NBA BENEFIT PLANS

$1,000 Copay Plan

Schedule of Benefits Summary

Effective January 1, 2023

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 not a contract and should not be regarded as one. In the event there are discrepancies between this document and the contract, the terms and the conditions of the contract will govern.

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

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

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

Karen (KC) Coufal | Vice President

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

Jennifer Muehlhausen Assistant Vice President-Active Enrollment

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

James Strickland | Billing/Accounting Coordinator

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

Kathy Reiss | Member Bank Education Coordinator

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

Scott Yank | Executive Vice President & CFO, NBISCO

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

Covered Services are reimbursed based on the allowable charge. Blue Cross and Blue Shield of Nebraska In-Network Providers have agreed to accept the benefit payment as payment in full, not including deductible, 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.

Payment for Services	In-Network Provider	Out-of-Network Provider
Deductible (the amount the covered person pays each calendar year for covered services before the coinsurance is payable) • Individual • Family (Embedded*)	 $1,000 $2,000	 $2,000 $4,000
Coinsurance (the percentage amount the covered person must pay for most covered services after the deductible has been met) • Covered person pays	 25%	 50%
Out-of-Pocket Limit (does not include premium, penalty and amounts not covered by the plan) • Individual • Family	 $3,000 $6,000	 $6,000 $12,000

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.

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.

***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
- Urgent care
- Emergency room
- Telehealth services
- Allergy injections & serum
- Prescription drugs

The copay amount varies by the type of covered service. Refer to the appropriate category for benefit information.

Out-of-Pocket Limit incudes:

- Deductible
- Coinsurance
- Medical copays
- Prescription drug copays

Covered Services – Illness or Injury	In-Network Provider	Out-of-Network Provider
Physician Office • Primary care physician office visit • Specialist physician office visit • Other covered services and supplies provided in the physician's office (with or without an office visit billed)	 $30 Copay $60 Copay Deductible and Coinsurance	 Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance
• Allergy injections and serum	$10 Copay	Deductible and Coinsurance
• Other injections	Deductible and Coinsurance	Deductible and Coinsurance
Convenient Care/Retail Clinics (Quick Care)	Same as a primary care physician	Same as a primary care physician
Urgent Care Facility Services	$75 Copay	Deductible and Coinsurance
Telehealth Services	$10 Copay	Not covered
Emergency Care Services (services received in a hospital emergency room setting) • Facility • Professional services	 $200 Copay then Coinsurance Deductible and Coinsurance	 In-network level of benefits In-network level of benefits
Outpatient Hospital or Facility Services Services such as surgery, laboratory and radiology, cardiac and pulmonary rehabilitation, observation stays, and other services provided on an outpatient basis	Deductible 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 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 visit include office visits (including the initial visit to diagnose pregnancy) and consultations.

Other covered services not part of the physician office benefit (refer to the appropriate category for benefit information) include: Allergy injections & serum; other injections; advanced diagnostic imaging (CT, MRI, MRA, MRS, PET & SPECT scans and other nuclear medicine); pregnancy services; preventative services; radiation therapy & chemotherapy; surgery & anesthesia; therapy & manipulations; durable medical equipment; sleep studies; biofeedback; psychological evaluations, assessments and testing.

Payment for Services	In-Network Provider	Out-of-Network Provider
Preventative Services		
• Affordable Care Act (ACA) required preventative services may be subject to limits that include, but are not limited to, age, gender and frequency)	Plan pays 100%	Plan pays 100%
• ACA required covered preventative services (outside of limits)	Plan pays 100%	Plan pays 100%
• Other covered preventative 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 preventative 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		
○ Preventative 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 Preventative Services		
○ Preventative Services	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.		

Mental Illness and/or Substance Dependence and Abuse Covered 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 Services	Deductible and Coinsurance	Not covered
• All Other Outpatient Items & Services	Deductible and Coinsurance	Deductible and Coinsurance
Emergency Care Services (services received in a hospital emergency room setting)		
• Facility	$200 Copay then 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 • Air ambulance	 Deductible and Coinsurance Deductible and Coinsurance	 In-network level of benefits In-network level of benefits
Autism Spectrum Disorder	Same as mental illness	Same as mental illness
Biofeedback	Deductible and Coinsurance	Deductible and Coinsurance
Bone Anchored Hearing Aids and Cochlear Implants	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
Eye Glasses 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)	Deductible and Coinsurance	Deductible and Coinsurance
Hearing Aids (up to age 19, limited to $3,000 every 48 months)	Same as any other illness	Same as any other illness
Home Health Aide, Skilled Nursing and Respiratory Care • Home health aide (limited to 60 days per calendar year) • Skilled nursing care (limited to 8 hours per day) • Respiratory care (limited to 60 days per calendar year)	 Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance	 Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance
Home Infusion Therapy	Deductible and Coinsurance	Deductible and Coinsurance
Hospice Services	Deductible and Coinsurance	Deductible and Coinsurance
Independent Laboratory • Diagnostic • Preventative	 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

Other Covered Services – Illness or Injury	In-Network Provider	Out-of-Network Provider
Infertility • Services to Diagnose • Treatment to Promote Fertility	Same as any other illness Not covered	Same as any other illness Not covered
Nicotine Addiction • Medical services and therapy • Nicotine addiction classes & alternative therapy, such as acupuncture	Same as substance dependence and abuse Not covered	Same as substance dependence and abuse Not covered
Obesity • Non-surgical treatment • Surgical treatment	Not covered Deductible and Coinsurance	Not covered Deductible and Coinsurance
Oral Surgery and Dentistry Services such as: impacted wisdom teeth; incision and drainage of abscesses; excision of tumors and cysts; and bone grafts to the jaw IV sedation for oral surgery and to remove impacted teeth Dental treatment when due to an accidental injury to naturally healthy teeth (treatment related to accidents must be provided within 12 months of the date of injury)	Deductible 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) • Newborn care **NOTE:** Newborns are covered at birth, subject to the plan's enrollment provisions.	Deductible and Coinsurance Deductible and Coinsurance	Deductible and Coinsurance Deductible and Coinsurance
Radiation Therapy and Chemotherapy	Deductible and Coinsurance	Deductible and Coinsurance
Radiology (X-ray) Services and other Diagnostic Test	Deductible and Coinsurance	Deductible and Coinsurance
Rehabilitation Services – Inpatient Facility	Deductible and Coinsurance	Deductible and Coinsurance

Other Covered Services – Illness or Injury	In-Network Provider	Out-of-Network Provider
Rehabilitation Services • Cardiac rehabilitation (limited to 18 sessions per diagnosis) • Pulmonary rehabilitation (Chronic lung disease is limited to 18 sessions per diagnosis, not to exceed 18 sessions per calendar year. Lung, heart-lung transplants and lung volume are limited to 18 sessions following renewal and prior to surgery plus 18 sessions within six months of discharge from hospital following surgery.)	Deductible 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
Vision Exams • Diagnostic (to diagnose an illness) • Preventative (routine exam including refraction)	See physician office services Not covered	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 drugs	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)	25% Coinsurance, $100 min Copay, $150 max Copay	Not covered
Contraceptives		
• Preferred generic	Plan pays 100%	50% Coinsurance
• Preferred brand name	Plan pays 100%	50% Coinsurance
• Non-preferred generic	Same as any other non-preferred generic drug	
• Non-preferred brand name	Same as any other non-preferred brand name	
Diabetic Insulin		
• Preferred generic	Plan pays 100%	50% Coinsurance
• Preferred brand name	Plan pays 100%	50% Coinsurance
• Non-preferred generic	Same as any other generic drug	
• Non-preferred brand name	Same as any other non-preferred brand name	
Infant Formulas*	50% Coinsurance, $50 min Copay, $75 max Copay	50% Coinsurance
Infertility (FDA approved prescription drugs to promote fertility)	Not covered	Not covered
Nicotine Addiction (FDA approved prescription drugs and over-the-counter nicotine addiction drugs and deterrents)	Plan pays 100%	50% Coinsurance
Obesity (FDA approved prescription drugs)	Not covered	Not covered
This plan uses a prescription drug list (PDL). The PDL for this plan is PDL 10, and the pharmacy network is Network C. You can find this prescription drug list and network listing on NebraskaBlue.com. Or you may contact Member Services at the phone number on the back of your I.D. card.		

***Infant Formulas:** Infant Formulas are a category of drugs that are limited to: Neocate, Elecare, Cyclinex-1, Cyclinex2, Pro Phree and Vivonex. Benefits are payable for these drugs. See the summary above.