Schedule of Benefits Summary

Group Name: Nebraska Bankers Association VEBA | Effective Date: January 01, 2019

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. 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 www.nebraskablue.com.		
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:

- Physician Office
- Urgent Care
- Emergency Room
- Telehealth Services
- Allergy Injections and 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 includes:

- 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	$30 Copay	Deductible and Coinsurance
• Specialist Physician Office Visit	$60 Copay	Deductible and Coinsurance
• Other Covered Services and supplies provided in the Physician's Office (with or without an office visit billed)	Deductible and Coinsurance	Deductible and Coinsurance
• Allergy Injections and Serum	$10 Copay	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) 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; Preventive Services; Radiation Therapy & Chemotherapy; Surgery & Anesthesia; Therapy & Manipulations; Durable Medical Equipment; Sleep Studies; Biofeedback; Psychological Evaluations, Assessments, and Testing.		
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	$200 Copay then 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

Preventive Services	In-network Provider	Out-of-network Provider
Preventive Services		
• Health Care Reform (HCR) 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%
• HCR 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; comprehensive 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

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	$30 Copay	Deductible and Coinsurance
• Telehealth Services	$10 Copay	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 Deductible and Coinsurance (In-network level of benefits if due to an emergency)
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

Other Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Hearing Aids	Not Covered	Not Covered
Home Health Aide and Skilled Nursing Home Health Aide (limited to 60 days per Calendar Year) Skilled Nursing Care (limited to 8 hours per day)	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 • Preventive	Deductible and Coinsurance Same as Preventive Services In-network level of benefits	In-network level of benefits Same as Preventive Services In-network level of benefits
Infertility • Services to diagnose • Treatment to promote fertility	Same as any other illness Not Covered	Same as any other illness Not Covered
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

Other Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
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	Deductible and Coinsurance	Deductible and Coinsurance
NOTE: Newborns are covered at birth, subject to the plan's enrollment provisions.		
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
Rehabilitation Services • Cardiac rehabilitation (limited to 18 sessions per diagnosis)	Deductible and Coinsurance	Deductible and Coinsurance
• 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
Renal Dialysis	Deductible and Coinsurance	Deductible and Coinsurance
Respiratory Care (limited to 60 days per Calendar Year)	Deductible and Coinsurance	Deductible and Coinsurance

Other Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
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)	Deductible and Coinsurance	Deductible and Coinsurance
• Chiropractic or osteopathic manipulative treatments or adjustments (combined limit to 30 sessions per Calendar Year)	Deductible and Coinsurance	Deductible and Coinsurance
Vision Exams • Diagnostic (to diagnose an illness)	See Physician Office Services	See Physician Office Services
• Preventive (routine exam including refraction)	Not Covered	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
Prescription Drug Deductible (the amount the Covered Person pays each Calendar Year for Covered Prescription Drugs before the Prescription Drug Copayments are applicable) • Individual • Family	Not Applicable Not Applicable	
Retail – per 30-day supply • Preferred Generic Drugs (including non-preferred contraceptives) • Non-preferred Generic Drugs • Preferred Brand Name Drugs • Non-preferred Brand Name Drugs	$10 Copay 50% Coinsurance, $25 min Copay, $50 max Copay 25% Coinsurance, $25 min Copay, $50 max Copay 50% Coinsurance, $50 min Copay, $75 max Copay	$10 Copay + 25% Penalty 50% Coinsurance, $25 min Copay, $50 max Copay + 25% Penalty 25% Coinsurance, $25 min Copay, $50 max Copay + 25% Penalty 50% Coinsurance, $50 min Copay, $75 max Copay + 25% Penalty
Mail order – per 30-day supply • Preferred Generic Drugs (including non-preferred contraceptives) • Non-preferred Generic • Preferred Brand Name Drugs • Non-preferred Brand Name Drugs	$10 Copay 50% Coinsurance, $25 min Copay, $50 max Copay 25% Coinsurance, $25 min Copay, $50 max Copay 50% Coinsurance, $50 min Copay, $75 max Copay	Not Covered Not Covered Not Covered Not Covered
Specialty Drugs (to be considered in-network, specialty drugs must be purchased through a designated specialty pharmacy)	25% Coinsurance, $100 min Copay, $150 max Copay	50% Coinsurance, $300 min Copay, $450 max Copay
Contraceptives • Preferred - Generic - Brand Name • Non-preferred - Generic - Brand Name	Plan Pays 100% Plan Pays 100% Same as any other non-preferred generic Same as any other non-preferred brand name	25% Penalty 25% Penalty
Infant Formulas*	50% Coinsurance, $50 min Copay, $75 max Copay	50% Coinsurance, $50 min Copay, $75 max Copay + 25% Penalty
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%	25% Penalty
Obesity FDA approved prescription drugs	Not Covered	Not Covered

***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.

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. For more complete information about your plan, including benefits, exclusions and contract limitations, please refer to the master group contract. In the event there are discrepancies between this document and the contract, the terms and conditions of the contract will govern.