

Schedule of Benefits Summary

Group Name: Douglas County Nebraska

Effective Date: January 01, 2019

Payment for Services	In-network Provider	Out-of-network Provider
<p>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 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.</p>		
<p>In-network Provider: The provider network is shown on your I.D. card. For help in locating In-network Providers, visit www.nebraskablue.com.</p>		
<p>Deductible (the amount the Covered Person pays each Calendar Year for Covered Services before the Coinsurance is payable)</p> <ul style="list-style-type: none"> Individual Family (Embedded*) 	<p>\$600 \$1,200</p>	<p>\$1,600 \$3,200</p>
<p>Coinsurance (the percentage amount the Covered Person must pay for most Covered Services after the Deductible has been met)</p> <ul style="list-style-type: none"> Covered Person Pays 	<p>20%</p>	<p>40%</p>
<p>Coinsurance Limit (the maximum Coinsurance the Covered Person must pay each Calendar Year. (this amount does not include the Deductible or applicable Copayments)</p> <ul style="list-style-type: none"> Individual Family (Embedded*) 	<p>\$1,500 \$3,000</p>	<p>\$2,600 \$5,200</p>
<p>Deductible and Coinsurance Limit (combination of the deductible and coinsurance amounts only; does not include any copayments or amounts not covered by the plan)</p> <ul style="list-style-type: none"> Individual Family (Embedded*) 	<p>\$2,100 \$4,200</p>	<p>\$4,200 \$8,400</p>
<p>Once the annual Deductible and Coinsurance Limit is reached, most Covered Services are payable by the plan at 100% for the rest of the Calendar Year.</p>		
<p>In-network and Out-of-network Deductible, Coinsurance and Deductible and Coinsurance 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.</p>		
<p>Day, session or visit limits for certain services shown on this summary are not applicable to Mental Illness and/or Substance Dependence and Abuse.</p>		
<p>*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.</p>		

Copayment(s) (copay(s)) apply to:

- Physician Office
- Telehealth Services
- Urgent Care Facility
- Emergency Care
- Preventive Hearing Exams
- Prescription Drugs

The Copay amount varies by the type of Covered Service. Refer to the appropriate category for benefit information.

Coinsurance Limit includes:

- Coinsurance

Copays not included in the Coinsurance Limit will continue to apply, even once the Coinsurance Limit for the year is reached.

Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Physician Office <ul style="list-style-type: none"> Primary Care Physician Office Visit Specialist Physician Office Visit Other Covered Services and supplies provided in the Physician’s Office <ul style="list-style-type: none"> with an office visit billed without an office visit billed 	\$30 Copay \$30 Copay Applicable office visit copay Deductible and Coinsurance	Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance
<ul style="list-style-type: none"> Allergy Injections and Serum <ul style="list-style-type: none"> with an office visit billed without an office visit billed 	Plan Pays 100% Plan Pays 100%	Deductible and Coinsurance Deductible and Coinsurance
<ul style="list-style-type: none"> Other Injections <ul style="list-style-type: none"> with an office visit billed (only one copay applies per day per provider) without an office visit billed 	Applicable office visit copay Deductible and Coinsurance	Deductible and Coinsurance Deductible and Coinsurance
<p>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.</p> <p>Specialist Physician is a physician who is not a Primary Care Physician.</p> <p>Office Visit Benefits for Primary Care and Specialist Physician Office Visit include office visits (including the initial visit to diagnose pregnancy) and consultations.</p> <p>Other Covered Services not part of the Physician Office Benefit (Refer to the appropriate category for benefit information) include: Pregnancy Services; Preventive Services; Therapy & Manipulations; Durable Medical Equipment; Sleep Studies; Biofeedback; Psychological Evaluations, Assessments, and Testing.</p>		
Telehealth Services	\$15 Copay	Not Covered
Convenient Care/Retail Clinics (Quick Care)	Same as a Primary Care Physician	Same as a Primary Care Physician
Urgent Care Facility Services (a single copay applies to each urgent care visit)	\$50 Copay	Deductible and Coinsurance
Emergency Care Services (services received in a Hospital emergency room setting) <ul style="list-style-type: none"> Facility Professional Services Note: Non-emergency services provide in an emergency room are not covered.	\$250 Copay Plan Pays 100%	In-network level of benefits In-network level of benefits
Outpatient Hospital or Facility Services <ul style="list-style-type: none"> Services such as surgery, laboratory and radiology, cardiac and pulmonary rehabilitation, observation stays 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
This is a Grandfathered Health Plan. Accordingly, not all HCR required preventive services are available without cost sharing, including Women's Preventive Services.		
Preventive Services		
<ul style="list-style-type: none"> Exams and immunizations, including but not limited to: routine physical including metabolic screening test including PKU, immunizations (including HPV up to age 26), well baby/well child care, routine gynecological exam including breast and pelvic exam, treatment of minor infections, Pap test, lab, x-ray, PSA and digital rectal exams, bone mineral test, and other preventive tests 		
- Covered Children up to age 6	\$30 Copay (Copay waived when an office visit is not billed) Then Plan Pays 100%	Deductible and Coinsurance
- Covered Persons age 6 and older	\$30 Copay for the first \$750 (Copay waived when an office visit is not billed) Then Deductible and Coinsurance	Deductible and Coinsurance
• Mammograms (including 3-D)	Plan Pays 100%	Deductible and Coinsurance
• Scopic Procedures	Plan Pays 100%	Deductible and Coinsurance
• Hearing Exams	\$30 Copay	Deductible and Coinsurance
NOTE: HPV vaccine is limited to one complete dosage per lifetime. Women over age 18 but under age 26 who have not yet received the vaccine may receive the vaccine.		

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	\$15 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	\$250 Copay	In-network level of benefits
• Professional Services	Plan Pays 100%	In-network level of benefits
(Copayment is waived if admitted to the hospital within 24 hours for the same diagnosis)		

Other Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Acupuncture (limited to a maximum allowable of \$25 per visit and 30 visits per Calendar Year)	Deductible and Coinsurance	Deductible and Coinsurance
Advanced Diagnostic Imaging (CT, MRI, MRA, MRS, PET & SPECT scans and other Nuclear Medicine) <ul style="list-style-type: none"> • Physician office • All other outpatient places of service 	Same as Physician Office Deductible and Coinsurance	Same as Physician Office Deductible and Coinsurance
Ambulance (to the nearest facility for appropriate care) <ul style="list-style-type: none"> • Ground Ambulance • Air Ambulance 	Deductible and Coinsurance Deductible and Coinsurance	In-network level of benefits In-network level of benefits
Autism Spectrum Disorder (Covered Persons up to age 21)	Same as Mental Illness	Same as Mental Illness
Biofeedback	Deductible and Coinsurance	Deductible and Coinsurance
Bone Anchored Hearing Aids and Cochlear implants (subject to the benefit maximum for Hearing Aids)	Deductible and Coinsurance	Deductible and Coinsurance
Botox for Hyperhidrosis	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) Purchase, including repair/replacement, is limited to once every three years.	Deductible and Coinsurance	Deductible and Coinsurance
Eye Glasses or Contact Lenses	Not Covered	Not Covered

Other Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Hearing Aids (limited to a single purchase per ear, including repair and replacement, every 3 Calendar Years, and subject to a maximum of \$5,000 per Calendar Year)	Deductible and Coinsurance	Deductible and Coinsurance
Home Health Aide and Skilled Nursing <ul style="list-style-type: none"> • Home Health Aide • Skilled Nursing Care (limited to 100 visits per calendar year, 4 hours equals one visit) 	Deductible and Coinsurance	Deductible and Coinsurance
	Deductible and Coinsurance	Deductible and Coinsurance
Home Infusion Therapy	Deductible and Coinsurance	Deductible and Coinsurance
Hospice Services (limited to 360 days while covered under the Plan)	Deductible and Coinsurance	Deductible and Coinsurance
Independent Laboratory <ul style="list-style-type: none"> • Diagnostic • Preventive 	Deductible and Coinsurance	Deductible and Coinsurance
	Same as Preventive Services	Same as Preventive Services
Infertility <ul style="list-style-type: none"> • Services to diagnose • Treatment to promote fertility 	Not Covered	Not Covered
	Not Covered	Not Covered
Massage Therapy Services (limited to a maximum allowable of \$25 per visit, and limited to one visit and treatment per day with a maximum of 12 visits per Calendar Year)	Deductible and Coinsurance	Deductible and Coinsurance
Nicotine Addiction <ul style="list-style-type: none"> • Medical services and therapy • Nicotine addiction classes & alternative therapy 	Same as Substance Dependence and Abuse	Same as Substance Dependence and Abuse
	Not Covered	Not Covered
Obesity (morbid obesity) <ul style="list-style-type: none"> • Non-surgical treatment • Surgical Treatment 	Same as any other illness	Same as any other illness
	Same as any other illness	Same as any other illness
Oral Surgery and Dentistry Dental treatment when due to an accidental injury to naturally healthy teeth and severe enough that initial contact with a Physician or dentist occurs within 72 hours of the accident (treatment related to accidents must be started within 3 months of the injury and completed within 12 months of the date of injury).	Deductible and Coinsurance	Deductible and Coinsurance
Organ and Tissue Transplantation	Deductible and Coinsurance	Deductible and Coinsurance
Orthognathic surgery, jaw alignment and treatment for the TMJ (limited to treatment of obstructive sleep disorder)	Same as any other illness	Same as any other illness
Ostomy Supplies	Deductible and Coinsurance	Deductible and Coinsurance

Other Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal Infections (PANDAS)	Deductible and Coinsurance	Deductible and Coinsurance
Physician Professional Services Services, such as, surgery, surgical assistant, anesthesia, inpatient hospital visits and other non-surgical services <ul style="list-style-type: none"> • Physician office • All other places of service 	Same as Physician Office Deductible and Coinsurance	Same as Physician Office Deductible and Coinsurance
Pregnancy, Maternity and Newborn Care <ul style="list-style-type: none"> • Pregnancy and maternity (Payment for prenatal and postnatal care is included in the payment for the delivery) • Newborn care (limited to 96 hours) NOTE: Newborns are covered at birth, subject to the plan’s enrollment provisions.	Deductible and Coinsurance Plan Pays 100%	Deductible and Coinsurance Plan Pays 100%
Radiation Therapy and Chemotherapy <ul style="list-style-type: none"> • Physician office • All other places of service 	Same as Physician Office Deductible and Coinsurance	Same as Physician Office Deductible and Coinsurance
Radiology (x-ray) Services and other Diagnostic Test <ul style="list-style-type: none"> • Physician office • All other places of service 	Same as Physician Office Deductible and Coinsurance	Same as Physician Office Deductible and Coinsurance
Rehabilitation Services – Inpatient Facility (in lieu of an Inpatient Hospitalization) (limited to 100 days per Calendar Year Skilled Nursing Facility and Inpatient Rehabilitation Facility combined)	Deductible and Coinsurance	Deductible and Coinsurance
Rehabilitation Services <ul style="list-style-type: none"> • Cardiac rehabilitation (limited to 36 sessions per Calendar Year) • Pulmonary Rehabilitation (limited to 20 sessions per Calendar Year) 	Deductible and Coinsurance Deductible and Coinsurance	Deductible and Coinsurance Deductible and Coinsurance
Renal Dialysis <ul style="list-style-type: none"> • Physician office • All other places of service 	Same as Physician Office Deductible and Coinsurance	Same as Physician Office 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	Not Covered	Not Covered
Skilled Nursing Facility (in lieu of an Inpatient Hospitalization) (limited to 100 days per Calendar Year Skilled Nursing Facility and Inpatient Rehabilitation Facility combined)	Deductible and Coinsurance	Deductible and Coinsurance
Sleep Studies	Deductible and Coinsurance	Deductible and Coinsurance
Temporomandibular and Craniomandibular Joint Disorder	Not Covered	Not Covered
Therapy & Manipulations <ul style="list-style-type: none"> • Physical or occupational therapy services, osteopathic physiotherapy (combined limit to 60 sessions per Calendar Year for both rehabilitative and habilitative services) • Speech therapy (when the speech impediment or dysfunction results from Injury, stroke or a congenital anomaly and limited to 20 sessions per Calendar Year) • Chiropractic manipulative treatments or adjustments (limited to one visit and treatment per day and subject to a combined limit of 30 sessions per Calendar Year) • Osteopathic manipulative treatments or adjustment 	Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance	Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance
Transportation and Lodging (when the recipient lives more than 50 miles from the Blue Distinction facility) (Limited to an overall maximum while covered of \$10,000 per Covered Person in connection with transplant procedures or cancer related Services.)	Lodging for adult patient (while not a Hospital Inpatient) and one companion is limited to a per diem of \$50 per person Lodging for Covered minor child patient (while not a Hospital Inpatient) and two companions is limited to a per diem of \$100 per day	
Vision Exams <ul style="list-style-type: none"> • Diagnostic (to diagnose an illness) • Preventive (routine exam including refraction) limited to one exam per Calendar Year 	Applicable Office Visit Copay \$20 Copay	Deductible and Coinsurance Deductible and Coinsurance (up to \$40 allowance)
Wigs (when required as a result of cancer) limited to an overall maximum of \$500 per person while covered under the Plan	Plan Pays 100%	Same as In-network level of benefits
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 and/or Coinsurance are applicable) <ul style="list-style-type: none"> • Individual • Family 		Not Applicable Not Applicable
Retail – per 31-day supply <ul style="list-style-type: none"> • Generic drugs (including non-preferred contraceptives) • Preferred Brand Name Drugs • Non-preferred Brand Name Drugs 	\$15 Copay \$30 Copay \$60 Copay	50% 50% 50%
Mail order – per 90-day supply <ul style="list-style-type: none"> • Generic drugs (including non-preferred contraceptives) • Preferred Brand Name Drugs • Non-preferred Brand Name Drugs 	\$30 Copay \$60 Copay \$120 Copay	Not Covered Not Covered Not Covered
Specialty drugs (specialty drugs must be purchased through a designated specialty pharmacy after two fills)	Same as retail	50%
Contraceptives <ul style="list-style-type: none"> • Preferred <ul style="list-style-type: none"> - Generic - Brand Name • Non-preferred <ul style="list-style-type: none"> - Generic - Brand Name 	Plan Pays 100% Plan Pays 100% Same as any other Generic Drugs Same as any other Non-preferred Brand Name	50% 50%
Infertility FDA approved prescription drugs to promote fertility	Not Covered	Not Covered
Nicotine Addiction (limited to 180 day supply of Chantix per calendar year)	Plan Pays 100%	50%
Obesity FDA approved prescription drugs	Not Covered	Not Covered

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.