for:
  - any dependent when coverage is provided by a Single Membership, except when benefits are specifically provided by the Plan for a newborn or adopted child;
  - any person who does not qualify as an Eligible Dependent; or
  - any Covered Person before his or her effective date of coverage, or after the effective date of cancellation or termination of coverage;
- military service related illness or injury;
- Services for which there is no legal obligation to pay, including:
  - Services for which no charge would be made if coverage did not exist;
  - any charge above the charge that would have been made if no coverage existed; or
  - any service which is normally furnished without charge;
- charges in excess of the Contracted Amount; or
- charges made separately for Services and/or procedures, supplies and materials when they are considered to be included within the charge for a total Service payable, or if the charge is payable to another provider.

  EXCEPTION: If such charges are made separately when they are considered to be included within the charge for a total Service performed by a BCBSNE In-network Provider, then this amount is not the patient's liability.

- employer-required Services and supplies as a condition of employment including, but not limited to immunizations, blood testing, work physicals and drug tests;
- charges made pursuant to a Covered Person's engagement in an illegal occupation or commission of or attempt to commit a felony;
- computed tomography (CT) of the heart with quantitative evaluation of coronary calcium, or electron beam computed tomography, for screening of cardiovascular, cerebrovascular and peripheral vascular disease;
- take-home supplies from an Inpatient facility;
- private Duty Nursing;
- long-term rehabilitation therapy, including residential Cognitive Training programs;
- respite care when not provided as part of a covered Hospice benefit;
- Home health aide, Skilled Nursing Care or Hospice related Services as follows:
  - Services performed by volunteers;
  - pastoral Services, or legal or financial counseling Services;
  - Services primarily for the convenience of the patient, or a person other than the patient; or
  - home delivered meals;
- shipping and handling charges;
- Services provided at the following places of service, unless otherwise approved by BCBSNE:
  - day care;
  - school (except Mental Illness Covered Services by an Approved Provider);
  - library;
  - church; or
  - employee worksite (except immunizations);
- Services provided in association with a health fair or other employer sponsored wellness event, unless otherwise approved by BCBSNE;
- Services otherwise covered under the Plan, when:
  - required solely for purposes of camp, travel, career, employment, insurance, marriage, adoption or other administrative reason;
  - related to judicial or administrative proceedings or orders;
  - conducted for the purpose of medical research; or
  - required to obtain or maintain a license of any type;
- foreign language and sign language Services;
- driving tests or exams;
- autopsies;
- any amount Paid by the Policyholder for Eligible Claims Expenses which arise out of or are caused or contributed to by war or an act of war. War means declared or undeclared war, whether civil or international, and any substantial armed conflict between organized forces of a military nature.
- removal of skin tags;
- replacement of lost, broken, destroyed or stolen Covered Prescription Drug Products within the Covered Person's control. BCBSNE may allow one fill per year, per medication;
- Services provided under a direct primary care agreement;
- Services by a Provider which were pre-paid by the Covered Person by virtue of a discount program, coupon, retail or online offer;
- over-the-counter supplies, devices, tests, medications and non-prescription medications (unless otherwise required by law or specifically designated for coverage by BCBSNE);
- hair analysis, including evaluation of alopecia or age-related hair loss; and
- wigs, hair prostheses and hair transplants, regardless of the reason for the hair loss;
- services by a Doula;
- short term storage and retrieval for cord blood, breast milk, and other materials, except as specifically identified as covered;
- social Services, and
- transportation, except as otherwise covered under the Plan;

PRESCRIPTION DRUG BENEFITS

Prescription Drug Benefits are subject to the applicable Copay, Deductible and/or Coinsurance amounts shown in the Benefit Summary. Prorated cost-sharing may apply if a partial supply is required by the prescribing physician and/or the pharmacist for the purpose of synchronizing medications. All covered prescription drug products must be Medically Necessary, and:

- be FDA-approved,*
- be evaluated for coverage by the Pharmacy and Therapeutics Committee of BCBSNE or the Pharmacy Benefit Manager,
- be dispensed by a registered pharmacist, and
- require a Physician's or Dentist's prescription.

*Specific non FDA-approved drugs may be covered, based on clinical guidelines or evidence as determined by the Pharmacy and Therapeutics committee, or as required by law.

A Copay, Deductible and/or Coinsurance will be assessed for each prescribed drug, supply and/or unit. Covered prescription drug products also include insulin and diabetic supplies, including: needles, syringes, test strips, lancet/lancet devices, alcohol wipes/swabs, glucose/sugar test tablets, insulin pump supplies and continuous glucose monitoring devices and supplies.

Benefits are also available under Other Covered Services for diabetic and insulin supplies which are Covered Services under the Plan, but are not covered under the Rx Nebraska Prescription Drug Program.

Your prescription drug benefit is based on a tiered benefit design that features multiple levels of cost-sharing for different prescription classifications. The tiers may include classifications such as Generic and Brand-name Drugs, Specialty Drugs, and preferred and non-preferred drugs. Sub-classifications may be based on cost or other factors. For example, a Prescription Drug List (PDL) which is a list of covered drugs, classifies drugs as Generic and Brand Name -- that classification may include sub-categories of preferred and non-preferred drugs. The PDL, including a list of designated Specialty Drugs, is available at NebraskaBlue.com/Pharmacy, or you may contact the BCBSNE Member Services Department.

Whenever appropriate, Generic Drugs will be used to fill prescriptions. If a bioequivalent Generic Drug is available and has multiple manufacturers, or meets other criteria as determined by the PBM or Us, reimbursement for the drug dispensed will be based on the price of the Generic Drug, unless prohibited by law. If the Covered Person or the ordering provider requests a Brand Name Drug when a Generic Drug equivalent is available, the Covered Person may be required a penalty equal to the difference in cost between the Brand Name Drug and the Generic Drug. If the ordering provider requires a Brand Name Drug equivalent,the penalty may be waived when meeting certain requirements. This penalty will be in addition to the applicable Copay, Deductible and Coinsurance.

NOTE: Prepackaging by the manufacturer may limit the quantity dispensed to an amount which is less than the maximum dispensing amount available under your coverage. If that happens, benefits will be provided in compliance with the manufacturer's packaging guidelines.

Additional terms specifically used in conjunction with your Prescription Drug Benefits are defined at the end of this section.

Generic Drugs Can Save You Money. Generic drugs are drugs that are labeled by their chemical name rather than by a brand name. However, all drugs, whether generic or brand, must meet the same government standards for safety and effectiveness. Why pay more for a brand name drug if its generic twin is available at a lower cost? Ask your physician to prescribe generic drugs whenever possible.

Accessing Benefits

If the prescription or supply is purchased at an In-network Pharmacy, and you present your BCBSNE identification card to the pharmacist at the time of purchase, you will only be required to pay your financial liability at the time the prescription is filled. In-network Pharmacies will file claims to BCBSNE or to the Pharmacy Benefit Manager (PBM). The Benefit Summary shows your financial liability and the dispensing amount for each benefit tier. See the section titled Drug Copayment Program below for additional information regarding amounts you may be required to pay.

If the covered prescription is filled at an Out-of-network Pharmacy, or if you do not present your I.D. card at the time of purchase at an In-network Pharmacy, you will be required to pay the pharmacy's usual retail price. You must file a Claim with BCBSNE. Eligible Claims will be reimbursed based on the Allowance for the drug less the applicable Copay, Deductible and/or Coinsurance.

To locate In-network pharmacies nationwide, call toll-free: 1-877-800-0746.

Other Coverage: If a Covered Person has prescription drug coverage under more than one health plan, Coordination of Benefits provisions will apply when the Services are covered under both the primary and secondary plan's pharmacy benefits. No penalty will be imposed for submission of a paper claim when BCBSNE is paying as the secondary payer.

Services Not Covered Under The Prescription Drug Program

In addition to the Services and supplies listed in the section titled "Exclusions — What's Not Covered," the following are not covered:

- abortifacients, including but not limited to Mifeprex (Mifepristone);
- cosmetic alteration drugs, and health and beauty aids for such things as the promotion of hair growth/restoration, to control perspiration, to enhance athletic performance or improve natural appearance;
- diagnostic agents (except diabetic test strips) and bulk powders/chemicals;
- diet, weight loss or appetite suppressant drugs (Anorexics), dietary and herbal or nutritional supplements;drugs or medicinals for treatment of fertility/infertility;
- DME or devices of any type including, but not limited to contraceptive devices, therapeutic devices or artificial appliances;
- general anesthetic;
- home infusion therapy;
- insulin pumps;
- Investigative drugs or drugs classified by the FDA as experimental;
- nutrition care, nutritional supplements and substances, except when specifically identified as covered such as infant and pediatric formulas;
- ostomy supplies;
- over-the-counter supplies, devices, tests, medications and non-prescription medications, unless specifically covered under the Plan or required by law;
- prescription medications administered or intended for use in an Inpatient setting;
- prescription medications determined by the FDA as having no clinical value (ex: DESI indicator class 06), or determined by the Pharmacy and Therapeutics Committee to have insufficient or unfavorable safety and/or efficacy;
- prescription medications for the primary purpose of sex transformation, both prior to and after surgery;
- prescription medications purchased in a foreign country, unless the covered person is living in another country or needs prescription medications to treat an emergency medical condition arising while he or she is traveling in a foreign country or otherwise mandated by federal legislation. Evidence of residency or emergency medical condition must be provided with the Claim;
- prescription medications that have (or are comprised of) therapeutically equivalent over-the-counter/non-prescription products, except as specifically covered under this Plan, or otherwise required by law. This limitation may apply to specific drugs or categories of prescription drugs;
- prescription medications obtained or purchased from a facility owned, operated or controlled by any federal government agency when the care is related to military service;

- repackaged medications;
- replacement of lost, broken, destroyed or stolen Covered Prescription Drug Products, within the Covered Person's control. BCBSNE may allow one fill per year, per medication.
- Services, drugs and medical supplies which are not cost effective compared to established alternatives or which are provided for convenience or personal use;
- unit dose packaging, or sample, clinic or institutional packs not intended for retail of covered prescription drug products; and
- other drugs, injectables and supplies that are not covered, as determined by BCBSNE, as permitted by law.

Limitations

- Benefits are not available for covered prescription amounts in excess of the supply limit (day or quantity).
- Lost, destroyed or stolen medications are limited to one replacement per prescription per calendar year.
- Compounded medications must contain at least one FDA approved drug, and compound ingredients must require a prescription and be FDA-approved. Compounded medications that include non-FDA approved ingredients or ingredients that do not require a prescription are not covered.
- Injectables are limited to Claims from providers who are contracting with Prime Therapeutics, and filed as a pharmacy Claim.
- Certain prescription drugs, based on the route or method of administration, may be payable only under the medical provision of the Plan, and not under the prescription drug coverage. This includes, but is not limited to, intravenous, intrathecal, intravesical and epidural routes of administration.
- Excessive pattern of drug usage:
  - If a Covered Person's usage of prescription drugs indicates an excessive pattern of usage that is not Medically Necessary (as determined by BCBSNE), the Covered Person will be limited to one In-network Pharmacy and/or prescribing provider of his/her choice, and approved by BCBSNE, for obtaining covered prescription drugs. If such a limitation applies, benefits will not be available for prescription drugs obtained from any other pharmacy. A Covered Person may also be limited from receiving Prescription Drug products prescribed by a certain prescriber and/or pharmacy and deny prescription claims if We determine that utilization exceeds certain threshold amounts.
- Any cost-sharing for prescription drugs paid with a pharmaceutical discount or Copay card will not apply to the Out-of-pocket Limit.
- Any FDA approved medication is not excluded from coverage if used for appropriate off-label cancer or HIV/AIDS diagnosis treatment. BCBSNE will determine whether the off-label use is appropriate based on recognition in United States Pharmacopeia Drug information or recognized in multiple major peer-reviewed medical literature that are not sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier. All other exclusions listed herein will apply to situations of experimental or investigational medications not approved by the FDA.

Preauthorization

Under the Rx Nebraska Drug Coverage Program preauthorization is required for prescriptions as determined by BCBSNE. We reserve the right to change drugs requiring preauthorization at any time without prior notice. The PDL for this plan and the pharmacy network are shown on the Schedule of Benefits Summary. For more information on prescription medications requiring preauthorization, visit the BCBSNE website, NebraskaBlue.com/PreAuth, or call the Member Services Department at the phone number shown on the back of your I.D. card.

Requesting Preauthorization

A written request to BCBSNE must be made prior to the initial purchase of the prescription. This request must be accompanied by appropriate documentation from the Covered Person's Physician, Dentist or other medical provider demonstrating the Medical Necessity of the drug. This written request should be directed to:

Blue Cross and Blue Shield of Nebraska
Attention: Pharmacy
P.O. Box 3248
Omaha, Nebraska 68180-0001

Preauthorization forms can be found on the BCBSNE website: NebraskaBlue.com/PreAuth

Upon receipt of the necessary information, BCBSNE will respond in writing advising the provider and the Covered Person whether or not benefits are available.

Note: The limitation, preauthorization and PDL may be updated at any time without notice. Additional information about your pharmacy benefits can be found on the BCBSNE website at NebraskaBlue.com/PreAuth.

Drug Copayment Program
Your health plan includes a drug Copayment program that utilizes manufacturer coupon assistance for the payment of select drugs purchased at designated pharmacies. For Covered Persons enrolled in this program, a variable Copayment may apply, which takes into account the manufacturer subsidy available toward the Covered Person's cost for the drug. Under this program, cost-share may be zero, and in no case will it be more than the applicable cost-share required under the plan. Subsidy amounts paid by the manufacturer, or the plan, do not apply to the Deductible or Out-of-pocket Limit. If a Covered Person is not enrolled in the program, their standard cost-share will apply. This program may not be available to Covered Persons enrolled in an HSA eligible plan.

PDL (Formulary) Exception Process
You or your Physician may request an exception for prescription drugs not otherwise excluded under the plan. The request for a PDL exception must be in writing on the appropriate PDL Exception form, identified as a PDL exception request, and include the name of the Covered Person and any additional information to be considered for review. Submit the request to the address on the back of your I.D. card. If approved, the PDL exception drug will be covered at the applicable tier payment level for the excepted drug. If the request for an exception is denied, an appeal may be made subject to the appeal procedures stated in this document.

Additional Provisions

- The Covered Person by accepting benefits under the Plan, authorizes and directs In-network Pharmacies and the PBM to furnish copies of all information and records concerning the person to BCBSNE.
- BCBSNE and the PBM will not be liable for any claim, injury, demand or judgment based on tort or other grounds arising out of or in connection with the sale, compounding, dispensing, manufacturing, or use of any prescription or supply.
- Services that are determined not Medically Necessary are the Covered Person's liability, as the agreement the In-network Pharmacy has with the PBM does not contain a hold harmless provision for these services.
- Many drugs are subject to rebate arrangements between the manufacturer of the drug and the PBM. Rebates are not reflected in the cost paid by the Covered Person for the drug. All or part of the rebates may be passed through to BCBSNE.
- When identical chemical entities including over-the-counter drugs and a similar prescription alternative are available, BCBSNE may determine that only one of those drug products is covered and those equivalent products are not covered.
- Emergency contraceptives are covered when based on product labeling and/or FDA documentation, a prescription is required to purchase emergency contraceptives. Benefits are limited to one regimen per prescription.

Definitions

The following terms are specifically used in conjunction with your Prescription Drug Benefits.

Allowance: The amount determined by BCBSNE to be payable to the Covered Person who has used an Out-of-network Pharmacy for a Covered Service. The Allowance may be one of the following:

- the lesser of the usual retail price or the applicable Contracted Amount payable for similar Services by similar In-network Pharmacies; and
- as otherwise determined by BCBSNE or our PBM to be appropriate based on industry standards for similar Covered Services.

Brand Name Drug: Single source and multisource brand drugs as set forth in the Medi-Span Master Drug Database File or such other recognized source relied upon by the PBM or BCBSNE. All products identified as "brand-name" by a manufacturer, pharmacy, or a provider may not be classified as Brand Name Drugs by the PBM or BCBSNE.

Compound Medication: A prescribed medication in which the ingredients are combined, mixed or altered specifically to meet the needs of a patient. A covered Compound Medication must contain at least one FDA-approved prescription ingredient.

Contracted Amount: The amount the In-network Pharmacy has agreed to accept as payment in full for a covered prescription drug product pursuant to an agreement with the PBM.

Extended Supply Network: A limited network of retail In-network Pharmacies, for which a retail purchase of a Covered prescription product in excess of 30 days may be purchased.

Generic Drug: A Generic Drug as set forth in the Medi-Span Master Drug Database File or such other recognized source relied upon by the PBM or BCBSNE. All products identified as "generic" by a manufacturer, pharmacy, or provider may not be classified as Generic Drugs by the PBM or BCBSNE.

In-network Pharmacies: Licensed pharmacies that have entered into written agreements with the PBM as designated by BCBSNE. The prescription drug coverage for your Plan may include more than one level of In-network (Preferred) pharmacies.

Narrow Therapeutic Index: Medications that generally require careful dosage adjustment and patient monitoring due to small variances in a patient's blood levels which can change the effectiveness and toxicity of the drug.

Out-of-network Pharmacies: Licensed pharmacies that have not entered into written agreements with the PBM as designated by BCBSNE.

Pharmacy and Therapeutics Committee: The PBM/BCBSNE panel of physicians, pharmacists and other health care professionals who are responsible for pharmacy management activities such as managing and updating the PDL (Formulary).

Pharmacy Benefit Manager (PBM): Prime Therapeutics, LLC, (Prime) has been retained by BCBSNE to administer the Rx Nebraska Prescription Drug Program.

Preauthorization: The process of obtaining authorization from BCBSNE or the PBM for specified medications or specified quantities of medications.

Prescription Drug List (Formulary): A continually updated list of covered pharmaceutical products, which represents the current clinical judgment of Physicians and other experts in the diagnosis and treatment of disease and preservation of health. This list is provided to In-network Pharmacies, Covered Persons, Physicians and other health care providers, and is also available on-line at NebraskaBlue.com/Pharmacy, or by contacting BCBSNE Member Services. Drugs listed on the Prescription Drug List (PDL) may be referred to a "Preferred," while drugs not listed on the PDL may be referred to as "Non-Preferred." BCBSNE reserves the right to change the PDL at any time without prior notice in compliance with federal law.

Specialty Drugs: Designated complex self-administered injectable and oral drugs that have very specific manufacturing, storage, and dilution requirements, used to treat serious or chronic medical conditions such as multiple sclerosis, rheumatoid arthritis, hemophilia, hepatitis C, Crohn's disease, and anemia. These drugs are generally covered up to a 30-day supply. Specialty Drugs may only be available through a designated Specialty Pharmacy.

Specialty Pharmacy: A licensed pharmacy designated by BCBSNE or the PBM to provide Specialty Drugs.

ELIGIBILITY AND ENROLLMENT

Your employer determines eligibility requirements and validates eligibility for enrollment and coverage under the health Plan. For additional information not found in this Summary Plan Description, please contact your employer.

Who's Eligible

An employee must be scheduled to work a minimum of 17.5 hours per week on a regular calendar year basis in order to be eligible for coverage. Eligibility for coverage will be determined by your employer. Coverage being effective the first of the month following the date of hire and/or meeting the eligibility criteria, provided that employee enrolls for coverage within 31 days. Bank Board of Directors are eligible for coverage selected by their bank, until they reach the age of 65.

The individual who enrolls for coverage or the "employee" is referred to as a Subscriber. Dependents are generally your spouse and children; in order to be an Eligible Dependent, they must meet the definition of an Eligible Dependent. For the complete definition of an Eligible Dependent, please refer to the section of this book titled "Definitions."

Initial Enrollment

Subscribers and dependents must enroll within 31 days of their initial eligibility or during a special enrollment period, or late enrollment provisions may apply.

Types of Membership

You may enroll in one of the following membership types under your Plan:

- **Single Membership:** This option provides coverage to you only.
- **Subscriber-Spouse Membership:** This option provides coverage to you and your spouse.
- **Single Parent Membership:** This option provides coverage to you and your Eligible Dependent children, but not to a spouse.
- **Family Membership:** This option provides coverage to you, your spouse and Eligible Dependent children.

NOTE: If two eligible persons in the same employer Group are married to each other, each person and/or their Eligible Dependents may not enroll under more than one membership unit. Also, if two eligible persons have a parent/child relationship and both are employed by the same employer Group, the parent and child may elect to enroll either as two employees, or the parent may enroll as an employee with dependent coverage.

Special Enrollment

A special enrollment period of 31 days is allowed for:

- enrollment of eligible persons due to marriage, birth, adoption or placement for adoption;
- enrollment of eligible persons who declined coverage under this plan due to having had other group health plan or health insurance coverage at the time it was previously offered, and who have lost that other coverage due to:
  - exhaustion of COBRA continuation coverage;
  - a loss of eligibility, including loss due to death, divorce, legal separation, termination of employment or reduction in hours, or due to the plan no longer offering benefits to the class of individuals that includes the person (when the other coverage was not COBRA);
  - moving out of the service area of an HMO or other arrangement that only provides benefits to individuals who reside, live or work in the service area; or
  - the employer ceasing to make contribution for the other coverage (when the other coverage was not COBRA).

A special enrollment period of 60 days is allowed for:

- enrollment of eligible persons who were covered under Medicaid or State Child Health Insurance Program (SCHIP), which has been terminated due to loss of eligibility; or
- enrollment of eligible persons who have become eligible for premium assistance for this Group health Plan coverage under Medicaid or SCHIP.

The Subscriber must enroll (or already be enrolled) in order to enroll his or her dependents in this Plan. In the case of a marriage, birth or adoption, a Subscriber who is eligible, but who has not previously enrolled, may enroll at this time with or without the newly Eligible Dependent. Likewise an eligible spouse who has not previously enrolled, may enroll as a special enrollee with or without the new dependent child. Please contact your Human Resource Department for additional information.

Late Enrollment/Open Enrollment

A "late enrollee" is defined as a Subscriber or dependent who does not timely enroll, or does not enroll for coverage within the first period in which he or she is eligible to enroll. A person who enrolls for coverage during a "special enrollment period" is not considered a late enrollee. Late enrollment is allowed at any time. For additional information on late enrollment, please contact your Human Resource Department.

Adding A Dependent

Dependents may enroll if you, the eligible employee, are covered under the Plan. In order to add a dependent, he or she must meet the definition of an Eligible Dependent and you must be enrolled under a membership option that provides coverage for dependents. Please contact your Human Resource Department for enrollment information and instructions.

Effective Date Of Coverage

Provided that an appropriate membership option is in place and, if applicable, any additional premium is paid, the effective date of coverage will be as follows:

- **Marriage:** The effective date of coverage for new spouses will be the first of the month in which the event took place, provided the request for enrollment is made within 31 days of the marriage.
- **Newborn Children:** Coverage will begin at birth for your newborn child for a period of 31 days. To continue coverage, you must enroll the child within that 31-day period. If your spouse was not enrolled at the time of the child's birth, he or she may also enroll within this 31-day period, and the effective date will be the date of the child's birth.
- **Adopted Children:** Coverage for an adopted child will be effective on the earlier of the date the child is placed with you for adoption, or the date a court order grants custody to you. You must enroll the child within 31 days of the placement/custody order. If your spouse was not enrolled at the time of the adoption, he or she may also enroll within this 31-day period, and the effective date will be the date of the placement/adoption.
- **Loss of Other Coverage:** The effective date of coverage for persons enrolling as a special enrollee following a loss of other coverage will be no later than the last day of month in which eligibility for other coverage is lost.

Qualified Medical Child Support Orders (QMCSO)

A QMCSO is a court order that requires an employee to provide medical coverage for his or her children (called alternate recipients) in situations involving divorce, legal separation, or paternity disputes. The order may direct the Group health Plan to enroll the child(ren), and also creates a right for the alternate recipient to receive plan information, submit claims, and receive benefits for Services.

QMCSOs are specifically defined under the law, and are required to include certain information in order to be considered "qualified." A National Medical Support Notice received by the employer or plan from a state agency, regarding coverage for a child, will also be treated as a QMCSO. The Plan Administrator or its designee, will review the Order or Notice to determine whether it is qualified, and make a coverage determination. The Plan Administrator or its designee will notify affected employees and the alternate recipient(s) if a QMCSO is received.

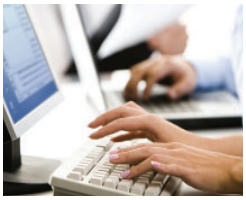
You have the right to request a copy of the Plan's procedures governing QMCSO determinations from the Plan Administrator, at no charge.

Active Employees Age 65 And Over

Federal law affects the way employers provide coverage to eligible active employees and their spouses who are 65 and over. These active employees and their spouses ages 65 and over generally continue full coverage under the employer Group plan as their primary coverage, and Medicare (if elected) as secondary coverage. Under this law, if the employee elects Medicare as their primary carrier, the group plan may not pay as secondary coverage and will be terminated.

Family Medical Leave Act (FMLA)

The Family Medical Leave Act of 1993, as amended, requires that subject to certain limitations, most employers of 50 or more persons must offer continued coverage to eligible employees and their covered dependents, while the employee is on an approved FMLA leave of absence. In addition, an employee who has terminated his/her Group health coverage while on an approved FMLA leave is entitled to reenroll for Group health coverage upon return to work. Please check with your employer for details regarding your eligibility under FMLA.



If You Receive Covered Services From An In-network Provider

Contracting Providers and many other Hospitals and Physicians will file the Claim to BCBSNE on your behalf. Out-of-state Contracting Providers will file a Claim with their local Blue Cross and Blue Shield plan for processing through the BlueCard Program. When BCBSNE receives a Claim from a Contracting Provider, payment will be made directly to the provider, unless otherwise provided by state or federal law. You are responsible for meeting any applicable Deductible and paying any applicable Copay and/or Coinsurance amounts. You may be asked to pay amounts that are your liability at the time of service, or the provider may bill you for those amounts.

Filing A Claim

You must file your own Claim if your health care provider is not a Contracting Provider and does not file for you. You may obtain a Claim form by contacting BCBSNE's Member Services Department, or you can find a form on the website at NebraskaBlue.com/Forms.

All submitted Claims must include:

- correct BCBSNE ID number, including the alpha prefix;
- name of patient;
- the date and time of an accident or onset of an illness, and whether or not it occurred at work;
- diagnosis;
- an itemized statement of services, including the date of service, description and charge for the service;
- complete name, address and professional status (MD, RN, etc.) of the health care provider;
- prescription number, if applicable;
- the name and identification number of other insurance, including Medicare; and
- the primary plan's explanation of benefits (EOB), if applicable.

Claims cannot be processed if they are incomplete, and may be denied for "lack of information" if required information is not received.

Claims should be filed by a Provider or Covered Person as soon as possible after the date of Service. Contracting Providers will file claims on the Covered Person's behalf; the Covered Person is responsible to provide their identification number in order for the claim to be filed. Claims that are not filed by a BCBSNE Contracting Provider in accordance with BCBSNE's timely tiling requirement will become the Contracting Provider's liability.

A covered Person is responsible to file a claim for Services provided by a non-contracting Provider if the provider does not submit on his or her behalf.

If a claim is not filed within 12 months of the date of service (except in the absence of legal capacity), benefits will not be allowed.

In Nebraska, Claim forms should be sent to:
Blue Cross and Blue Shield of Nebraska
P.O. Box 3248
Omaha, Nebraska 68180-0001

If health care Services are provided in a state other than Nebraska, Claims should be filed to the Blue Cross and Blue Shield plan servicing the area where the Services were received. If you need assistance in locating the plan, please contact BCBSNE's Member Services Department.

Payment Of Benefits For Non-Contracting Provider Claims

Payment will be made, at BCBSNE's option, to the Covered Person, to his or her estate, to the provider or as required by state or federal law. Benefits may also be paid to an alternate recipient or custodial parent, if pursuant to a QMCSO.

No assignment, whether made before or after Services are provided, of any amount payable according to this Group health Plan shall be recognized or accepted as binding upon BCBSNE, unless otherwise provided by state or federal law.

Payment For Services That Are The Covered Person's Responsibility

Under certain circumstances, if BCBSNE pays the provider amounts that are your responsibility, such as Copays, Deductibles, or Coinsurance, we may collect such amounts from you. You agree that BCBSNE has the right to collect such amounts from you.

Right To Amend Provider Agreements Or Benefit Payment Procedures

Agreements with health care providers may be changed or terminated, and benefit payments to In-network Providers may be altered. Benefit payments may be calculated on a charge basis, a Contracted Amount or similar charge, global fee basis, through a Preferred Provider Organization, or in any other manner agreed upon by BCBSNE or the On-site Plan and the provider. However, any payment method agreed upon will not affect the method of calculating the Deductible and Coinsurance.

Claim Determinations

A "Claim" may be classified as a "Preservice" or "Postservice."

Preservice Claims — In some cases, under the terms of the health Plan, the Covered Person is required to Preauthorize benefits in advance of a Service being provided, or benefits for the Service may be reduced or denied. This required request for a benefit is a "Preservice" Claim." Preservice Claim determinations that are not Urgent Care Claims will be made with 15 calendar days of receipt, unless an extension is needed to obtain necessary information. If an extension is needed, BCBSNE will provide notice to the Covered Person and/or his or her provider prior to the expiration of the initial 15-day period. If additional information is requested, the Covered Person or his or her provider may be given up to 45 calendar days from receipt of notice to submit the specified information. A Claim determination will be made within 15 days of receipt of the information, or the end of the extension period.

(See the section of this book titled "Preauthorization Requirements" for more information on Preauthorizing benefits.)

Urgent Care — If your Preservice Claim is one for Urgent Care, the determination will be made within 72 hours of receipt of the Claim, unless further information is needed. If additional information is necessary, the Covered Person or his or her provider will be given no less than 48 hours to provide the specified information. Notification of the decision will be provided not later than 48 hours after the earlier of: our receipt of the information, or the end of the period allowed to submit the information.

Concurrent Care — If you request to extend a course of treatment beyond the care previously approved and it involves urgent care, a decision will be made within 24 hours of the request, if you submitted the request at least 24 hours before the course of treatment expires. In all other cases, the request for an extension will be decided as appropriate for a Preservice and Postservice Claims.

Postservice Claims — A Postservice Claim is any Claim that is not a Preservice Claim. In most cases, a Postservice Claim is a request for benefits or reimbursement of expenses for medical care that has been provided to a Covered Person. The instructions for filing a Postservice Claim are outlined earlier in this section. Upon receipt of a completed Claim form, a Postservice Claim will be processed within 30 days, unless additional information is needed. If additional information is requested, the Covered Person may be given not less than 45 days to submit the necessary information. A Claim determination will be made within 15 days of receipt of the information, or the expiration of the 45-day extension period. You will receive an EOB when a Claim is processed which explains the manner in which your Claim was handled.

Explanation Of Benefits

Every time a Claim is processed for you, an EOB form will be sent. The front page of the EOB provides you with a summary of the payment including:

- the patient's name and the Claim number;
- the name of the individual or institution that was paid for the Service;
- the total charge associated with the Claim;
- the covered amount;
- any amount previously processed by this Plan, Medicare or another insurance company;
- the amount(s) that you are responsible to pay the provider;
- the total Deductible and/or Coinsurance that you have accumulated to date; and
- other general messages.

A more detailed breakdown of the charges including provider discounts, amount paid and cost sharing amounts (e.g. noncovered charges, Deductible and Copays) are shown on the back of your EOB.

Also included on your EOB is information regarding your right to appeal a benefit determination, or request additional information.

Save your EOBs in the event that you need them for other insurance or for tax purposes.

APPEAL PROCEDURES

BCBSNE has the discretionary authority to determine eligibility for benefits under the health Plan, and to construe and interpret the terms of the Plan, consistent with the terms of the Administrative Services Agreement.

You have the right to seek and obtain a review of "adverse benefit determinations" arising under this health Plan.

Appeal Procedure Definitions

Adverse Benefit Determination: A determination by BCBSNE or its Utilization Review designee, of the denial, reduction, or termination of a benefit, or a failure to provide or make payment (in whole or in part) of a benefit. This includes any such determination that is based on:

- the application of Utilization Review;
- a determination that the Service is Investigative;
- a determination that the Service is not Medically Necessary or appropriate;
- an individual's eligibility for coverage or to participate in a plan;
- an unexpected ("surprise") balance bill from an Out-of-network Provider for emergency and certain non-emergency Services.

An Adverse Benefit Determination also includes any rescission of coverage, which is defined as a cancellation or discontinuance of coverage that has a retroactive effect, except if for failure to timely pay required premiums or contribution for coverage.

Final Internal Adverse Benefit Determination: An Adverse Benefit Determination that has been upheld by BCBSNE, or its Utilization Review designee, at the completion of the internal appeal process as described in this document.

Preservice Claim(s): Any Claim for a benefit under the Plan with respect to which the terms of the Contract require approval of the benefit in advance of obtaining medical care, and failure to do so will cause benefits to be denied or reduced.

Postservice Claim(s): Any Claim that is not a Preservice Claim or Urgent Care Claim.

Urgent Care Claim: A Claim for medical care or treatment for which the application of the time periods for making non-urgent care determinations:

- could seriously jeopardize the life or health of the Covered Person or the ability of the Covered Person to regain maximum function; or
- in the opinion of a physician with knowledge of the claimant's medical condition, would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Claim.

How To Appeal An Adverse Benefit Determination

A Covered Person or a person acting on his/her behalf (the "claimant") is entitled to an opportunity to appeal initial or final Adverse Benefit Determinations.

Internal Appeal

A request for an internal appeal must be submitted within six (6) months of the date the Claim was processed, or Adverse Benefit Determination was made. The written request for an appeal should be submitted on the designated appeal request form included in adverse benefit determinations letters. The form can also be found a NebraskaBlue.com/Forms or contact the Member Services Department at the number found on the back of you I.D. card. The appeal should also include:

- the name of the person submitting the appeal and his/her relationship to the patient;
- the reason for the appeal;
- any information that might help resolve the issue; and
- the date of service/Claim.

BCBSNE will provide the claimant a notice of receipt of the request within 3 days. The notice will include the name, address and telephone number of a person to contact regarding coordination of the review. The claimant does not have the right to be in attendance at the appeal review nor to have a representative in attendance but may submit additional information for consideration.

If the Adverse Benefit Determination was based on a medical judgment, including a Medical Necessity or Investigative determination, BCBSNE will consult with health care professionals with appropriate training and experience in the field of medicine involved in the medical judgment, to make the appeal determination. The appeal determination will be made by individuals who were not involved in the original determination.

Timing of Appeals Determinations

The table below describes the timing for appeals:

APPEAL	ERISA TIMING
PRE-SERVICE (NON-URGENT)	
• Written notice of the appeal determination within	30 calendar days
• You must appeal the internal appeal (1st level appeal) and file an external appeal (2nd level appeal) within	4 months after receiving the 1st level appeal decision
• Written notice of the external (2nd level) appeal decision will be provided within	45 calendar days from the date the IRO receives the appeal
POST-SERVICE	
• Written notice of the appeal determination will be provided to the claimant within	60 calendar days
• If additional time is needed and written notice is provided on or before the 15th day, the appeal determination will be provided to the claimant within	NA
• You must appeal the internal appeal (1st level appeal) and file an external appeal (2nd level appeal) within	4 months after receiving the internal (1st level) appeal decision
• Written notice of the external (2nd level) review decision will be provided within	45 calendar days from the date the IRO receives the appeal
EXPEDITED APPEAL (Urgent Care)	
• An expedited appeal will be reviewed, determined and notice provided to the claimant within	72 hours after receipt

Concurrent Care: A request for an expedited appeal of a concurrent care denial must be made within 24 hours of the denial. If the appeal is requested within the 24-hour time period, coverage will continue for health care Services pending notification of the review decision, as may be required by law. The decision time frame will be the same as for other expedited appeals.

The decision made pursuant to this appeal will be considered a Final Adverse Benefit Determination.

NOTE: When an adverse appeal determination involves medical judgment, upon receipt of a written request, the identity of the health care professionals who reviewed the appeal will be provided to the claimant.

Rights To Documentation

A claimant has the right to have access to, and request copies of, the documentation relevant to the Claim and Adverse Benefit Determination(s), including any new evidence or rationale considered or relied upon in connection with the Claim on review.

The claimant may submit additional comments, documents or records relating to the Claim for consideration during the appeal process.

External Review

Standard External Review: If the claimant has exhausted internal appeal reviews, an external review by an Independent Review Organization (IRO) may be requested for review of an Adverse Benefit Determination or Final Internal Adverse Benefits Determination for:

- Those involving medical judgment (excluding those that involve only contractual or legal interpretation without any use of medical judgement); or
- Rescission of coverage (whether or not the rescission has any effect on any particular benefit at the time) (ERISA self-funded only).

Medical judgment includes, but is not limited to

- Determinations based on the plan's or insurer's requirements for medical necessity;
- Appropriateness;
- Health care setting;
- Level of care, or effectiveness of a covered benefit, or its determination that a treatment is experimental or investigational.

The request must be submitted in writing within four months after the date of receipt of the Final Internal Adverse Benefit Determination. (An Adverse Benefit Determination based on an individual's eligibility for coverage or to participate in a plan is not eligible for External Review.)

The Covered Person will be required to authorize the release of any of his or her medical records which may be needed for the purpose of the external review.

Upon receipt of a request for an External Review, BCBSNE shall review the request to determine if it is complete and whether the request is eligible for External Review. BCBSNE will conduct the preliminary review within five (5) business days of receipt, and notify the claimant of the outcome within one business day. If it is determined that the request is not complete, or it is not eligible for External Review, the claimant will be notified of the reason for ineligibility, or advised of the information needed to make the request complete.

If the request is eligible for External Review, it will be forwarded to the IRO, including the documentation and information considered in making the initial Adverse or Final Adverse Benefit Determination. The claimant will be allowed an opportunity to submit additional information for consideration by the IRO. The IRO shall provide BCBSNE with any information submitted by the claimant, to allow BCBSNE an opportunity to reconsider its original determination.

The IRO shall complete its review and provide the claimant written notification and rationale for its decision within 45 calendar days of receipt of the request for review. No deference shall be given to the prior determinations made by BCBSNE pursuant to the internal appeal process.

Expedited External Review: An expedited External Review may be requested at the same time a claimant requests an expedited internal appeal of an Adverse Benefit Determination of an Urgent Care Claim if:

- the denial involves an Urgent Care Claim where the timeframe for completing an expedited internal appeal could seriously jeopardize the life or health of the Covered Person or the ability of the Covered Person to regain maximum function; or
- for non-ERISA Plans, the denial was based on a determination that the requested service or treatment is Investigative, if the Covered Person's treating physician certifies in writing that the service or treatment would be significantly less effective if not promptly initiated.

However, the claimant must first exhaust the internal appeal process unless otherwise waived by BCBSNE or as directed by the IRO, consistent with applicable law.

An expedited External Review may also be requested following a Final Internal Adverse Benefit Determination if:

- the Covered Person has a medical condition where the time frame for completion of a standard External Review would seriously jeopardize the life or health of the Covered Person, or would jeopardize his or her ability to regain maximum function; or
- the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay or health care Service for which the Covered Person has received emergency Services, but has not been discharged from the facility.

The decision of the IRO is the final review decision and is binding on BCBSNE and the claimant, except to the extent that the claimant may have other remedies available under applicable federal or state law. Once an external review decision has been made, the Covered Person or his/her representative may not file a subsequent request for an external review involving the same initial or final Adverse Benefit Determination.

When You Have Coverage Under More Than One Plan

This Plan includes a Coordination of Benefits (COB) provision. COB provisions apply when a Covered Person has coverage under more than one health Plan. This provision establishes a uniform order in which the Plans pay their Claims, limits the duplication of benefits, and provides for transfer of information between the Plans.

The order of benefit determination rules described in this section determine which Plan will pay as the primary Plan without regard to any benefits that might be payable by another Plan.

Definitions

For the purpose of this section, the terms are defined as:

Allowable Expense: A health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense.

The amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of Plan provisions include second surgical options, preauthorization of admissions, and preferred provider arrangements.

Closed Panel Plan: A Plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

Custodial Parent: The parent awarded custody by a court decree or, in the absence of a court decree, the parent with whom the child resides more than one half of the calendar year excluding temporary visitation.

Plan: As used in this section, any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts:

a. Plan includes: group and nongroup insurance contracts and subscriber contracts, health maintenance organization (HMO) contracts, Closed Panel Plans; other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits coverage in motor vehicle "no-fault" and traditional "fault" type contracts; group and nongroup insurance contracts and subscriber contracts that pay or reimburse for the cost of dental care; and Medicare or any other federal governmental Plan, as permitted by law.
b. Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage other than the medical benefits coverage in motor vehicle "no fault" and traditional "fault" contracts; uninsured or underinsured coverage under a motor vehicle policy; specified disease or specified accident coverage; limited benefit health coverage, as defined in state law; school accident coverage; disability income insurance; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; and coverage under other federal governmental Plans, unless permitted by law.

Each contract for coverage under a. or b. is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

Primary Plan: The Plan that will determine payment for its benefits first before those of any other Plan without considering any other Plan's benefits.

Secondary Plan: The Plan that will determine its benefits after those of another Plan and may reduce the benefits so that all Plan benefits do not exceed 100% of the total Allowable Expense. The Secondary Plan will not pay more than the Primary Plan's contracted reimbursement rate.

This Plan: The part of the contract providing health care benefits to which the COB provision applies and which may be reduced because of the benefits of other Plans. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

Order Of Benefit Determination Rules

1. The Primary Plan pays or provides its benefits according to its terms or coverage and without regard to the benefits under any other Plan.
2. A Plan that does not contain a coordination of benefits provision that is consistent with this Part is always primary unless the provisions of both Plans stated that the complying Plan is primary.
3. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.
4. Each Plan determines its order of benefits using the first of the following rules that apply:

    - **Subscriber And Dependent —** The Plan that covers the person as other than a dependent, such as a subscriber/policyholder/employee is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent and primary to the Plan covering the person as a subscriber, then the order of benefits between the two Plans is reversed so that the Plan covering the person as a subscriber is the Secondary Plan and the other Plan is the Primary Plan.

    - **Dependent Child Covered Under More Than One Plan —** Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:
        - For a dependent child whose parents are married or are living together, whether or not they have ever been married, the Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan. If both parents have the same birthday, the Plan that has covered the parents the longest is the Primary Plan (birthday rule).
        - For a dependent child whose parents are divorced, separated or not living together, whether or not they have ever been married, if a court decree states that one of the parents is responsible for the child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, the Plan of that parent's spouse is primary. This rule applies to Plan years beginning after the Plan is given notice of the court decree.
        - If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the order of benefits shall be determined by the "birthday rule" stated above.
        - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the order of benefits shall be determined by the "birthday rule" stated above.
        - If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
            - the Plan covering the custodial parent;
            - the Plan covering the spouse of the custodial parent;
            - the Plan covering the non-custodial parent; and then
            - the Plan covering the spouse of the non-custodial parent.

- For a dependent child covered under more than one Plan of individuals who are not parents of the child, the above provisions shall apply as if those individuals were the parents.
- For an Eligible Dependent child covered under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule below for "Longer or Shorter Length of Coverage" applies. In the event the Eligible Dependent child's coverage under the spouse's plan began on the same date as his or her coverage under the parents' plan(s), the order of benefits shall be determined by applying the "birthday rule" above, to the child's parent(s) and to his or her spouse.

- **Active Employee, Retired or Laid-Off Employee —** The Plan that covers a person as an active employee, that is, an employee who is neither retired nor laid off, is the Primary Plan. The Plan covering that same person as a retired or laid-off employee is the Secondary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the first rule (Subscriber and Dependent) can determine the order of benefits.
- **COBRA or State Continuation Coverage —** If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as a subscriber/member/employee/retiree or covering the person as a dependent of a subscriber/member/employee/retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the first rule (Subscriber and Dependent) can determine the order of benefits.
- **Longer or Shorter Length Of Coverage —** The Plan that has covered the person longer is the Primary Plan and the Plan that has covered the person the shorter period of time is the Secondary Plan. The start of a new Plan does not include a change in the amount or scope of a Plan's benefits; a change in the entity that pays, provides or administers the Plan's benefits; or a change from one type of Plan to another, such as from a single employer Plan to a multiple employer Plan.

If the above rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

Administration Of Coordination Of Benefits

The order of benefit determination rules govern the order in which each Plan will pay a Claim for benefits. The Plan that pays first is called the Primary Plan. The Plan that pays after the Primary Plan is called the Secondary Plan.

If This Plan is the Primary Plan, there shall be no reduction of benefits. Benefits will be paid without regard to the benefits of any other Plan.

If This Plan is the Secondary Plan, it may reduce its benefits so that the total benefits paid or provided by all Plans for any Claim are not more than the total Allowable Expenses. In determining the amount to be paid for any Claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the Claim do not exceed the total Allowable Expense for that Claim. In addition, the Secondary Plan shall credit to its Plan Deductible any amounts it would have credited to its Deductible in the absence of other health coverage. Also, if the Primary Plan is medical payments coverage under a motor vehicle policy, the Secondary Plan shall credit payments from the motor vehicle insurance policy to Deductibles, Copayments and Coinsurance after discounts under the health plan.

Miscellaneous Provisions

If these COB rules do not specifically address a particular situation, BCBSNE may, at its discretion, rely on the National Association of Insurance Commissioners Coordination of Benefits Model Regulation as an interpretive guide.

To properly administer these COB rules, certain facts are needed. This Plan may obtain or release information to any insurance company, organization or person. BCBSNE need not notify, or obtain the consent of any person to do so. Any person who claims benefits under This Plan agrees to furnish the information that may be necessary to apply COB rules and determine benefits.

If another Plan pays benefits that should have been paid under This Plan, this Plan may reimburse the other Plan amounts determined to be necessary. Amounts paid to other Plans in this manner will be considered benefits paid under This Plan and This Plan is released from liability for any such amounts.

If the amount of the benefits paid by This Plan exceeds the amount it should have paid, This Plan has the right to recover any excess from any other insurer, any other organization, or any person to or for whom such amounts were paid, including Covered Persons under This Plan.

Termination Of Coverage

Coverage under your Group health Plan will terminate for you and/or your dependents on the earliest of the following dates:

- the date the entire Contract is terminated;
- the last day of the month in which you terminate employment;
- the last day of the month in which you cease to be eligible under the health plan; or a dependent ceases to be an Eligible Dependent;
- the last day of the month in which BCBSNE receives a request from you or the employer to terminate coverage for you or a dependent, or the date requested in the notice, if later;
- the last date for which premium is paid; or
- another date as specified by your employer.

You and/or your Eligible Dependents may be eligible to continue coverage under the Group health plan as detailed in this section.

Continuation Of Coverage Under The Federal Continuation Law (COBRA)

If you terminate your employment, or if a dependent loses coverage due to certain "Qualifying Events," continued coverage under the Group health Plan may be available. Payment for continued coverage under the federal continuation law is at the employee's or dependent's own expense. Please contact your employer for details regarding eligibility.

What Is The Federal Continuation Law?

The Consolidated Omnibus Budget Reconciliation Act (COBRA), is a federal law which provides that a Covered Person who would lose coverage due to the occurrence of a "Qualifying Event," may elect to continue coverage under the Group health Plan. A person who is eligible to continue coverage is called a "Qualified Beneficiary." A Qualified Beneficiary also includes a child born to, or placed for adoption with the Covered Person during the period of COBRA coverage. Please share the information found in this section with your Eligible Dependents.

Termination Of Employment Or Reduction In Hours — COBRA provides that if you should lose eligibility for coverage due to:

- voluntary or involuntary termination of employment (other than for gross misconduct);
- a lay-off for economic reasons; or
- a reduction in work hours,

you and your covered dependents may be able to continue the Group coverage at your own expense for up to 18 months. Your employer is required to notify the Plan Administrator within 30 days of the loss of coverage. The Plan Administrator will send the Qualified Beneficiaries a COBRA notification within 14 days after receiving notice from the employer. If the employer and Plan Administrator are the same entity, the COBRA notification will be sent within 44 days of the date of the loss of coverage.

Disability — If a Qualified Beneficiary is determined by the Social Security Administration to have been disabled any time during the first 60 days of COBRA continuation coverage, the COBRA coverage period for the disabled individual and his or her related beneficiaries may be extended to 29 months instead of 18 months when loss of coverage is due to termination or reduction in hours of employment. You must provide written notice of the disability determination to the plan within 18 months of becoming eligible for COBRA and no later than 60 days after the date of the Social Security Administration's determination.

If the Social Security Administration determines that you or the dependent are no longer disabled, the extended continuation of coverage period (19th through 29th month) will be terminated the month that begins more than 30 days after the determination. You must notify the plan within 30 days of a determination that an individual is no longer disabled.

Change In Dependent Status, Divorce/Separation Or Medicare Entitlement — COBRA requires that continued coverage under the Group health Plan be offered to your covered spouse and eligible children if they would otherwise lose coverage as a result of:

- divorce or legal separation;
- a child losing dependent status; or
- the employee becoming entitled to Medicare.

When one of these circumstances occur, you or the dependent are obligated to notify the employer or Plan Administrator within 60 days. Failure to provide timely and proper notice may result in the loss of the right to COBRA.

After receiving a timely notice of such an event, your employer or the Plan Administrator will send the Qualified Beneficiaries an election form and the information needed to apply for coverage, if eligible, within 14 days of the date the notice is received. Coverage may be continued at the individual's expense for up to 36 months.

Your Death — If you should die while you are covered under this Group health Plan, continued coverage is available to your spouse and Eligible Dependents.

COBRA provides that subject to certain limitations, your surviving spouse and children may continue the Group health coverage at their own expense for up to 36 months. Federal law requires your employer to send the surviving family members instructions as to how to apply for continued coverage if they are eligible.

Special Provisions — If an employer files Chapter 11 bankruptcy, special provisions regarding COBRA continuation coverage may apply for a retiree or deceased retiree's surviving spouse and dependent children. Please check with your employer for details.

Electing COBRA Coverage

Qualified beneficiaries will be sent a written notice of the right to continue health coverage and an election form(s).

REMINDER: In the case of a divorce or legal separation, or if a child loses dependent status, you must notify your employer or Plan Administrator of this Qualifying Event within 60 days. Failure to provide timely and proper notice may result in the loss of the right to COBRA coverage.

Qualified Beneficiaries must complete and return the COBRA election form in order to continue coverage. The notice will include instructions for completing and returning the form. The election form must be received by the later of:

- 60 days after the day health coverage would otherwise end; or
- 60 days after the notice is sent to you by the employer or Plan Administrator.

COBRA continuation coverage may only begin on the day after coverage under the Group health Plan would otherwise end. The required premium, including any retroactive premium, must be paid from the day coverage would have otherwise ended. The premium must be paid within 45 days after the day continued coverage is elected. Succeeding premiums must be paid monthly within 30 days of the premium due date. The COBRA notice and election form will inform you or your dependents of the monthly premium amount, and to whom such premium should be paid.

Second Qualifying Event — In the event your family experiences another Qualifying Event while receiving an 18-month period of COBRA coverage (or the extended 29-month period), your covered spouse and dependents are eligible to extend the original COBRA coverage period to a maximum of 36 months if notice of the second event is properly given to the employer or Plan Administrator. This extension may be available to the spouse and children receiving continuation coverage if: a) you die; b) you become entitled to Medicare; c) you get divorced or legally separated; or d) the dependent child is no longer eligible as a dependent, but only if the second event would have caused the spouse or child to lose coverage under the plan had the first Qualifying Event not occurred. In all of these cases, you or the dependent must notify the employer or Plan Administrator within 60 days of the second Qualifying Event.

Termination Of COBRA Coverage — A Qualified Beneficiary's COBRA continuation coverage will end at midnight on the earliest of:

- the day your employer ceases to provide any Group health Plan to any employee;
- the day the premium is due and unpaid;
- the day the individual first becomes covered under any other group health plan (after the COBRA election);
- the day the individual again becomes covered as an employee or dependent under this Plan;
- the day an insured person becomes entitled to benefits under Medicare (after COBRA election); or
- the day health insurance has been continued for the maximum period of time allowed (18, 29 or 36 months).

NOTE: In the event more than one continuous provision applies, the periods of continued coverage may run concurrently, but never for more than 36 months.

Uniformed Services Employment And Reemployment Rights (Military Leave)

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) requires that continued coverage under an employer Group health Plan be offered to an employee and covered dependents if coverage would otherwise be lost due to a military leave.

Continuation Of Group Health Coverage

If coverage under your employee Group health Plan ends because of service in the uniformed services, you may elect to continue health coverage for yourself and your covered dependents, until the earlier of:

- 24 consecutive months from the date active duty began; or
- the day after the date on which You fail to apply for, or return to employment, in accordance with USERRA.

You are responsible for payment of the required premium to continue coverage. If the leave for military service is less than 31 days, your required premium is the standard employee share of the applicable premium; for a leave in excess of 30 days, the required premium shall be no more than 102% of the total premium applicable for your membership option. Your employer will inform you of the amount and procedure for payment of premiums.

A Covered Person's continued coverage under these USERRA provisions will end at midnight on the earliest of:

- the day the employer ceases to provide any Group health Plan for its employees;
- the day premium is due and unpaid;
- the day a Covered Person again becomes covered under this Plan;
- the day coverage has been continued for the period of time stated above.

Reemployment

Following service in the uniformed services, an employee may be eligible to apply for reemployment with the employer in accordance with USERRA. Such reemployment includes the right to reenroll for Group health coverage provided by the employer, with no new waiting periods imposed.

Please contact your employer for further information regarding your rights under USERRA.

Benefit Plan Document

This SPD provides an overview of your benefits. It is not intended to be a complete description of every detail of the Group health Plan. All coverage and benefit determinations are governed by the Benefit Plan Document, which consists of the Administrative Services Agreement, this SPD, and other documents entered into between the Group and BCBSNE.

Fraud Or Misrepresentation

A Covered Person's coverage may be canceled or rescinded for fraud or intentional misrepresentation of material fact about a claim or eligibility for this coverage.

If coverage is rescinded, the amount of premium paid will be reduced by any benefits that were paid, and will be refunded. If benefits paid exceed the premium received, BCBSNE may recover the difference.

Contracting Providers

BCBSNE does not engage in the practice of medicine and all Contracting Providers provide Services under the terms of the Plan as independent practitioners of the healing arts. Such providers are not employees or agents of BCBSNE or the On-site Plan, and BCBSNE will not be liable for any act, error, or neglect of any Hospital, Physician or other provider or their agent, employee, successor or assignee.

Subrogation

Subrogation is the right to recover benefits paid for Covered Services provided as the result of Injury or Illness which was caused by another person or organization. When benefits are paid under the Group health Plan, the Plan shall be subrogated to all of the Covered Person's right of recovery against any person or organization to the extent of the benefits paid. The Subscriber, the Covered Person or the person who has the right to recover for a Covered Person (usually a parent or spouse), agrees to make reimbursement to the Plan if payment is received from any source.

This subrogation shall be a first priority lien on the full or partial proceeds of any settlement, judgment, or other payment recovered by or on behalf of the Covered Person, whether or not there has been full compensation for all his or her losses, or as provided by applicable law. The Plan's rights shall not be defeated by allocating the proceeds in whole or in part to nonmedical damages.

Contractual Right To Reimbursement

If a Covered Person receives full or partial proceeds from any other source for Covered Services for an Illness or Injury, the Group health Plan has a contractual right of reimbursement to the extent benefits were paid under the Plan for the same Illness or Injury. This contractual right to reimbursement shall be a first priority lien against any proceeds recovered by the Covered Person, whether or not the Covered Person has been fully compensated for all his or her losses, or as provided by applicable law.

Such proceeds may include, but are not limited to, any settlement; judgment; payments made under insurance; individual or group no fault auto insurance; individual or group medical payment coverage; bodily injury overage; uninsured or underinsured motorist protection; or proceeds otherwise paid by any source. This contractual right to reimbursement is in addition to and separate from the subrogation right. The Group health Plan's rights shall not be defeated by allocating the proceeds in whole or in part to nonmedical damages. For Covered Persons residing in Michigan, this Plan is always secondary to automobile no-fault coverage, personal injury protection coverage, or medical payments coverage.

When BCBSNE recovers proceeds under this contractual right to reimbursement for all or a part of the Claim, amounts previously credited to a Covered Person's Deductible or Coinsurance liability may be removed. Future Claims will be subject to the reinstated Deductible or Coinsurance.

No adult Subscriber may assign any rights to recover medical expenses from any third party to any minor or other dependent of the adult Subscriber or to any other person, without the express written consent of Group health Plan. The right to recover, whether by subrogation or reimbursement, shall apply to settlements or recoveries of deceased persons, minor dependents of a Subscriber, incompetent or disabled Subscribers, or their incompetent or disabled Eligible Dependents.

The Subscriber agrees to fully cooperate and assist in any way necessary to recover such payments, including but not limited to notifying BCBSNE of a claim or lawsuit filed on his or her behalf, or on behalf of any Eligible Dependent for an Injury or Illness. The Subscriber, Eligible Dependent or an authorized representative shall contact BCBSNE prior to settling any claim or lawsuit to obtain an updated itemization of its subrogation Claim or reimbursement amount due. Upon receiving any proceeds, the Subscriber, Eligible Dependent or an authorized representative must hold such proceeds in trust until such time as the proceeds can be transferred to the Group health Plan. The party holding the funds that rightfully belong to the Group health Plan shall not interrupt or prejudice the Plan's recovery of such payments.

Costs incurred in enforcing these provisions shall also be recovered, including, but not limited to, attorneys' fees, litigation and court costs, and other expenses.

Workers' Compensation

Benefits are not available for Services provided for Injuries or Illnesses arising out of and in the course of employment, whether or not the Covered Person fails to assert or waives his or her right to Workers' Compensation or Employer Liability Law. The employer is required to furnish or pay for such Services or a settlement can be made, pursuant to Workers' Compensation laws. (See also the section of this book titled "Exclusions — What's Not Covered.")

If a Covered Person enters into a lump-sum settlement which include compensation for past or future medical expenses for an Injury or Illness, payment will not be made under the Group health plan for Services related to that Injury or Illness.

Benefits are not payable for services determine to be not compensable due to noncompliance with terms, rules and conditions under Workers' Compensation laws, or a Certified or otherwise Licensed Workers' Compensation Managed Care Plan. In addition, benefits are not payable for Services that are related to the work Injury or Illness, but are determined to be not necessary or reasonable by the employer or Workers' Compensation carrier.

In certain instances, benefits for such Services are paid in error under the Group health Plan. If payment is received by the Covered Person for such Services, reimbursement must be made. This reimbursement may be refunded from any recovery made from the employer, or the employer's Workers' Compensation carrier, as permitted by law. Reimbursement must be made directly by the Subscriber when benefits are paid in error due to his or her failure to comply with the terms, rules and conditions of Workers' compensation laws, or a Certified or Licensed Workers' Compensation Managed Care Plan.

Legal Actions

The Subscriber cannot bring a legal action to recover under the Contract for at least 60 days after written proof of loss is given to BCBSNE. The Subscriber cannot start a legal action after three years from the date written proof of loss is required.

Your ERISA Rights

As a participant in this Group health Plan, you are entitled to certain rights and protections under ERISA (Employee Retirement Income Security Act of 1974).

ERISA provides that all plan participants shall be entitled to:

- Receive Information About Your Plan and Benefits
  - Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the plan, including insurance contracts, and collective bargaining agreements, and a copy of the latest annual report filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
  - Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts, collective bargaining agreements, copies of the latest annual report and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
  - Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
- Continue Group Health Plan Coverage
  - Continue health coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event (COBRA). You or your dependents may have to pay for such coverage. Review your Summary Plan Description and the documents governing the Plan for the rules regarding Your COBRA continuation rights.

Prudent Actions By Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your Claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a Claim or benefit which is denied or ignored in whole or in part, you may file suit in a state or federal court. If you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in a federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay these costs and fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs or fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

DEFINITIONS

ACA: The Patient Protection and Affordable Care Act and implementing regulations and sub-regulatory guidance.

Advanced Diagnostic Imaging: Highly developed technologies that use computerized imaging or radio isotropic enhancements to play a decisive role in diagnostics, such as computerized tomography (CT) scans, magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), MRI of the breast, magnetic resonance spectroscopy (MRS), functional brain MRI (fMRI), positron emission tomography (PET) scans, single photon emission computed tomography (SPECT) scans and other nuclear medicines.

Administrative Services Agreement (ASA): The agreement entered into between the Group and BCBSNE for administration of the Group's self-insured, or partially self-insured, health care programs for eligible employees.

Aggregate Deductible and/or Out-of-pocket Limit: The term Aggregate is used to describe a manner in which the Deductible and Out-of-pocket Limit are accumulated under a multi-person Membership Unit. Aggregate Deductible means the entire family amount must be met before benefits are available to any family member (for Services subject to the Deductible). Aggregate Out-of-pocket Limit means the entire family amount must be met before cost-sharing is no longer applicable. Family members may combine their Covered Expenses to satisfy the family amounts.

Allowable Charge: An amount used by BCBSNE to calculate payment for Covered Services. This amount will be based on either the Contracted Amount for In-network Providers or the Out-of-network Allowance for Out-of-network Providers.

Ambulance Services: Any privately or publicly owned motor vehicle or aircraft that is especially designed, constructed or modified, and equipped and is intended to be used and is maintained or operated for the overland or air transportation of patients upon the streets, roads, highways, airspace or public ways or any other motor vehicles or aircraft used for such purposes.

Ambulatory Surgical Facility: A Certified facility that provides surgical treatment to patients not requiring inpatient hospitalization. Such facility must be Licensed as a health clinic as defined by state statutes, but shall not include the offices of private Physicians or dentists whether for individual or group practice.

Approved Clinical Trial: A phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is one of the following:

- A federally funded or approved trial.
- A clinical trial conducted under an FDA investigational new drug application.
- A drug trial that is exempt from the requirement of an FDA investigational new drug application.

Routine patient costs for purposes of an Approved Clinical Trial shall mean Covered Services:

- for which benefits are payable absent a clinical trial;
- required solely for providing the experimental or investigative Services or monitoring its effect, or preventing complications; and
- needed for reasonable and necessary care arising from the provision of an experimental or Investigative Services.

Approved Provider: A Licensed practitioner of the healing arts who provides Covered Services within the scope of his or her License or a Licensed or Certified facility or other health care provider, payable according to the terms of the Plan, Nebraska law or pursuant to the direction of BCBSNE.

Auxiliary Provider: A Certified social worker, psychiatric registered nurse, Certified alcohol and drug abuse counselor or other Approved Provider who is performing Services within his or her scope of practice and who is supervised, and billed for, by a qualified Physician, Licensed Psychiatrist or Licensed Psychologist, or as otherwise permitted by state law. Certified master social workers or Certified professional counselors performing mental health Services who are not Licensed Mental Health Practitioners are included in this definition.

Benefit Plan Document: The agreement between BCBSNE and the Group which includes the Administrative Services Agreement and any attachments or addenda, this Summary Plan Description, and the individual enrollment information of Subscribers and their Eligible Dependents.

Benefit Summary: A summary of the cost-sharing amounts, benefit maximums or limits, and other specific information regarding coverage under the Plan. The Summary may be provided as a separate document, and/or included within this Summary Plan Description.

Benefit Year: A consecutive period of time, specified by your employer/plan sponsor, in which benefits are accumulated toward the Deductible, Out-of-pocket Limit and any applicable benefit maximums or limits. Your Benefit Year may be a calendar year or other 12-month period, as shown on your Benefit Summary.

BlueCard® Program: This Blue Cross and Blue Shield Association (BCBSA) program is a collection of policies, provisions and guidelines that enables BCBSNE to process Claims incurred by Covered Persons residing or traveling outside its Service Area by utilizing the discounts negotiated by the On-site plan and its Contracting Providers.

Certification: Successful voluntary compliance with certain prerequisite qualifications specified by regulatory entities. Agencies and programs may be deemed to be in compliance when they are accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Commission on the Accreditation of Rehabilitation Facilities (CARF), American Association for Ambulatory Health Care (AAAHC), American Association for Accreditation of Ambulatory Plastic Surgery Facilities (AAAAPSF), Medicare or as otherwise provided in the Plan provisions or state law.

Claim: A request for benefits under this Plan.

Cognitive Training: A rehabilitative intervention aimed at retraining or facilitating the recovery of mental and information processing skills including perception, problem-solving, memory storage and retrieval, language organization and expression.

Coinsurance: The percentage amount the Covered Person must pay for Covered Services.

Congenital Abnormality: A condition existing at birth which is outside the broad range of normal, such as cleft palate, birthmarks, webbed fingers or toes. Normal variations in size and shape of the organ such as protruding ears are not considered a Congenital Abnormality.

Contracted Amount: The Allowable Charge agreed to by BCBSNE or a Host Blue plan and Contracting Providers, for Covered Services received by a Covered Person.

Contracting Provider: An In-network Provider or a BlueCard Program Preferred or Participating Provider.

Convenient Care/Retail Clinic: A medical clinic located in a retail location such as a grocery or drug store, where a provider offers treatment of minor medical conditions, immunizations and physicals without an appointment.

Copayment (Copay): A fixed dollar amount of the Allowable Charge, payable by the Covered Person for a Covered Service, as indicated in the Benefit Summary. Copayments are separate from and do not accumulate to the Deductible.

Cosmetic: Any Services provided to improve or change the patient's physical appearance or characteristics, from which no significant improvement in physiologic function can be expected, regardless of emotional or psychological factors.

Covered Person: Any person entitled to benefits for Covered Services pursuant to the Benefit Plan Document administered by BCBSNE.

Covered Services: Hospital, medical or surgical procedures, treatments, drugs, supplies, Durable Medical Equipment, or other health, mental health or dental care, including any single Service or combination of Services, for which benefits are payable under the Benefit Plan Document, while the ASA is in effect.

Creditable Coverage: Coverage of the individual under any of the following: (a) a group health plan, as defined by HIPAA; (b) health insurance coverage consisting of medical care offered by a health insurance issuer in the group or individual market; (c) Part A or Part B of Medicare; (d) Medicaid, other than coverage consisting solely of benefits under section 1928 (for pediatric immunizations); (e) Title 10 U.S.C. Chapter 55 (medical and dental care of the uniformed services); (f) a medical care program of the Indian Health Service or a tribal organization; (g) a State health benefits risk pool; (h) the Federal Employees Health Benefits Program; (i) a public health plan, which means a plan providing health coverage that is established by a State, the U.S. government, or a foreign country, or a political subdivision thereof; (j) a health plan of the Peace Corps, or (k) a State Children's Health Insurance Program (SCHIP).

Creditable Coverage does not include coverage described in HIPAA as "excepted benefits," including: coverage only for accidents; disability income coverage; liability insurance, including general liability and automobile liability and any supplement thereto; credit only insurance; or coverage for on site medical clinics.

Other excepted benefits include: limited scope dental or vision coverage or long term care coverage; non coordinated coverages offered separately, such as specified disease or illness policies, hospital or other fixed indemnity insurance; and supplemental benefits such as Medicare Supplemental health insurance, TRICARE supplemental programs or other similar supplemental coverage.

Custodial Care: The level of care that consists primarily of assisting with the activities of daily living such as bathing, continence, dressing, transferring and eating. The purpose of such care is to maintain and support the existing level of care and preserve health from further decline.

Custodial Care includes:

- care given to a Covered Person who:
  - is intellectually or physically disabled; and
  - needs a protected, monitored or controlled environment or assistance to support the basics of daily living, in an institution or at home; and
  - may be ventilator dependent or require routine catheter maintenance;
- health-related Services that are provided for the primary purpose of meeting the personal needs of the Covered Person or maintaining a level of function (even if the specific Services are considered to be skilled Services), as opposed to improving that function to an extent that might allow for a more independent existence; and
- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively, such as recording pulse, temperature, and respiration; supervising medications that can usually be self-administered; or administration and monitoring of feeding systems.

Deductible: An amount of Allowable Charges that must be paid by the Covered Person each Benefit Year before benefits are payable by the Plan.

Durable Medical Equipment: Equipment and supplies which treat an Illness or Injury, to improve the functioning of a particular body part, or to prevent further deterioration of the patient's medical condition. Such equipment and supplies must be designed and used primarily to treat conditions that are medical in nature, and be able to withstand repeated use. Durable Medical Equipment includes such items as prosthetic devices, orthopedic braces, crutches and wheelchairs. It does not include sporting or athletic equipment or items purchased for the convenience of the family. This term also includes items commonly referred to as home medical equipment.

Eligibility Waiting Period: Applicable to new Subscribers only, the period between the first day of employment and the first date of coverage under the Plan. This period may include the probationary period required by the Plan. This period will not exceed 90 days.

Eligible Dependent:

- The spouse of the Subscriber unless the marriage has been ended by a legal, effective decree of dissolution, divorce or separation;
- Children to age 26. "Children" means:
  - the Subscriber's biological and adopted sons and daughters;
  - a grandchild who lives with the Subscriber in a regular child-parent relationship where the grandchild receives no support or maintenance from the parent and where the Subscriber is a court-appointed guardian of the grandchild;
  - a stepchild (the son or daughter of the Subscriber's current spouse); or
  - a child, other than a grandchild or stepchild, for whom the Subscriber is a court-appointed guardian, but does not include a foster child.
- Reaching age 26 will not end the covered child's coverage under the plan as long as the child is, and remains both incapable of self-sustaining employment, or of returning to school as a full-time student, by reason of intellectual or physical disability; and dependent upon the Subscriber for support and maintenance.

Physical or intellectual disability" means a severe disability of a person which: a) is attributed to a physical or mental impairment or combination of physical or mental impairments; b) is manifested before the person attains age 26; c) is likely to continue indefinitely; and d) results in incapability of performing self-sustaining employment.

"Severe disability" means substantial functional limitations in three (3) or more of the following areas of major life activities:

- self-care;
- receptive and expressive language;
- learning;
- mobility;
- self-direction; or
- capacity for independent living; and reflects the person's need for treatment or other services which are of an indefinite duration and are individually planned and coordinated.

A physician's statement may be required.

Proof of the requirements stated above must be received by the group health plan from the Subscriber within 31 days of the child's reaching age 26 and after that, as required (but not more often than yearly after two years of such handicap). Determination of eligibility under this provision will be made by the Group. Any extended coverage under this paragraph will be subject to all other provisions of the Plan.

Embedded Deductible and/or Out-of-pocket Limit: The term Embedded is used to describe a manner in which the Deductible and Out-of-pocket Limit are accumulated under a multi-person Membership Unit. An Embedded accumulation means that family members' amounts are combined to satisfy the family amount, however no one family member must contribute more than the individual amount (Embedded amount) to satisfy the family amount.

Emergency Medical Condition: A medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including, but not limited to, severe pain that a prudent lay person, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- placing the health of the person afflicted with such condition in serious jeopardy or, in the case of a behavioral condition, placing the health of such persons or others in serious jeopardy;
- serious impairment to such person's bodily functions;
- serious impairment of any bodily organ or part of such person; or
- serious disfigurement of such person.

Emergency Services: Health care Services Medically Necessary to screen and stabilize a Covered Person in connection with an Emergency Medical Condition and the provider or facility determines such individual is able to travel using nonmedical transportation.

Essential Health Benefits: The ACA identifies ten categories of Covered Services as Essential Health Benefits: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Group: The employer/entity providing health coverage for its employees/participants pursuant to the agreement with BCBSNE.

Habilitative Services: Health care Services that help a person keep, learn, or improve skills and functioning for daily living. These Services may include physical and occupational therapy, speech-language pathology and other Services for people with disabilities in a variety of Inpatient and/or Outpatient settings.

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

Hospital: An institution or facility duly Licensed by the State of Nebraska or the state in which it is located, which provides medical, surgical, diagnostic and treatment Services with 24 hour per day nursing Services, to two or more nonrelated persons with an Illness, Injury or Pregnancy, under the supervision of a staff of Physicians Licensed to practice medicine and surgery.

Host Blue: A Blue Cross and/or a Blue Shield plan in another Blue Cross and Blue Shield Association Service Area, which administers Claims through the BlueCard Program for Nebraska Covered Persons residing or traveling in that Service Area.

Implant: An artificial material grafted or implanted into or onto bone.

Illness: A condition which deviates from or disrupts normal bodily functions or body tissues in an abnormal way, and is manifested by a characteristic set of signs or symptoms.

Independent Laboratory: A freestanding facility offering radiology and pathology Services which is not part of a Hospital and is Licensed by the proper authority in the state in which it is located.

Injury: Physical harm or damage inflicted to the body from an external force.

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 BCBSNE 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.

Investigative: A technology, a drug, biological product, device, diagnostic, treatment or procedure that has not been Scientifically Validated. BCBSNE will determine whether a technology is Investigative.

Late Enrollee: An individual who does not enroll for coverage during the first period in which he or she is eligible, or when eligible, during a Special Enrollment Period.

Licensure (Licensed): Permission to engage in a health profession that would otherwise be unlawful in the state where Services are performed, and which is granted to individuals who meet prerequisite qualifications. Licensure protects a given scope of practice and the title.

Long Term Acute Care (LTAC): Specialized acute Hospital care for medically complex patients who are critically ill, have multi-system complications and/or failures, and require hospitalization in a facility offering specialized treatment programs and aggressive clinical and therapeutic intervention on a 24-hour/seven-day-a-week basis.

Medicaid: Grants to states for Medical Assistance Programs, Title XIX of the Social Security Act, as amended.

Medically Necessary or Medical Necessity: Health care Services ordered by a Treating Physician exercising prudent clinical judgment, provided to a Covered Person for the purposes of prevention, evaluation, diagnosis or treatment of that Covered Person's Illness, Injury or Pregnancy, that are:

- consistent with the prevailing professionally recognized standards of medical practice; and, known to be effective in improving health care outcomes for the condition for which it is recommended or prescribed. Effectiveness will be determined by validation based upon scientific evidence, professional standards and consideration of expert opinion;
- clinically appropriate in terms of type, frequency, extent, site and duration for the prevention, diagnosis or treatment of the Covered Person's Illness, Injury or Pregnancy. The most appropriate setting and the most appropriate level of Service is that setting and that level of Service, considering the potential benefits and harms to the patient. When this test is applied to the care of an Inpatient, the Covered Person's medical symptoms and conditions must require that treatment cannot be safely provided in a less intensive medical setting;
- not more costly than alternative interventions, including no intervention, and are at least as likely to produce equivalent therapeutic or diagnostic results as to the prevention, diagnosis or treatment of the patient's Illness, Injury or Pregnancy, without adversely affecting the Covered Person's medical condition; and
- not provided primarily for the convenience of the following:
  - the Covered Person;
  - the Physician;
  - the Covered Person's family;
  - any other person or health care provider; and
- not considered unnecessarily repetitive when performed in combination with other prevention, evaluation, diagnoses or treatment procedures.

BCBSNE will determine whether Services are Medically Necessary. Services will not automatically be considered Medically Necessary because they have been ordered or provided by a Treating Physician.

Medicare: Health Insurance for the Aged and Disabled, Title XVIII of the Social Security Act, as amended.

Membership Unit: The category of persons to be provided benefits, pursuant to the Subscriber's enrollment.

- **Single Membership:** This option provides benefits for Covered Services provided to the Subscriber only.
- **Subscriber-Spouse Membership:** This option provides benefits for Covered Services provided to the Subscriber and his or her spouse.
- **Single Parent Membership:** This option provides benefits for Covered Services provided to the Subscriber and his or her Eligible Dependent children, but not to a spouse.
- **Family Membership:** This option provides benefits for Covered Services provided to the Subscriber and his or her Eligible Dependents.

Other Membership Units may be available as determined by BCBSNE and the Group.

Mental Health Services Provider: A qualified Physician, Licensed Psychologist, Licensed Special Psychologist, Licensed Psychiatrist and Licensed Mental Health Practitioners are payable providers under the Plan. A Mental Health Practitioner may also be a Licensed Professional Counselor, Licensed Marriage and Family Therapist or a Licensed Clinical Social Worker who is duly Certified/Licensed for such practice by state law. It also includes, for purposes of the Plan, Auxiliary Providers supervised, and billed for, by a professional as permitted by state law. All mental health Services must be provided under appropriate supervision and consultation requirements as set forth by state law.

- **Licensed Psychologist:** A person Licensed to engage in the practice of psychology in this or another jurisdiction. The terms Certified, registered, chartered, or any other term chosen by a jurisdiction to authorize the autonomous practice of psychology shall be considered equivalent terms.
- **Licensed Psychiatrist:** A person Licensed to engage in the practice of psychiatry to diagnose and treat complex and serious Mental Health conditions. In addition to psychotherapy, treatment provided by a Licensed Psychiatrist may involve prescribing medications.
- **Licensed Special Psychologist:** A person who has a doctoral degree in psychology from an institution of higher education accredited by the American Psychological Association but who is not Certified in clinical psychology. Such person shall be issued a special License to practice psychology that continues to require supervision by a Licensed Psychologist or qualified Physician for any practice that involves major mental and emotional disorders. This psychologist may provide mental health Services without supervision.
- **Licensed Mental Health Practitioner:** A person Licensed to provide treatment, assessment, psychotherapy, counseling, or equivalent activities to individuals, families or groups for behavioral, cognitive, social, mental, or emotional disorders, including interpersonal or personal situations. Mental health practice shall include the initial assessment of organic mental or emotional disorders (as defined by state law), for the purpose of referral to, or consultation with a qualified Physician or a Licensed Psychologist.

  Mental health practice shall not include the practice of psychology or medicine, prescribing drugs or electroconvulsive therapy, treating physical disease, Injury, or deformity, diagnosing major Mental Illness or disorder except in consultation with a qualified Physician or a Licensed Psychologist, measuring personality or intelligence for the purpose of diagnosis or treatment planning, using psychotherapy with individuals suspected of having major mental or emotional disorders except in consultation with a qualified Physician or Licensed Psychologist, or using psychotherapy to treat the concomitants of organic Illness except in consultation with a qualified Physician or Licensed Psychologist.

Mental Health: 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 Benefit Plan Document.

Out-of-network Allowance: An amount BCBSNE uses to calculated payment for Covered Services to an Out-of-network Provider. This amount will be determined by BCBSNE or by the Host Blue plan, as applicable.

- If determined by BCBSNE: the Out-of-network Allowance is calculated as the lesser of the billed charge or an allowance established using a pre-determined method based on the type of service. Such methods include, but are not limited to :
  - a fee schedule based on a percentage of the Medicare allowance for the service;
  - a per diem or daily rate allowance;
  - a percentage of billed charges;
  - an APR-DRG grouping methodology.

- If determined by a Host Blue Plan: the out-of-network Allowance will be the amount that the Host Blue Plan passes to BCBSNE. The Host Blue Plan's allowance may be based on:
  - a negotiated price for their participating providers;
  - the billed charge;
  - their local payment for nonparticipating providers;
  - price arrangement required by any applicable state law.

Out-of-network Provider: A provider of health care Services who has not contracted with BCBSNE to provide Services as a part of a Preferred Provider network in Nebraska.

Out-of-pocket Limit: The maximum amount of cost-share each Covered Person or Membership Unit must pay in a Benefit 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, unless otherwise stated. The Out-of-pocket Limit does not include premium amounts, amounts over the Allowable Charge, or penalties for failure to comply with Preauthorization requirements or as may be imposed under the 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.

Outpatient Program: An organized set of resources and Services administered by a Certified provider, which is directed toward the accomplishment of a designed set of objectives. Day treatment, partial care and Outpatient Programs which provide primary treatment for Mental Health or Substance Use Disorder must be provided in a facility which is Licensed by the Department of Health and Human Services Regulation and Licensure, (or equivalent state agency) or accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the Commission on the Accreditation of Rehabilitation Facilities (CARF).

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 Participating network.

Physical Rehabilitation: The restoration of a person who was disabled as the result of an Injury or an acute physical impairment to a level of function which allows that person to live as independently as possible. A person is disabled when such person has physical disabilities and needs active assistance to perform the normal activities of daily living, such as eating, dressing, personal hygiene, ambulation and changing body position.

Physician: Any person holding a License and duly authorized to practice medicine and surgery and prescribe drugs.

Plan: The group health plan of benefits established by the Plan Administrator/Sponsor.

Plan Administrator: The administrator of the Group Health Plan as defined by ERISA.

Preauthorization/Preauthorized: A determination by Us or Our designee, that an admission, extension of stay or other health or dental care service has been reviewed and based of the information provided, meets the clinical requirements for Medical Necessity, appropriateness, level of care, or effectiveness under the auspices of the applicable health benefit plan.

Preferred Provider Organization: A panel of Hospitals, Physicians and other health care providers who belong to a network of Preferred Providers, which agrees to more effectively manage health care costs.

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

Pregnancy: Includes obstetrics, abortions, threatened abortions, miscarriages, premature deliveries, ectopic pregnancies, cesarean sections or other conditions or complications caused by Pregnancy. For purposes of this Plan, Pregnancy also includes a condition or complication caused by Pregnancy, but separate from, and not part of the Pregnancy. It occurs prior to the end of the Pregnancy, and is adversely affected by it. Postpartum depression and similar diagnoses are not considered complications of Pregnancy.

Preventive: Services which focus on the prevention of disease and health maintenance, including the early diagnosis of disease, discovery and identification of high risk for a specific problem, and interventions to avert a health problem in nonsymptomatic individuals.

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.

Private Duty Nursing: Continuous nursing care (beyond the accepted BCBSNE definition of a skilled nursing visit) in homes or facilities. Private Duty Nursing is primarily non-skilled in nature but may include skilled Services and is generally provided to chronically ill patients over the long term.

Qualified Beneficiary: Under COBRA, an individual who must in certain circumstances, be offered the opportunity to elect COBRA coverage under a group health plan. The term generally includes a covered employee's spouse or dependent children who were covered under the group health plan on the day before a Qualifying Event, as well as a covered employee who was covered under the group health plan on the day before a Qualifying Event that is a termination of employment or a reduction in hours. The term also includes a child born to or adopted by a covered employee during a period of COBRA coverage.

Qualifying Event: The circumstances that entitle persons to elect COBRA coverage.

Residential Treatment Program: Services or a program organized and staffed to provide both general and specialized non-hospital based interdisciplinary Services 24 hours a day; seven days a week for persons with behavioral health disorders. Residential treatment may be provided in freestanding, nonhospital-based facilities or in units of larger entities, such as a wing of a hospital. Residential Treatment Programs may include nonhospital addiction treatment centers; intermediate care facilities; psychiatric treatment centers or other nonmedical settings.

Schedule of Benefits: A summarized personal document issued by BCBSNE which provides information such as Subscriber, Group and Plan identification information, Deductible and Coinsurance amounts, and the type of Membership Unit selected.

Scientifically Validated: A technology, a drug, biological product, device, diagnostic, treatment or procedure is Scientifically Validated if it meets all of the factors set forth below:

1. Technologies, drugs, biological products, devices and diagnostics must have final approval from the appropriate government regulatory bodies. A drug or biological product must have final approval from the Food and Drug Administration (FDA). A device must have final approval from the FDA for those specific indications and methods of use that is being evaluated. FDA or other governmental approval is only one of the factors necessary to determine Scientific Validity.
2. The Scientific Evidence must permit conclusions concerning the effect of the technology on health outcomes. The evidence should consist of well-designed and well-conducted investigations published in peer-reviewed journals. The quality of the body of studies and the consistency of the results are considered in evaluating the evidence.

   The evidence should demonstrate that the technology can measure or alter the physiological changes related to a disease, injury, Illness or condition. In addition there should be evidence based on established medical facts that such measurement or alteration affects the health outcomes.

Opinions and evaluations by national medical associations, consensus panels or other technology evaluation bodies are evaluated according to the scientific quality of the supporting evidence and rationale. Our evidence includes, but is not limited to: Blue Cross and Blue Shield Association Technology Evaluation Center technology evaluations; Hayes Directory of New Medical Technologies' Status; Centers for Medicare and Medicaid Services (CMS) Technology Assessments, and United States Food and Drug Administration (FDA) approvals.

3. The technology must improve the health outcome.
4. The technology must improve the health outcome as much as or more than established alternatives.
5. The improvement must be attainable outside the investigational settings.

BCBSNE will determine whether a technology is Scientifically Validated.

Services: Hospital, medical or surgical procedures, treatments, drugs, supplies, Home (Durable) Medical Equipment, or other health, mental health or dental care, including any single service or combination of such Services.

Service Area: The geographic area in which a Blue Cross and Blue Shield plan is authorized to use the Blue Cross and Blue Shield brands pursuant to its license agreement with Blue Cross and Blue Shield Association.

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 Enrollee: An eligible person who enrolls for coverage during a Special Enrollment Period.

Special Enrollment Period: A period of time during which a Special Enrollee is allowed to enroll because of a loss of coverage, marriage, birth, adoption or placement for adoption, without being considered a Late Enrollee, subject to certain criteria as further described in this SPD.

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.

Subscriber: An individual who enrolls for health coverage and is named on an identification card issued pursuant to the Benefit Plan Document, and who is:

- an employee hired by an employer who makes application for health coverage for its employees;
- a COBRA Qualified Beneficiary.

Substance Use Disorder: Alcoholism, drug abuse and nicotine dependence or addiction.

Substance Use Disorder Treatment Center: A facility Licensed by the Department of Health and Human Services Regulation and Licensure, (or equivalent state agency), accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the Commission on the Accreditation of Rehabilitation Facilities (CARF). Such facilities are not Licensed as a Hospital, but provides Inpatient or Outpatient care, treatment, Services, maintenance, accommodation or board in a group setting primarily and exclusively for individuals having any type of Substance Use Disorder.

Total Care: Also known as value-based programs. Total Care is an outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local providers that is evaluated against cost and quality metrics/factors and is reflected in provider payment. Total Care (value-based programs) may include, but are not limited to, Accountable Care Organizations, Global Payment Costs of Care arrangements, Patient Centered Medical Homes and Shared Savings arrangements.

Treating Physician: A Physician who has personally evaluated the patient. This may include a Physician or oral surgeon, a Certified nurse midwife, a Certified nurse practitioner or Certified Physician's assistant, within the practitioner's scope of practice.

Urgent Care Facility: A facility, other than a Hospital, that provides covered health Services that are required to prevent serious deterioration of one's health, and that are required as a result of an unforeseen sickness, Injury or the onset of acute or severe symptoms.

We, Our or Us: Blue Cross and Blue Shield of Nebraska (BCBSNE).

Work-hardening: Physical therapy or similar Services provided primarily for strengthening an individual for purposes of his or her employment.

PLAN INFORMATION

Nebraska Bankers Association Voluntary Employees' Beneficiary Association
P.O. Box 80008
233 South 13th Street, Suite 700
Lincoln, Nebraska 68508
Telephone (402) 475-8322
Fax (402) 474-4376

Summary Plan Description: Health

Plan Name and Address: Nebraska Bankers Association VEBA Group Insurance PPO Plans
233 South 13th Street, Suite 700 Lincoln, Nebraska 68508

Employer Identification Number: 47-6092059

Plan Number: 501

The Employee Retirement Income Security Act of 1974 (ERISA) requires that certain information be furnished to eligible participants in an Employee Benefits Plan. When attached to your Certificate of Coverage, this becomes your Summary Plan Description. This plan is maintained pursuant to a Trust Agreement and contributions are made by employers and by participants. Contributions are based on the amount of insurance premiums necessary to provide Plan coverage. In the event of a discrepancy between the master group contract and the certificate of coverage, the terms of the master group contract will prevail. The NBA VEBA reserves the right to amend or terminate the Plan at any time. The group health plan is self-insured by the employers through a pooled arrangement. Blue Cross Blue Shield of Nebraska, P.O. Box 3248, Omaha, Nebraska 68180 is the claims payer for group health and dental plans.

Plan Administration: The employee benefits plan is provided through NBA VEBA and is administered by Nebraska Bankers Insurance and Services Company (NBISCO), 233 South 13th Street, Suite 700, Lincoln, Nebraska 68508. The NBA VEBA is directed by ten individual trustees appointed by the NBA VEBA member institutions via an online survey. The trustees are made up of two representatives from each of the five groups of the NBA. Each trustee serves for two, three-year terms on the board. If you would like a list of the current trustees, you may contact NBISCO.

Agent for Service of Legal Process: Scott Yank, Executive Vice President, NBISCO
NBISCO, 233 South 13th Street, Suite 700, Lincoln, Nebraska 68508.

The Plan Year: Beginning January 1 is a Plan Year for the purpose of accounting and all reports to the United States Department of Labor and other regulatory bodies.

Eligibility for Participation and Benefits: Employees, and Bank Board of Directors under age 65, of a bank or bank holding company and their spouses and dependents; employees of a bank or bank holding company subsidiary or affiliate and their spouses and dependents are eligible for this Plan.

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