Schedule of Benefits Summary

Extraordinary Care - PPO

Group Name: The Nebraska Medical Center dba
Nebraska Medicine

Effective Date: January 01, 2017

Payment for Services	Tier I Select In-network Provider	Tier II In-network Provider	Tier III 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.			
Nebraska Medicine BlueChoice is a select group of Preferred Providers. Tier I Select In-network benefits are available when a Covered Person under this Plan receives Covered Services from a Tier I Select In-network Provider. Not all Covered Services shown on this document are available from a Tier I Select In-network Provider.			
Deductible (the amount the Covered Person pays each Calendar Year for Covered Services before the Coinsurance is payable)			
• Individual	$500	$1,000	$2,000
• Family (Embedded*)	$1,200	$2,400	$4,800
Coinsurance (the percentage amount the Covered Person must pay for most Covered Services after the Deductible has been met)			
• Covered Person Pays	20%	20%	50%
Out-of-pocket Limit (does not include premium, penalty and amounts not covered by the plan)			
• Individual	$2,500	$5,000	$8,000
• Family (Embedded*)	$5,000	$10,000	$16,000
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 are separate and do not cross accumulate; however, Tier I and Tier II do cross accumulate. All other limits (days, visits, sessions, dollar amounts, etc.) do cross accumulate between In-network and Out-of-network, unless noted differently.			
*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.			

NOT ALL COVERED SERVICES ARE AVAILABLE FROM A TIER I SELECT IN-NETWORK PROVIDER

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

- Physician Office
- Telehealth Services
- Prescription Drugs
- Urgent Care
- Emergency Care

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

NOT ALL COVERED SERVICES ARE AVAILABLE FROM A TIER I SELECT IN-NETWORK PROVIDER

Covered Services – Illness or Injury	Tier I Select In-network Provider	Tier II In-network Provider	Tier III Out-of-network Provider
Physician Office • Primary Care Physician Office Visit	$20 Copay	$20 Copay	Deductible and Coinsurance
• Specialist Physician Office Visit	$40 Copay	$40 Copay	Deductible and Coinsurance
• Other Covered Services and supplies provided in the Physician's Office (with or without an office visit billed)	Applicable office visit Copay	Applicable office visit Copay	Deductible and Coinsurance
• Laboratory Services	Plan Pays 100%	Plan Pays 100%	Deductible and Coinsurance
• Allergy Injections and Serum	Plan Pays 100%	Plan Pays 100%	Deductible and Coinsurance
• Allergy Testing	Plan Pays 100%	Plan Pays 100%	Deductible and Coinsurance
• Injections (excluding allergy injections and Specialty Drugs and Medicines)	Plan Pays 100%	Plan Pays 100%	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.			
Convenient Care/Retail Clinics (Quick Care)	Same as a Primary Care Physician	Same as a Primary Care Physician	Deductible and Coinsurance
Telehealth Services (by a designated Provider)	Not Applicable	$10 Copay	Not Covered
Urgent Care Facility Services (a single Copay applies to each Urgent Care visit)	$50 Copay	$50 Copay	Not Covered
Emergency Care Services (services received in a Hospital emergency room setting) • Facility • Professional Services (Copayment is waived if admitted to the hospital within 24 hours for the same diagnosis)	$200 Copay If True Emergency Plan Pays 100%	Tier I In-network level of benefits Tier I In-network level of benefits	Tier I In-network level of benefits Tier I In-network level of benefits

NOT ALL COVERED SERVICES ARE AVAILABLE FROM A TIER I SELECT IN-NETWORK PROVIDER

Covered Services – Illness or Injury	Tier I Select In-network Provider	Tier II In-network Provider	Tier III Out-of-network Provider
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	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	Deductible and Coinsurance

Preventive services	Tier I Select In-network Provider	Tier II In-network Provider	Tier III 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%	Deductible and Coinsurance
• Other covered preventive services not required by ACA	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
3-D Mammogram • First mammogram of the calendar year (regardless of diagnosis)	Plan Pays 100%	Not Covered	Not Covered
• Additional mammograms	Same as any other illness	Not Covered	Not Covered
Immunizations • Pediatric (up to age 7)	Plan Pays 100%	Plan Pays 100%	Deductible and Coinsurance
• Age 7 and older	Plan Pays 100%	Plan Pays 100%	Deductible and Coinsurance
• Related to an illness	Same as any other illness	Same as any other illness	Same as any other illness
For Services billed as preventive, including physicals, laboratory, well-baby care, well-child care, well-woman care, mammograms, prostate cancer screening, colon cancer screening, diabetes screening, certain osteoporosis screenings, behavioral health screening, flu shots, and adult childhood immunizations.			

NOT ALL COVERED SERVICES ARE AVAILABLE FROM A TIER I SELECT IN-NETWORK PROVIDER

Mental Illness and/or Substance Dependence and Abuse Covered Services	Tier I Select In-network Provider	Tier II In-network Provider	Tier III Out-of-network Provider
Inpatient Services	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Outpatient Services			
• Office Visit	$20 Copay	$20 Copay	Deductible and Coinsurance
• All Other Outpatient Items & Services	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Emergency Care Services (services received in a Hospital emergency room setting)			
• Facility	$200 Copay If True Emergency	Tier I In-network level of benefits	Tier I In-network level of benefits
• Professional Services (Copayment is waived if admitted to the hospital within 24 hours for the same diagnosis)	Plan Pays 100%	Tier I In-network level of benefits	Tier I In-network level of benefits

NOT ALL COVERED SERVICES ARE AVAILABLE FROM A TIER I SELECT IN-NETWORK PROVIDER

Other Covered Services – Illness or Injury	Tier I Select In-network Provider	Tier II In-network Provider	Tier III Out-of-network Provider
Acupuncture (when in lieu of anesthesia for covered surgery)	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Advanced Diagnostic Imaging (CT, MRI, MRA, MRS, PET & SPECT scans and other Nuclear Medicine)	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Ambulance (to the nearest facility for appropriate care) • Ground Ambulance • Air Ambulance	Coinsurance Coinsurance	Tier I In-network level of benefits Coinsurance (Tier I In-network level of benefits if due to a true emergency)	Tier I In-network level of benefits Coinsurance (Tier I In-network level of benefits if due to a true emergency)
Autism Spectrum Disorder	Not Covered	Not Covered	Not Covered
Biofeedback	Not Covered	Not Covered	Not Covered
Cochlear implants	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Contact Lenses or Lens Implants Only covered if required following cataract surgery	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Dermatological Services	Same as any other illness	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	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	Deductible and Coinsurance

NOT ALL COVERED SERVICES ARE AVAILABLE FROM A TIER I SELECT IN-NETWORK PROVIDER

Other Covered Services – Illness or Injury	Tier I Select In-network Provider	Tier II In-network Provider	Tier III Out-of-network Provider
Hearing Aids	Not Covered	Not Covered	Not Covered
Home Health Care (Home Health Aide and Skilled Nursing Care limited to 100 visits per Calendar Year)	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Home Infusion Therapy	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Hospice Services (Certification required) • Inpatient and Outpatient • Counseling Services • Bereavement Services	 Plan Pays 100% Same as any other Mental Illness Same as any other Mental Illness	 Deductible and Coinsurance Same as any other Mental Illness Same as any other Mental Illness	 Deductible and Coinsurance Same as any other Mental Illness Same as any other Mental Illness
Independent Laboratory • Diagnostic • Preventive	 Plan Pays 100% Same as Preventive	 Tier I In-network level of benefits Same as Preventive	 Tier I In-network level of benefits Same as Preventive
Infertility • Services to diagnose • Treatment to promote fertility (limited to $5,000 per Covered Person while covered)	 Same as any other illness Deductible and Coinsurance	 Same as any other illness Deductible and Coinsurance	 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	 Same as Substance Dependence and Abuse Not Covered
Obesity • Non-surgical treatment • Surgical Treatment (including post-surgery follow-up care)	 Not Covered Deductible and Coinsurance	 Not Covered Not Covered	 Not Covered Not Covered
Oral Surgery and Dentistry Services such as incision and drainage of abscesses and excision of tumors and cysts. 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	Deductible and Coinsurance

NOT ALL COVERED SERVICES ARE AVAILABLE FROM A TIER I SELECT IN-NETWORK PROVIDER

Other Covered Services – Illness or Injury	Tier I Select In-network Provider	Tier II In-network Provider	Tier III Out-of-network Provider
Organ and Tissue Transplantation • Recipient - Nebraska Medicine - Other Facility (Limited benefit for Services not available at a Nebraska Medicine facility) - Professional • Travel Expenses (when the transplant is not available at a Nebraska Medicine facility and the facility is outside a 75 mile radius of the Covered Person's home)	Deductible and Coinsurance Not Applicable Deductible and Coinsurance Not Applicable	Not Covered Deductible and Coinsurance Deductible and Coinsurance $50 per diem (Covered Person only) $100 per diem (Covered Person and one companion) $10,000 Benefit Maximum per transplant	Not Covered Not Covered Not Covered Not Covered
Ostomy Supplies	Deductible and Coinsurance	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	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	Deductible and Coinsurance Deductible and Coinsurance
Radiation Therapy and Chemotherapy	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Radiology (x-ray) Services and other Diagnostic Test	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance

NOT ALL COVERED SERVICES ARE AVAILABLE FROM A TIER I SELECT IN-NETWORK PROVIDER

Other Covered Services – Illness or Injury	Tier I Select In-network Provider	Tier II In-network Provider	Tier III Out-of-network Provider
Rehabilitation Services – Inpatient Facility (limited to a per person maximum of 60 days per Calendar Year)	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Rehabilitation Services • Cardiac rehabilitation	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
• Pulmonary Rehabilitation	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Renal Dialysis	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Respiratory Care	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Sexual Dysfunction	Not Covered	Not Covered	Not Covered
Skilled Nursing Facility (limited to 100 Days per Calendar Year)	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Sleep Studies	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Specialty Drugs and Medicines (other than those purchased through a Specialty Pharmacy)	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Temporomandibular and Craniomandibular Joint Disorder	Deductible and Coinsurance	Deductible and Coinsurance	Not Covered

NOT ALL COVERED SERVICES ARE AVAILABLE FROM A TIER I SELECT IN-NETWORK PROVIDER

Other Covered Services – Illness or Injury	Tier I Select In-network Provider	Tier II In-network Provider	Tier III Out-of-network Provider
Therapy & Manipulations • Physical or occupational therapy services, or osteopathic physiotherapy (combined limit to 60 Sessions per Calendar Year) • Speech therapy (limited to 30 Sessions per Calendar Year) • Chiropractic or osteopathic manipulative treatments or adjustments (combined limit to 26 Sessions per Calendar Year)	Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance	Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance	Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance
Vision Exams • Diagnostic (to diagnose an illness) • Preventive (routine exam including refraction)	See Physician Office Services Not Covered	See Physician Office Services Not Covered	See Physician Office Services Not Covered
Wigs (during or following chemotherapy or radiation therapy, limited to 2 per Calendar Year)	Deductible and Coinsurance	Tier I In-network level of benefits	Tier I In-network level of benefits
All Other Covered Services	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance

NOT ALL COVERED SERVICES ARE AVAILABLE FROM A TIER I SELECT IN-NETWORK PROVIDER

Prescription Drugs through Nebraska Medicine or Bellevue Medical Center	Nebraska Medicine or Bellevue Medical Center
Retail – per 30-day supply	
• Generic drugs (including non-formulary contraceptives)	$5 Copay
• Formulary Brand Name Drugs	$15 Copay
• Non-formulary Brand Name Drugs	$30 Copay
• Specialty	20% Coinsurance, ($150 maximum Copay)
Mail order – per 90-day supply	
• Generic drugs (including non-formulary contraceptives)	$10 Copay
• Formulary Brand Name Drugs	$30 Copay
• Non-formulary Brand Name Drugs	$60 Copay
Diabetic Supplies - Retail per 30-day supply	
• Formulary	$5 Copay
• Non-formulary	$30 Copay
NOTE: Copay applies to each supply	
Diabetic Supplies - Mail order per 90-day supply	
• Formulary	$10 Copay
• Non-formulary	$60 Copay
NOTE: Copay applies to each supply	
Contraceptives	
• Formulary	
- Generic	Plan Pays 100%
- Brand Name	Plan Pays 100%
• Non-formulary	
- Generic	Same as any other Generic Drugs
- Brand Name	Same as any other Non-formulary Brand Name
Infertility	
• Specialty Drugs	20% Coinsurance, ($150 maximum Copay)
• Non-specialty Drugs	Same as any other Retail Drug
FDA approved prescription drugs to promote fertility (Combined limit of $10,000 for medical and pharmacy infertility benefits while covered)	
Nicotine Addiction	
FDA approved prescription drugs and over-the-counter nicotine addiction drugs and deterrents	Plan Pays 100%
Obesity	
FDA approved prescription drugs	Not Covered

NOT ALL COVERED SERVICES ARE AVAILABLE FROM A TIER I SELECT IN-NETWORK PROVIDER

Prescription Drugs through pharmacies other than Nebraska Medicine or Bellevue Medical Center	In-network Provider	Out-of-network Provider
Retail – per 30-day supply		
• Generic drugs	$15 Copay	50%
• Formulary Brand Name Drugs	$30 Copay	50%
• Non-formulary Brand Name Drugs	$60 Copay	50%
• Specialty Drugs	Not Covered	Not Covered
Mail order – per 90-day supply		
• Generic drugs	Not Covered	Not Covered
• Formulary Brand Name Drugs	Not Covered	Not Covered
• Non-formulary Brand Name Drugs	Not Covered	Not Covered
Diabetic Supplies - Retail		
• Formulary	50%	50%
• Non-formulary	50%	50%
Diabetic Supplies - Mail order		
• Formulary	Not Covered	Not Covered
• Non-formulary	Not Covered	Not Covered
Contraceptives		
• Formulary		
- Generic	Plan Pays 100%	50%
- Brand Name	Plan Pays 100%	50%
• Non-formulary		
- Generic	Same as any other Generic Drugs	
- Brand Name	Same as any other Non-formulary Brand Name	
Infertility		
• Specialty Drugs	Not Covered	
• Non-specialty Drugs	Same as any other Retail Drug	
FDA approved prescription drugs to promote fertility (limited to $5,000 while covered)		
Nicotine Addiction FDA approved prescription drugs and over-the-counter nicotine addiction drugs and deterrents	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.

NOT ALL COVERED SERVICES ARE AVAILABLE FROM A TIER I SELECT IN-NETWORK PROVIDER

NOT ALL COVERED SERVICES ARE AVAILABLE FROM A TIER I SELECT IN-NETWORK PROVIDER