

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 (Aggregate*) 	<p>\$3,000 \$6,000</p>	<p>\$10,000 \$20,000</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>0%</p>	<p>50%</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 (Aggregate*) 	<p>NA NA</p>	<p>\$10,000 \$20,000</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 (Aggregate*) 	<p>\$3,000 \$6,000</p>	<p>\$20,000 \$40,000</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>*Aggregate – If you have single coverage, you only need to satisfy the individual Deductible and Out-of-pocket Limit. If you have family coverage the individual amounts do not apply - the entire family Deductible must be met prior to any benefits becoming available, and the entire family Out-of-pocket must be met before cost-sharing no longer applies. 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:

- This plan has no medical or prescription drug copays

Coinsurance Limit includes:

- Coinsurance

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 (with or without an office visit billed) 	Deductible	Deductible and Coinsurance
<ul style="list-style-type: none"> Allergy Injections and Serum 	Deductible	Deductible and Coinsurance
<ul style="list-style-type: none"> Other Injections 	Deductible	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	Deductible	Not Covered
Convenient Care/Retail Clinics (Quick Care)	Same as a Primary Care Physician	Same as a Primary Care Physician
Urgent Care Facility Services	Deductible	Deductible and Coinsurance
Emergency Care Services (services received in a Hospital emergency room setting) <ul style="list-style-type: none"> Facility Professional Services <p>Note: Non-emergency services provide in an emergency room are not covered.</p>	Deductible Deductible	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 Scopic procedures 	Deductible Deductible	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	Deductible and Coinsurance

Preventive Services	In-network Provider	Out-of-network Provider
Preventive Services <ul style="list-style-type: none"> Affordable Care Act (ACA) required preventive services (may be subject to limits that include, but are not limited to, age, gender, and frequency) ACA required covered preventive services (outside of limits) Other covered preventive services not required by ACA, such as: <ul style="list-style-type: none"> Laboratory tests as specified by Us, including urinalysis and complete blood count; prostate cancer screening (PSA) and hearing exams All other laboratory tests; radiology, cardiac stress tests; EKG; pulmonary function and other screenings and services Mammograms, including 3-D (Preventive only) 	Plan Pays 100% Plan Pays 100% Plan Pays 100% Same as an illness Plan Pays 100%	Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance Same as an illness Deductible and Coinsurance
Immunizations <ul style="list-style-type: none"> Pediatric (up to age 7) Age 7 and older Related to an illness 	Plan Pays 100% Plan Pays 100% Same as any other illness	Deductible and Coinsurance Deductible and Coinsurance 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	Deductible and Coinsurance
Outpatient Services <ul style="list-style-type: none"> Office Services Telehealth Services All Other Outpatient Items & Services 	Deductible Deductible Deductible	Deductible and Coinsurance Not Covered Deductible and Coinsurance
Emergency Care Services (services received in a Hospital emergency room setting) <ul style="list-style-type: none"> Facility Professional Services 	Deductible Deductible	In-network level of benefits In-network level of benefits

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	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 services 	Same as Physician Office Deductible	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	In-network level of benefits
Autism Spectrum Disorder (Covered Persons up to age 21)	Same as Mental Illness	Same as Mental Illness
Biofeedback	Deductible	Deductible and Coinsurance
Bone Anchored Hearing Aids and Cochlear implants (subject to the benefit maximum for Hearing Aids)	Deductible	Deductible and Coinsurance
Botox for Hyperhidrosis	Deductible	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	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	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	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	Deductible and Coinsurance
	Deductible	Deductible and Coinsurance
Home Infusion Therapy	Deductible	Deductible and Coinsurance
Hospice Services (limited to 360 days while covered under the Plan)	Deductible	Deductible and Coinsurance
Independent Laboratory <ul style="list-style-type: none"> • Diagnostic • Preventive 	Deductible	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	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	In-network level of benefits
Organ and Tissue Transplantation	Deductible	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	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	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	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 	Deductible	Deductible and Coinsurance
NOTE: Newborns are covered at birth, subject to the plan's enrollment provisions.		
Radiation Therapy and Chemotherapy	Deductible	Deductible and Coinsurance
Radiology (x-ray) Services and other Diagnostic Test	Deductible	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	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	Deductible and Coinsurance
	Deductible	Deductible and Coinsurance
Renal Dialysis	Deductible	Deductible and Coinsurance
Respiratory Care (limited to 60 days per Calendar Year)	Deductible	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 	Deductible Deductible Deductible	Deductible and 50% Coinsurance Deductible and 50% Coinsurance Deductible and 50% Coinsurance
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 	Deductible Deductible Deductible	Not Covered Not Covered Not Covered
Specialty drugs (specialty drugs must be purchased through a designated specialty pharmacy after two fills)	Same as retail	Deductible and 50% Coinsurance
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% Coinsurance 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

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.