# Schedule of Benefits Summary

Group Name: Nebraska Bankers Association VEBA | Effective Date: January 01, 2021

| 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**<br>(the amount the Covered Person pays each Calendar Year for Covered Services before the Coinsurance is payable)<br>• Individual<br>• Family (Embedded*) | <br><br>$500<br>$1,000 | <br><br>$1,000<br>$2,000 |
| **Coinsurance**<br>(the percentage amount the Covered Person must pay for most Covered Services after the Deductible has been met)<br>• Covered Person Pays | <br><br>25% | <br><br>50% |
| **Out-of-pocket Limit**<br>(does not include premium, penalty and amounts not covered by the plan)<br>• Individual<br>• Family | <br><br>$2,500<br>$5,000 | <br><br>$5,000<br>$10,000 |
| 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

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
- Prescription Drug Copays

| Covered Services – Illness or Injury | In-network Provider | Out-of-network Provider |
|---|---|---|
| **Physician Office**<br>• Primary Care Physician Office Visit | Deductible and Coinsurance | Deductible and Coinsurance |
| • Specialist Physician Office Visit | Deductible and Coinsurance | 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 | 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.<br>***Specialist Physician*** is a physician who is not a Primary Care Physician.<br>***Office Visit Benefits*** for Primary Care and Specialist Physician Office Visit include office visits (including the initial visit to diagnose pregnancy) and consultations.<br>***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 | Deductible and Coinsurance |
| **Urgent Care Facility Services** | Deductible and Coinsurance | Deductible and Coinsurance |
| **Telehealth Services** | Deductible and Coinsurance | Not Covered |
| **Emergency Care Services** (services received in a Hospital emergency room setting)<br>• Facility | Deductible and Coinsurance | In-network level of benefits |
| • Professional Services | Deductible and Coinsurance | In-network level of benefits |
| **Outpatient Hospital or Facility Services**<br>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**<br>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 Inpatient 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 www.nebraskablue.com 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 |

| 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 | 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)<br>• Ground Ambulance<br>• Air Ambulance | Deductible and Coinsurance<br>Deductible and Coinsurance | In-network level of benefits<br>Deductible and Coinsurance (In-network level of benefits if due to an emergency) |
| **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**<br>Services include education, self-management training, podiatric appliances and equipment. | Deductible and Coinsurance | Deductible and Coinsurance |
| **Durable Medical Equipment and Supplies (including Prosthetics)**<br>(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**<br>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** (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**<br>• Home Health Aide (limited to 60 days per Calendar Year)<br>• Skilled Nursing Care (limited to 8 hours per day)<br>• Respiratory Care (limited to 60 days per Calendar Year) | Deductible and Coinsurance<br>Deductible and Coinsurance<br>Deductible and Coinsurance | Deductible and Coinsurance<br>Deductible and Coinsurance<br>Deductible and Coinsurance |
| **Home Infusion Therapy** | Deductible and Coinsurance | Deductible and Coinsurance |
| **Hospice Services** | Deductible and Coinsurance | Deductible and Coinsurance |
| **Independent Laboratory**<br>• Diagnostic<br>• Preventive | Deductible and Coinsurance<br>Same as Preventive Services In-network level of benefits | In-network level of benefits<br>Same as Preventive Services In-network level of benefits |
| **Infertility**<br>• Services to diagnose<br>• Treatment to promote fertility | Same as any other illness<br>Not Covered | Same as any other illness<br>Not Covered |
| **Nicotine Addiction**<br>• Medical services and therapy<br>• Nicotine addiction classes & alternative therapy, such as acupuncture | Same as Substance Dependence and Abuse<br>Not Covered | Same as Substance Dependence and Abuse<br>Not Covered |
| **Obesity**<br>• Non-surgical treatment<br>• Surgical Treatment | Not Covered<br>Deductible and Coinsurance | Not Covered<br>Deductible and Coinsurance |
| **Oral Surgery and Dentistry**<br>Services such as, impacted wisdom teeth, incision and drainage of abscesses, excision of tumors and cysts and bone grafts to the jaw.<br><br>IV sedation for oral surgery and to remove impacted teeth.<br><br>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**<br>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**<br>• 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**<br>• 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 |

| Other Covered Services – Illness or Injury | In-network Provider | Out-of-network Provider |
|---|---|---|
| **Sexual Dysfunction** | Deductible and Coinsurance | Deductible and Coinsurance |
| **Skilled Nursing Facility**<br>(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**<br>• 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**<br>• 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.<br>(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**<br>(the amount the Covered Person pays each Calendar Year for Covered Prescription Drugs before the Prescription Drug Copayments are applicable)<br>• Individual<br>• Family | Not Applicable<br>Not Applicable | |
| **Retail – per 30-day supply**<br>• Preferred Generic Drugs (including non-formulary contraceptives)<br>• Non-preferred Generic Drugs<br>• Preferred Brand Name Drugs<br>• Non-preferred Brand Name Drugs | $10 Copay<br>50% Coinsurance, $25 min Copay, $50 max Copay<br>25% Coinsurance, $25 min Copay, $50 max Copay<br>50% Coinsurance, $50 min Copay, $75 max Copay | $10 Copay + 50% Coinsurance<br>50% Coinsurance<br>50% Coinsurance<br>50% Coinsurance |
| **Mail order – per 30-day supply**<br>• Preferred Generic Drugs (including non-preferred contraceptives)<br>• Non-preferred Generic<br>• Preferred Brand Name Drugs<br>• Non-preferred Brand Name Drugs | $10 Copay<br>50% Coinsurance, $25 min Copay, $50 max Copay<br>25% Coinsurance, $25 min Copay, $50 max Copay<br>50% Coinsurance, $50 min Copay, $75 max Copay | Not Covered<br>Not Covered<br>Not Covered<br>Not Covered |
| **Specialty Drugs**<br>(specialty drugs must be purchased through a designated pharmacy after one fill) | 25% Coinsurance, $100 min Copay, $150 max Copay | Not Covered |
| **Contraceptives**<br>• Preferred<br>- Generic<br>- Brand Name<br>• Non-preferred<br>- Generic<br>- Brand Name | Plan Pays 100%<br>Plan Pays 100%<br>Same as any other non-preferred generic<br>Same as any other non-preferred brand name | 50% Coinsurance<br>50% Coinsurance |
| **Infant Formulas*** | 50% Coinsurance, $50 min Copay, $75 max Copay | 50% Coinsurance |
| **Infertility**<br>FDA approved prescription drugs to promote fertility | Not Covered | Not Covered |
| **Nicotine Addiction**<br>FDA approved prescription drugs and over-the-counter nicotine addiction drugs and deterrents | Plan Pays 100% | 50% Coinsurance |
| **Obesity**<br>FDA approved prescription drugs | Not Covered | Not Covered |
| **This plan uses a prescription drug list (PDL). The PDL for this plan is PDL10, and the Pharmacy Network is Network C You can find this prescription drug list and network listing on www.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, 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.