

# NBA BENEFIT PLANS

## **\$500 Deductible Plan**

### **Schedule of Benefits Summary**

Effective January 1, 2024

**NBA** Benefit Plans

 **BlueCross  
BlueShield**  
Nebraska

An independent licensee of the Blue Cross  
and Blue Shield Association

# NBA BENEFIT PLANS CONTACTS

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

For more information about the NBA Benefit Plans and to access additional copies of the Benefits Summaries and the Benefit Coordinator login, visit [nebankers.org/benefit-plans](http://nebankers.org/benefit-plans).

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

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

## **Karen (KC) Coufal | Vice President**

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

## **Jennifer Muehlhausen | Assistant Vice President-Active Enrollment**

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

## **James Strickland | Billing/Accounting Coordinator**

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

## **Kathy Reiss | Member Bank Education Coordinator**

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

## **Scott Yank | Executive Vice President & CFO, NBISCO**

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

Covered Services are reimbursed based on the allowable charge. Blue Cross and Blue Shield of Nebraska In-Network Providers have agreed to accept the benefit payment as payment in full, not including deductible, 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](http://NebraskaBlue.com/Find-a-Doctor).

Payment for Services	In-Network Provider	Out-of-Network Provider
<b>Deductible</b> (the amount the covered person pays each calendar year for covered services before the coinsurance is payable) <ul style="list-style-type: none"> <li>Individual</li> <li>Family (Embedded*)</li> </ul>	\$500 \$1,000	\$1,000 \$2,000
<b>Coinsurance</b> (the percentage amount the covered person must pay for most covered services after the deductible has been met) <ul style="list-style-type: none"> <li>Covered person pays</li> <li>Plan pays</li> </ul>	25% 75%	50% 50%
<b>Out-of-Pocket Limit</b> (includes: deductible, coinsurance and copays; does not include: premium, penalty and amounts not covered by the plan) <ul style="list-style-type: none"> <li>Individual</li> <li>Family</li> </ul>	\$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 illness and/or substance dependence and abuse.

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

**\*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 service. Refer to the appropriate category for benefit information.

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

Covered Services – Illness or Injury	In-Network Provider	Out-of-Network Provider
<b>Physician Office</b> <ul style="list-style-type: none"> <li>Primary care physician office visit</li> <li>Specialist physician office visit</li> <li>Other covered services and supplies provided in the physician's office (with or without an office visit billed)</li> </ul>	Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance	Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance
<ul style="list-style-type: none"> <li>Allergy injections and serum</li> <li>Other injections</li> </ul>	Deductible and Coinsurance Deductible and Coinsurance	Deductible and Coinsurance Deductible and Coinsurance
<b>Convenient Care/Retail Clinics (Quick Care)</b>	Same as a primary care physician	Deductible and Coinsurance
<b>Urgent Care Facility Services</b>	Deductible and Coinsurance	Deductible and Coinsurance
<b>Telehealth/Virtual Care Services</b> <ul style="list-style-type: none"> <li>Medical</li> <li>Mental health</li> </ul>	Deductible and Coinsurance See mental health and/or substance use disorder services	Not covered Not covered
<b>Emergency Room Services</b> (services received in a hospital emergency room setting) <ul style="list-style-type: none"> <li>Facility</li> <li>Professional Services</li> </ul>	Deductible and Coinsurance Deductible and Coinsurance	In-network level of benefits In-network level of benefits
<b>Outpatient Hospital or Facility Services</b> 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
<b>Inpatient Hospital or Facility Services</b> Charges for room and board, diagnostic testing, rehabilitation and other ancillary services provided on an inpatient basis	Deductible and Coinsurance	Deductible and Coinsurance
<b>Orthopedic Specialty Hospital or Facility Services</b>	Deductible and Coinsurance	Deductible and Coinsurance
<b>NOTE:</b> Deductibles and coinsurance may be waived if covered services are provided at a designated preferred Center. See <a href="http://NebraskaBlue.com/PreferredCenters">NebraskaBlue.com/PreferredCenters</a> for a list of covered services and designated hospitals.		

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

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

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

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

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

Preventative Services	In-Network Provider	Out-of-Network Provider
<b>Preventative Services</b> <ul style="list-style-type: none"> <li>Affordable Care Act (ACA) required preventative services may be subject to limits that include, but are not limited to, age, gender and frequency)</li> <li>ACA required covered preventative services (outside of limits)</li> <li>Other covered preventative services not required by ACA, such as: <ul style="list-style-type: none"> <li>Laboratory tests as specified by Us, including urinalysis and complete blood count; general health panel; metabolic panel; prostate cancer screening (PSA) and hearing exams</li> <li>All other laboratory tests; radiology, cardiac stress tests; EKG; pulmonary function and other screenings and services</li> </ul> </li> </ul>	Plan pays 100%  Plan pays 100%  Plan pays 100%  Plan pays 100%	Plan pays 100%  Plan pays 100%  Plan pays 100%  Plan pays 100%
<b>Immunizations</b> <ul style="list-style-type: none"> <li>Pediatric (up to age 7)</li> <li>Age 7 and older</li> <li>Related to an illness</li> </ul>	Plan pays 100% Plan pays 100% Same as any other illness	Plan pays 100% Plan pays 100% Same as any other illness
<b>Colorectal Cancer Screenings</b> (starting at age 45) <ul style="list-style-type: none"> <li>Colonoscopy screening <ul style="list-style-type: none"> <li>Diagnostic or preventative screening (one every five years)</li> <li>Screenings outside the age or frequency limit</li> </ul> </li> <li>Sigmoidoscopy/Proctoscopy screening <ul style="list-style-type: none"> <li>Preventative Screening (one every five years)</li> <li>Screenings outside the age or frequency limit</li> </ul> </li> <li>Barium enema, fecal occult blood tests, FIT DNA, CT of the colon and other tests as determined under ACA Preventative Services <ul style="list-style-type: none"> <li>Preventative services</li> <li>Diagnostic screenings</li> </ul> </li> </ul>	Plan pays 100%  Same as any other illness  Plan pays 100%  Same as any other illness  Plan pays 100% Same as any other illness	Deductible and Coinsurance  Deductible and Coinsurance  Deductible and Coinsurance  Deductible and Coinsurance  Deductible and Coinsurance Deductible and Coinsurance
<b>NOTE:</b> Related services will pay in the same manner as the colorectal cancer screening when performed on the same date of service. Screening limits accumulate based on a calendar year.		

Mental Illness and/or Substance Dependence and Abuse Covered Services	In-Network Provider	Out-of-Network Provider
<b>Inpatient Services</b>	Deductible and Coinsurance	Deductible and Coinsurance
<b>Outpatient Services</b> <ul style="list-style-type: none"> <li>Office services</li> <li>Telehealth/virtual care services</li> <li>All other outpatient items &amp; services</li> </ul>	Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance	Deductible and Coinsurance Not covered Deductible and Coinsurance
<b>Office services</b> 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. <b>Other covered services not part of the office benefit service are covered under all other outpatient items &amp; services.</b> 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.		
<b>Emergency Care Services</b> (services received in a hospital emergency room setting) <ul style="list-style-type: none"> <li>Facility</li> <li>Professional services</li> </ul>	Deductible and Coinsurance Deductible and Coinsurance	In-network level of benefits In-network level of benefits

Other Covered Services – Illness or Injury	In-Network Provider	Out-of-Network Provider
<b>Acupuncture</b>	Not covered	Not covered
<b>Advanced Diagnostic Imaging</b> (CT, MRI, MRA, MRS, PET & SPECT scans and other nuclear medicine)	Deductible and Coinsurance	Deductible and Coinsurance
<b>Ambulance</b> (to the nearest facility for appropriate care) <ul style="list-style-type: none"> <li>Ground ambulance</li> <li>Air ambulance</li> </ul>	Deductible and Coinsurance Deductible and Coinsurance	In-network level of benefits In-network level of benefits
<b>Autism Spectrum Disorder</b> <ul style="list-style-type: none"> <li>Testing and diagnosis</li> <li>Treatment</li> </ul>	Same as mental health Same as mental health	Same as mental health Same as mental health
<b>Biofeedback</b>	Deductible and Coinsurance	Deductible and Coinsurance
<b>Dermatological Services</b>	Same as any other illness	Same as any other illness
<b>Diabetic Services</b> Services include education, self-management training, podiatric appliances and equipment	Deductible and Coinsurance	Deductible and Coinsurance
<b>Durable Medical Equipment and Supplies (including Prosthetics)</b> (rental or purchase, whichever is least costly; rental shall not exceed the cost of purchasing)	Deductible and Coinsurance	Deductible and Coinsurance
<b>Hearing Services</b> <ul style="list-style-type: none"> <li>Bone anchored hearing aids</li> <li>Cochlear implants</li> <li>Hearing aids (up to age 19, limited to \$3,000 every 48 months)</li> </ul>	Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance	Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance
<b>Home Health Care Services</b> <ul style="list-style-type: none"> <li>Home health aide (limited to 60 days per calendar year)</li> <li>Home infusion therapy</li> <li>Skilled nursing care (limited to 8 hours per day)</li> <li>Respiratory care (limited to 60 days per calendar year)</li> </ul>	Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance	Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance
<b>Hospice Services</b>	Deductible and Coinsurance	Deductible and Coinsurance
<b>Independent Laboratory</b> <ul style="list-style-type: none"> <li>Diagnostic</li> <li>Preventative</li> </ul>	Deductible and Coinsurance Same as preventative services in-network level of benefits	In-network level of benefits Same as preventative services in-network level of benefits
<b>Infertility</b> <ul style="list-style-type: none"> <li>Services to diagnose</li> <li>Treatment to promote fertility</li> </ul>	Same as any other illness Not covered	Same as any other illness Not covered

Other Covered Services – Illness or Injury	In-Network Provider	Out-of-Network Provider
<p><b>Nicotine Addiction</b></p> <ul style="list-style-type: none"> <li>• Medical services and therapy</li> <li>• Nicotine addiction classes &amp; alternative therapy, such as acupuncture</li> </ul>	<p>Same as substance use disorder services</p> <p>Not covered</p>	<p>Same as substance use disorder services</p> <p>Not covered</p>
<p><b>Obesity</b></p> <ul style="list-style-type: none"> <li>• Non-surgical treatment</li> <li>• Surgical treatment</li> </ul>	<p>Not covered</p> <p>Deductible and Coinsurance</p>	<p>Not covered</p> <p>Deductible and Coinsurance</p>
<p><b>Oral Surgery and Dentistry</b></p> <p>Services such as: impacted wisdom teeth; incision and drainage of abscesses; excision of tumors and cysts; and bone grafts to the jaw</p> <p>IV sedation for oral surgery and to remove impacted teeth.</p> <p>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)</p>	<p>Deductible and Coinsurance</p>	<p>Deductible and Coinsurance</p>
<p><b>Organ and Tissue Transplantation</b></p>	<p>Deductible and Coinsurance</p>	<p>Deductible and Coinsurance</p>
<p><b>Ostomy Supplies</b></p>	<p>Deductible and Coinsurance</p>	<p>Deductible and Coinsurance</p>
<p><b>Physician Professional Services</b></p> <p>Inpatient and outpatient services, such as: surgery, surgical assistant, anesthesia, inpatient hospital visits and other non-surgical services</p>	<p>Deductible and Coinsurance</p>	<p>Deductible and Coinsurance</p>
<p><b>Pregnancy, Maternity and Newborn Care</b></p> <ul style="list-style-type: none"> <li>• Pregnancy and maternity (payment for prenatal and postnatal care is included in the payment for the delivery)</li> <li>• Newborn care (Newborns are covered at birth, subject to the plan's enrollment provisions.)</li> </ul>	<p>Deductible and Coinsurance</p> <p>Deductible and Coinsurance</p>	<p>Deductible and Coinsurance</p> <p>Deductible and Coinsurance</p>
<p><b>NOTE:</b> The plan pays 100% for the initial postpartum depression screening up to one year following a pregnancy or childbirth.</p>		
<p><b>Radiation Therapy and Chemotherapy</b></p>	<p>Deductible and Coinsurance</p>	<p>Deductible and Coinsurance</p>
<p><b>Radiology (X-ray) Services and other Diagnostic Test</b></p>	<p>Deductible and Coinsurance</p>	<p>Deductible and Coinsurance</p>
<p><b>Rehabilitation Services – Inpatient Facility</b></p>	<p>Deductible and Coinsurance</p>	<p>Deductible and Coinsurance</p>

Other Covered Services – Illness or Injury	In-Network Provider	Out-of-Network Provider
<b>Rehabilitation Services</b> <ul style="list-style-type: none"> <li>Cardiac rehabilitation (limited to 18 sessions per diagnosis)</li> <li>Pulmonary rehabilitation (Chronic lung disease is limited to 18 sessions per diagnosis, not to exceed 18 sessions per calendar year. Lung, heart-lung transplants and lung volume are limited to 18 sessions following renewal and prior to surgery plus 18 sessions within six months of discharge from hospital following surgery.)</li> </ul>	Deductible and Coinsurance	Deductible and Coinsurance
<b>Renal Dialysis</b>	Deductible and Coinsurance	Deductible and Coinsurance
<b>Sexual Dysfunction</b>	Deductible and Coinsurance	Deductible and Coinsurance
<b>Skilled Nursing Facility</b> (limited to 60 days per calendar year)	Deductible and Coinsurance	Deductible and Coinsurance
<b>Sleep Studies</b>	Deductible and Coinsurance	Deductible and Coinsurance
<b>Temporomandibular and Craniomandibular Joint Disorder</b>	Deductible and Coinsurance	Deductible and Coinsurance
<b>Therapy &amp; Manipulations</b> <ul style="list-style-type: none"> <li>Physical, occupational or speech therapy services, chiropractic or osteopathic physiotherapy (combined limit to 60 sessions per calendar year)</li> <li>Chiropractic or osteopathic manipulative treatments or adjustments (combined limit to 30 sessions per calendar year)</li> </ul>	Deductible and Coinsurance	Deductible and Coinsurance
<b>NOTE:</b> 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.		
<b>Vision Services</b> <ul style="list-style-type: none"> <li>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</li> <li>Vision Exam <ul style="list-style-type: none"> <li>Diagnostic (to diagnose an illness)</li> <li>Preventative (routine exam including refraction) limited to one exam per calendar year</li> </ul> </li> </ul>	Deductible and Coinsurance	Deductible and Coinsurance
<b>Voluntary Abortions</b>	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)	
<b>Wigs</b>	Not covered	Not covered
<b>All Other Covered Services</b>	Deductible and Coinsurance	Deductible and Coinsurance



Prescription Drugs	In-Network Provider	Out-of-Network Provider
<b>Retail – per 30-day supply</b> <ul style="list-style-type: none"> <li>Preferred generic drugs (including non-formulary contraceptives)</li> <li>Non-preferred generic drugs</li> <li>Preferred brand name drugs</li> <li>Non-preferred brand name drugs</li> </ul>	<p>\$10 copay</p> <p>50% Coinsurance, \$25 min Copay, \$50 max Copay</p> <p>25% Coinsurance, \$25 min Copay, \$50 max Copay</p> <p>50% Coinsurance, \$50 min Copay, \$75 max Copay</p>	<p>50% Coinsurance</p> <p>50% Coinsurance</p> <p>50% Coinsurance</p> <p>50% Coinsurance</p>
<b>Home Delivery – per 30-day supply</b> <ul style="list-style-type: none"> <li>Preferred generic drugs (including non-preferred contraceptives)</li> <li>Non-preferred generic drugs</li> <li>Preferred brand name drugs</li> <li>Non-preferred brand name drugs</li> </ul>	<p>\$10 Copay</p> <p>50% Coinsurance, \$25 min Copay, \$50 max Copay</p> <p>25% Coinsurance, \$25 min Copay, \$50 max Copay</p> <p>50% Coinsurance, \$50 min Copay, \$75 max Copay</p>	<p>Not covered</p> <p>Not covered</p> <p>Not covered</p> <p>Not covered</p>
<b>Specialty Drugs</b> (specialty drugs must be purchased through a designated pharmacy after one fill) <ul style="list-style-type: none"> <li>Preferred specialty</li> <li>Non-preferred specialty</li> </ul>	<p><i>Applies to both preferred &amp; non-preferred specialty:</i></p> <p>25% Coinsurance, \$100 min Copay, \$150 max Copay</p>	<p>Not covered</p> <p>Not covered</p>
<b>Contraceptive Drugs</b> <ul style="list-style-type: none"> <li>Preferred generic</li> <li>Preferred brand name</li> <li>Non-preferred generic</li> <li>Non-preferred brand name</li> </ul>	<p>Plan pays 100%</p> <p>Plan pays 100%</p> <p>Same as any other generic drugs</p> <p>Same as any other non-preferred brand name drugs</p>	<p>50% Coinsurance</p> <p>50% Coinsurance</p>
<b>Diabetic Insulin</b> <ul style="list-style-type: none"> <li>Preferred generic</li> <li>Preferred brand name</li> <li>Non-preferred generic</li> <li>Non-preferred brand name</li> </ul>	<p>Plan pays 100%</p> <p>Plan pays 100%</p> <p>Same as any other generic drugs</p> <p>Same as any other non-preferred brand name drugs</p>	<p>50% Coinsurance</p> <p>50% Coinsurance</p>
<b>Infant Formulas*</b>	<p>50% Coinsurance, \$50 min Copay, \$75 max Copay</p>	<p>50% Coinsurance</p>
<b>Infertility</b> (FDA approved prescription drugs to promote fertility)	<p>Not covered</p>	<p>Not covered</p>
<b>Nicotine Addiction</b> (FDA approved prescription drugs and over-the-counter nicotine addiction drugs and deterrents)	<p>Plan Pays 100%</p>	<p>50% Coinsurance</p>
<b>Obesity</b> (FDA approved prescription drugs)	<p>Not covered</p>	<p>Not covered</p>
<p><b>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 <a href="http://NebraskaBlue.com/Pharmacy">NebraskaBlue.com/Pharmacy</a>. Or you may contact Member Services at the phone number on the back of your I.D. card.</b></p>		

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

# ADDITIONAL BCBS RESOURCES

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

[nebankers.org/benefit-plans](https://nebankers.org/benefit-plans)

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

## **In the BCBS Resource Center, you can:**

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