# A Guide to Your Health Benefits

## City of Lincoln

$400 Deductible

(Effective Date: 11/01/2012)

98-452 1/2011

# IMPORTANT TELEPHONE NUMBERS

**Member Service**
Omaha and Toll-free . . . . . 1-888-592-8963
TTY/TTD (for the hearing impaired) . . . . . 402-390-1888

**Coordination of Benefits**
Omaha . . . . . 402-390-1840
Toll-free . . . . . 1-800-462-2924

**Subrogation**
Omaha . . . . . 402-390-1847
Toll-free . . . . . 1-800-662-3554

**Workers' Compensation**
Omaha . . . . . 402-398-3615
Toll-free . . . . . 1-800-821-4786

**Certification**
Omaha . . . . . 402-390-1870
Toll-free . . . . . 1-800-247-1103

**BlueCard Provider Information**
Toll-free . . . . . 1-800-810-BLUE (2583)
Website . . . . . www.bcbs.com

**Pharmacy Locator**
Toll-free . . . . . 1-877-800-0746

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# INTRODUCTION

**Welcome**

This document is your Summary Plan Description (SPD). It has been written to provide an easy way to obtain information about your group health plan (the Plan) as administered by Blue Cross and Blue Shield of Nebraska (BCBSNE), an independent licensee of the Blue Cross and Blue Shield Association.

Please note that the information provided in this SPD is only a summary and it is not intended to be a complete description of every detail of the Plan. Your group health care plan is adminstered in accordance with the provisions set forth in the Master Group Contract and the Administrative Services Agreement between the group and BCBSNE.

*NOTE: BCBSNE provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims. BCBSNE liability may occur only under a stop loss provision set forth in the Administrative Services Agreement.*

## How To Use This Document

For your convenience, defined terms are capitalized throughout this document. For an explanation of a defined term, refer to the Section titled "Definitions".

Please take some time to read this document and become familiar with it. We especially encourage you and your Eligible Dependents to review the benefit limitations by reading the Schedule of Benefits Summary and the Section titled "Benefit Descriptions".

As you read this SPD you will find that many of the sections of the document are related to other sections of the document. You may not have all the information you need by reading just one section. If, after reading this SPD you have questions about the coverage available to you, you should call BCBSNE Member Services Department**.**

Remember, neither your Physician nor the facility has a copy of your SPD and, therefore, they do not know what your benefits are.

## About Your I.D. Card

BCBSNE will issue you an identification card (I.D. card). Your I.D. number is a unique alpha numeric combination.

Always put your I.D. card in your wallet or purse, along with your driver's license, credit cards and other essential items. With your BCBSNE I.D. card, U.S. Hospitals and Physicians can identify your coverage and will usually submit their claims for you.

If you want extra cards for covered family members or need to replace a lost card, please contact BCBSNE Member Services Department. Remember, only persons who are eligible for coverage under your membership may use your BCBSNE I.D. card.

## What's A Schedule Of Benefits?

Your Schedule of Benefits is a personalized document that provides you with a basic overview of your coverage. It also shows the membership option that applies to you.

For additional information which may be unique to your coverage, please refer to the Schedule of Benefits Summary.

## About The Plan

This group health plan is a Preferred Provider Organization (PPO) health benefit plan. Claims administration is provided by Blue Cross and Blue Shield of Nebraska (BCBSNE).

NEtwork BLUE is a PPO (In-network) Provider network established by BCBSNE through contracts with a panel of Hospitals, Physicians and other health care providers who have agreed to furnish medical services to you and your family in a manner that will help manage health care costs. These providers are referred to as "In-network" or "Preferred Providers."

Blue Cross and Blue Shield Plans in other states (On-site Plans) have also contracted with health care providers in their geographic areas who are referred to as "Preferred Providers."

Use of the network is voluntary, but you should be aware that when you choose to use providers who do not participate in the local plan's network for non-emergency situations, you can expect to pay more than your applicable Coinsurance, Copayment and/or Deductible amounts. After this health plan pays its required portion of the bill, Out-of-network Providers may bill you for any amount not paid. This balance billing does not happen when you use In-network or Preferred Providers because these providers have agreed to accept a Contracted Amount as payment for services with no additional billing to you other than your applicable Coinsurance, Copayment and Deductible amounts. In-network Providers will also file claims for you.

For help in locating In-network Providers, managing your personal health care benefits, as well as accessing various resources and tools, visit BCBSNE online at www.bcbsne.com. You may also call Member Services using the toll-free number on your I.D. card or refer to the Important Telephone Numbers in the front of this book. If you would like a printed provider list, BCBSNE will furnish one without charge.

### Using Your Benefits Wisely

BCBSNE wants you to get the most from your group health coverage. You can save yourself a considerable amount of time and money by making efficient use of the health care system.

As you read this document, some "Good Care Tips" for efficient health care will be highlighted in boxes just like this one.

## How The Network Works

**Using In-network Providers:**

- Present I. D.
- Receive highest level of benefits
- Provider files claims for you
- Provider accepts insurance payment as payment in full (except Deductible, Copayment and /or Coinsurance amounts)
- No balance billing

**Using Out-of-network Providers:**

- You may be required to pay full cost at time of service
- You may be reimbursed at a lower benefit level
- You may have to file claims
- You're responsible for amounts that exceed the Allowable Charge

Remember, if more than one Physician is involved in your care, it is important for you to check the status of each provider.

## Exception

If you receive initial Inpatient or Outpatient care for an Emergency Medical Condition at an Out-of-network Hospital or by an Out-of-network Provider, benefits for covered Services for the initial care will be provided at the In-network benefit level. In order to continue to receive the highest level of benefits available after the initial care has been provided, you must use an In-network Provider. In addition, any Covered Services provided by an Out-of-network urgent Care Physician and/or other Out-of-network professional Provider will be paid at the In-network level when the corresponding facility charges are paid subject to the In-network benefit level.

*NOTE: You will still be responsible for amounts in excess of the Allowable Charge when you receive services from an Out-of-network Provider.*

### Be Informed

Out-of-Network Providers' charges may be higher than the benefit amount allowed by this health plan. You may contact BCBSNE Member Services Department concerning allowable benefit amounts in Nebraska for specific procedures. Your request must specify the service or procedure, including any service or procedure code(s) or diagnosis-related group, and the provider's estimated charge.

## BlueCard® Program

Blue Cross and Blue Shield plans across the country participate in the BlueCard Program. This program enables the Blue Cross and Blue Shield plan servicing the geographic area where health care Services are provided (On-site plan) to receive and process claims for Covered Services.

When you obtain health care Services through the BlueCard Program outside the geographic area BCBSNE serves, the amount you pay for Covered Services is calculated on the lower of:

- The billed charges for your Covered Services, or
- The Contracted Amount that the On-site Blue Cross and Blue Shield Plan (Host Blue) passes on to BCBSNE.

Often, this Contracted Amount will consist of a simple discount which reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price expected settlements with your health care provider or with a specified group of providers. The Contracted Amount may also be billed charges reduced to reflect an average expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The Contracted Amount may also be adjusted in the future to correct for over or underestimation of past prices. However, the amount you pay is considered the final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating subscriber liability for Covered Services that does not reflect the entire savings realized or expected to be realized on a particular claim or to add a surcharge. Should any state statutes mandate Subscriber liability calculation methods that differ from the usual BlueCard method noted above, or require a surcharge, BCBSNE would then calculate your liability for any covered health care Services in accordance with the applicable state statute in effect at the time you received your care.

## Locating A Provider Outside The NEtwork Blue Service Area

Selection of a provider of care still remains your choice. If you receive care from a provider who is a Preferred Provider with the On-site Blue Cross and/or Blue Shield Plan, you are eligible to receive the highest benefit level (preferred) possible under your group health plan. However, if you choose a non-Preferred Provider, the benefit level (non-preferred) will generally be less. For help in locating a Preferred Provider in another Blue Cross and/or Blue Shield service area, you may call the special toll-free number of the Blue Cross and Blue Shield BlueCard Program (1-800-810-2583) for assistance.

Also, for help in locating a provider, you can visit the "Blue National Doctor & Hospital Finder" at the Blue Cross and Blue Shield Association website: www.bcbs.com.

## How The Plan Components Work

Your Deductible, Copayment, Coinsurance and Coinsurance Limit are shown on your Schedule of Benefits Summary. The following is an explanation of each of those components.

**Allowable Charge** — An amount BCBSNE uses to calculate the payment of Covered Services. This amount will be based on either the Contracted Amount for In-network Providers or the Out-of-network Allowance for Out-of-network Providers.

**Coinsurance** — This is the percentage you must pay for Covered Services, after the Deductible is applied. (Your Coinsurance is generally lower if you receive Services from an In-network Provider.)

**Coinsurance Limit*** — The Coinsurance Limit is the total amount of Coinsurance each Covered Person must pay in a calendar year. The amount applied to the Coinsurance Limit for Covered Services by either In-network or Out-of-network Providers will be credited to both In-network and Out-of-network Coinsurance Limits.

Certain kinds of charges do not count toward your Coinsurance Limit. For example:

- Charges in excess of the Allowable Charge.
- Charges for Noncovered Services.

**Copayment (Copay)** — A fixed dollar amount of the Contracted Amount, payable by the Covered Person for a Covered Service.

**Deductible*** — You are responsible for your annual expenses until you reach the Plan's Deductible. After the Deductible is met, benefits for the rest of that calendar year will not be subject to any further Deductible. The amount applied to the Deductible for Covered Services by either In-network or Out-of-network Providers will be credited to both In-network and Out-of-network Deductibles. Unless otherwise noted on your Schedule of Benefits Summary, Copays and charges for Noncovered Services or amounts in excess of the Allowable Charge do not count toward your Deductible.

**If you have a family or multiple party membership, your plan my have either an aggregate or an embedded Deductible and/or Coinsurance Limit. Your Schedule of Benefits Summary will indicate whether your plan has an aggregate or an embedded amount.*

*Aggregate Deductible and/or Coinsurance Limit means the entire family amount must be met before benefits are available. Family members may combine their Covered expenses to satisfy the family amount.*

*Embedded Deductible and/or Coinsurance Limit means no one family member contributes more than the individual amount to satisfy the family amount.*

**Utilization Review** — Benefits are available under this group health plan for **Medically Necessary** and **Scientifically Validated** Services. Services provided by all health care providers are subject to utilization review by BCBSNE. Services will not automatically be considered Medically Necessary because they have been ordered or provided by a Physician. BCBSNE will determine whether Services provided are Medically Necessary under the terms of the plan, and benefits available.

**Certification Requirements** — Prior Certification is required for all Inpatient Hospital admissions as well as certain surgical procedures and specialized Services and supplies. In-network Hospitals will notify BCBSNE of an Inpatient admission. However, when you are admitted as an Inpatient to an Out-of-network Hospital, or to a Hospital outside the state of Nebraska, it is your responsibility to see to it that BCBSNE is notified of your admission. For more information, please refer to the section of this book titled "Certification Requirements."

For more definitions, please refer to the section of this book titled "Definitions."

LPU/LCEA**/E/DSS/X/M (**Subject to Contract approval)

| Payment for Services | In-Network Provider | Out-of-Network Provider |
|---|---|---|
| Covered Services are reimbursed based on the Allowable Charge. BlueCross and BlueShield 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 BlueCross and BlueShield, can't bill for amounts over the Contracted Amount. Out-of-Network Providers can bill for amounts over the Out-of-Network Allowance. | | |
| **Deductible**<br>(the amount the Covered Person pays each Calendar Year for Covered Services before the Coinsurance is payable) | | |
| • Individual | $400 | $800 |
| • Family (Embedded*) | $800 | $1,600 |
| **Coinsurance**<br>(the percentage amount the Covered Person must pay for most Covered Services after the deductible has been met) | | |
| • Covered Person Pays | 20% | 30% |
| **Coinsurance Limit**<br>(the maximum Coinsurance the Covered Person must pay each Calendar Year.<br>(this amount does not include the deductible or copayments) | | |
| • Individual | $1,000 | $2,000 |
| • Family (Embedded*) | $1,500 | $3,000 |
| **Deductible and Coinsurance Limit**<br>(combination of the deductible and coinsurance amounts only; does not include any copayments or amounts not covered by the plan) | | |
| • Individual | $1,400 | $2,800 |
| • Family | $2,300 | $4,600 |
| Once the annual Coinsurance Limit or the combined Deductible and Coinsurance Limit is reached, most Covered Services are payable by the plan at 100% for the rest of the Calendar Year. | | |
| *Embedded Deductible and/or Coinsurance – Embedded Deductible means that family members may combine their covered expenses to satisfy the required calendar year deductible. However, no one family member contributes more than the individual deductible amount. Embedded Family Coinsurance means family members may combine their covered expense to satisfy the family Coinsurance Limit. No one family member contributes more than the individual Coinsurance Limit to satisfy the family's Coinsurance Limit. | | |

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

- Physician Office
- Urgent Care Facility
- Emergency Care

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

Copays do not apply to:

- Deductible
- Coinsurance Limit; or
- Combined Deductible and Coinsurance Limit

Copays will continue to apply, even once the Coinsurance Limit or the combined Deductible and Coinsurance Limit for the year is reached.
A copay is a fixed dollar amount payable by the Covered Person for a Covered Service before any Deductible or Coinsurance is applied. Copays do not accumulate/apply toward satisfaction of the Deductible or Coinsurance Limit.

| Covered Services – Illness or Injury | In-Network Provider | Out-of-Network Provider |
|---|---|---|
| **Physician Office** | | |
| • Primary Care Physician Office Visit | $25 Copay | Deductible and Coinsurance |
| • Specialist Physician Office Visit | $25 Copay | Deductible and Coinsurance |
| • Other Covered Services and supplies provided in the Physicians Office (with or without an office visit billed) | Applicable office visit copay | Deductible and Coinsurance |
| • Allergy Injections and Serum (only one copay applies per day per provider) | Applicable office visit copay | Deductible and Coinsurance |
| • Other Injections | Applicable office visit copay | Deductible and Coinsurance |
| ***Primary Care Physician*** benefits include the office visit provided by 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*** benefits include the office visits provided by a physician who is not a Primary Care Physician.<br><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:*** Advanced Diagnostic Imaging (CT, MRI, MRA, MRS, PET & SPECT scans and other Nuclear Medicine); Pregnancy Services, Preventive Services, Therapies & Manipulations, Sleep Studies. | | |
| **Convenient Care/Retail Clinics (Quick Care)** | Same as a Primary Care Physician | Deductible and Coinsurance |
| **Urgent Care Facility Services (a single copay applies to each urgent care visit)** | $35 Copay | Deductible and Coinsurance |
| **Emergency Care Services** (services received in a Hospital emergency room setting) | | |
| • Facility | $150 Copay then Deductible and Coinsurance | In-Network level of benefits |
| • Professional Services | Deductible and Coinsurance | In-Network level of benefits |
| (Copayment is waived if admitted to the hospital within 24 hours for the same diagnosis) | | |
| **Outpatient Hospital or Facility Services**<br><br>Service 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>Service for room and board, diagnostic testing, rehabilitation and other ancillary services provided on an inpatient basis | $100 Copay then Deductible and Coinsurance | $100 Copay then 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% | Deductible and Coinsurance |
| • HCR required covered preventive services (outside of limits) | Plan Pays 100% | Deductible and Coinsurance |
| • Other covered preventive services not required by HCR | Plan Pays 100% | Deductible and Coinsurance |
| **Immunizations** | | |
| • Related to an illness | Same as any other illness | Same as any other illness |
| • Pediatric (up to age 7) | Plan Pays 100% | Coinsurance |
| • Age 7 and older | Plan Pays 100% | Deductible and Coinsurance |

| Mental Illness and/or Substance Dependence and Abuse Covered Services | In-Network Provider | Out-of-Network Provider |
|---|---|---|
| **Inpatient Services** | $100 Copay then Deductible and Coinsurance | $100 Copay then Deductible and Coinsurance |
| **Outpatient Services** | | |
| • Office Services | $25 Copay | Deductible and Coinsurance |
| • All Other Outpatient Items & Services | Deductible and Coinsurance | Deductible and Coinsurance |
| **Emergency Care Services** (services received in a Hospital emergency room setting) | | |
| • Facility | $150 Copay then Deductible and Coinsurance | In-Network level of benefits |
| • Professional Services | Deductible and Coinsurance | 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** | 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 | <br><br>Deductible and Coinsurance<br>Deductible and Coinsurance | <br><br>In-Network level of benefits<br>Deductible and Coinsurance<br>(In-Network level of benefits if due to emergency) |
| **Biofeedback** | Not Covered | Not Covered |
| **Cochlear implants** | Deductible and Coinsurance | Deductible and Coinsurance |
| **Contraceptive Management**<br>(not covered under federally mandated preventive services)<br>• Office visits, administration of injections and injections<br>• Other Contraceptive Services & Supplies | <br><br><br>$25 Copay<br><br>Deductible and Coinsurance | <br><br><br>Deductible and Coinsurance<br><br>Deductible and Coinsurance |
| **Dermatological Services** | Same as any other illness | Same as any other illness |
| **Diabetic Services**<br>• Self-management training<br>• Services include education, podiatric appliances and equipment.<br>• Supplies | <br>$25 Copay<br>Deductible and Coinsurance<br>See Prescription Drugs | <br>$50 Copay<br>Deductible and Coinsurance<br>See Prescription Drugs |
| **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** | Not Covered | Not Covered |
| **Home Health Aide and Skilled Nursing**<br>Home Health Aide and Skilled Nursing Care (limited to 60 days per Calendar Year combined) | Deductible and Coinsurance | Deductible and Coinsurance |
| **Home Infusion Therapy** | Deductible and Coinsurance | Deductible and Coinsurance |
| **Hospice Services** (limited to a total of 360 days) | Deductible and Coinsurance | Deductible and Coinsurance |
| **Independent Laboratory**<br>• Diagnostic<br>• Preventive | Plan Pays 100%<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>Not Covered | Not Covered<br>Not Covered |
| **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. Dental treatment when due to an accidental injury to naturally healthy teeth. (treatment related to accidents must be provided within 6 months of the date of injury) | Deductible and Coinsurance | Deductible and Coinsurance |
| **Organ and Tissue Transplantation** | Deductible and Coinsurance | Deductible and Coinsurance |
| **Ostomy Supplies** | Covered under Prescription Drugs | Covered under Prescription Drugs |

| 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 and Maternity Services**<br>Payment for prenatal (excluding the initial visit to diagnosis pregnancy) and postnatal care is included in the payment for the delivery. Services provided for Covered Newborns will be subject to a separate Deductible, Coinsurance and Coinsurance Limit. | Deductible and Coinsurance | Deductible and Coinsurance |
| **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**<br>(must follow within 90 days of discharge from acute hospitalization) | Deductible and Coinsurance | Deductible and Coinsurance |
| **Rehabilitation Services**<br>• Cardiac rehabilitation (limited to 36 sessions per calendar year)<br>• Pulmonary Rehabilitation | $25 Copay<br>See Therapy and Manipulations | Deductible and Coinsurance<br>See Therapy and Manipulations |
| **Renal Dialysis** | Deductible and Coinsurance | Deductible and Coinsurance |
| **Respiratory Care**<br>(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**<br>(limited to 60 days per Calendar Year) | Deductible and Coinsurance | Deductible and Coinsurance |
| **Sleep Studies** (attended sleep study) | Deductible and Coinsurance | Deductible and Coinsurance |
| **Temporomandibular and Craniomandibular Joint Disorder** (limited to a maximum of $2,500 while covered) | Deductible and Coinsurance | Deductible and Coinsurance |
| **Therapy & Manipulations**<br>(limited to 60 sessions per Calendar Year for combined therapy services)<br>• Physical, occupational or speech therapy services, and pulmonary rehabilitation<br>• Therapy evaluation/re-evaluation (not included in the session limit)<br>• Chiropractic or osteopathic services including:<br>- office visits;<br>- radiology;<br>- pathology;<br>- physiotherapy; and<br>- manipulations or adjustments | $25 Copay<br>Plan pays 100%<br>$25 Copay | Deductible and Coinsurance<br>Plan pays 100%<br>Deductible and Coinsurance |
| **Vision Exams**<br>• Diagnostic (to diagnose an illness)<br>• Preventive (routine exam including refraction) limited to one exam every 24 months | See Physician Office Service<br>$10 Copay | See Physician Office Services<br>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) | | |
| • Individual | Not Applicable | |
| • Family | Not Applicable | |
| ***Retail – per 30-day supply*** | | |
| • Generic drugs | $10 Copay | $10 Copay + 25% Penalty |
| • Formulary Brand Name Drugs | $25 Copay | $25 Copay + 25% Penalty |
| • Non-formulary Brand Name Drugs | $50 Copay | $50 Copay + 25% Penalty |
| ***Mail order – per 90-day supply*** | | |
| • Generic drugs | $20 Copay | Not Covered |
| • Formulary Brand Name Drugs | $50 Copay | Not Covered |
| • Non-formulary Brand Name Drugs | $100 Copay | Not Covered |
| ***Specialty Drugs***<br>(to be considered In-network, specialty drugs must be purchased through a designated specialty pharmacy) | $100 Copay | Not Covered |
| **Contraceptives** | | |
| • Formulary | | |
| ○ Generic | Plan Pays 100% | 25% Penalty |
| ○ Brand Name | Plan Pays 100% | 25% Penalty |
| • Non-formulary | | |
| ○ Generic | $10 Copay | $10 Copay + 25% Penalty |
| ○ Brand Name | $50 Copay | $50 Copay + 25% Penalty |
| ***Diabetic Supplies*** | Plan Pays 100% | No Copay +25% Penalty |
| **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% | Covered same as any other covered prescription drug |
| **Obesity**<br>FDA approved prescription drugs | Not Covered | Not Covered |

## Certification Process

BCBSNE requires that all Hospital stays, certain surgical procedures and specialized Services and supplies be Certified prior to receipt of such Services or supplies. Ultimately, it is your responsibility to see that Certification occurs; however, a Hospital or Provider may initiate the Certification.

When BCBSNE receives a request for Certification, the appropriateness of the setting and the level of medical care as well as the timing and duration of the admission is assessed by BCBSNE (or by persons designated by BCBSNE).

To initiate the Certification process, BCBSNE must be contacted by you, your family member, the Physician, the Hospital or someone acting on behalf of you or your family member. Notification of the intended receipt of Services may be made by telephone or in writing. We may require that the Certification include written documentation from the attending Physician, dentist or other medical provider demonstrating the Medical Necessity of the procedure or Service and the location where the Service will be provided.

In the case of an ongoing Inpatient admission, the care should continue to be Certified in order to assure that it is being provided in the most appropriate setting.

**Please remember that Certification does not guarantee payment. All other group plan provisions apply. For example: Copayments, Deductibles, Coinsurance, eligibility and exclusions.**

## Certification Exceptions

**Maternity**

Federal law provides for a length of stay of up to 48 hours following a normal vaginal delivery and 96 hours following a cesarean section unless otherwise agreed to by the patient and her physician. Certification is not required for an initial maternity admission. However, Certification is required if the hospitalization extends beyond these times.

**Emergencies**

BCBSNE must be notified of an admission for an Emergency Medical Condition within 24 hours of the admission or the next business day. If Certification is not received, the 24-hour period prior to the time of admission and the 24-hour period after such admission will be reviewed to determine if the patient's condition and treatment would have hindered his or her ability to provide notice.

***NOTE: Admission through the emergency room does not necessarily constitute an emergency admission.***

## Benefits Requiring Certification

The following Services, supplies or drugs must be Certified:

- Pulmonary rehabilitation;
- Durable Medical Equipment (subsequent purchases);
- Hospice Care;
- Inpatient Hospital admissions;
- Inpatient physical rehabilitation;
- Long Term Acute Care;
- Organ and tissue transplants;
- Prescription drugs (certain drugs as defined by BCBSNE);
- Skilled nursing care in the home.

## Unanticipated Costs

Failure to comply with the Certification requirements may result in unanticipated costs associated with the incurred expenses.

If Services are not properly Certified and benefits are reduced or denied, this unanticipated reduction becomes an additional amount that must be paid by you. However if the Hospital, Inpatient facility or Physician is an In-network Provider, they are liable for their Services which are determined by BCBSNE to be not Medically Necessary. An exception is made if you have agreed in writing to be responsible for such Services or the provider has documented in the medical record that you were notified of the determination. Any reductions made are not considered when computing your Coinsurance liability limit.

### Avoid Weekend Admissions

Ask your Physician to avoid nonemergency weekend admissions as most Hospitals do not perform surgical or other nonemergency procedures on weekends. Benefits may be denied if this kind of admission is not Medically Necessary.

**This section provides a general overview of covered health care Services. There may be items listed below that are not included in your actual benefits. Your Schedule of Benefits Summary shows your actual benefits.**

## What's Covered

The following list includes examples of the Services that are covered when Medically Necessary care is provided by an Approved Provider:

- *Abortions* unless otherwise shown as not covered under another section of this document;
- *Advanced diagnostic imaging;*
- *Allergy testing, serum and injections;*
- *Ambulance services;*
- *Anesthesia;*
- *Assistant surgeon* benefits for surgical procedures specifically identified by BCBSNE;
- *Blood, blood plasma, blood derivatives or blood fractionates, including administration and processing,* that is donated and for which there is not a charge;
- *Cardiac rehabilitation* when in an accredited program and when approved by BCBSNE;
- *Chemotherapy*, except as excluded (or not identified as covered) for or related to transplant procedures;
- *Chiropractic care;*
- *Circumcision;*
- *Cochlear implants;*
- *Contraceptive supplies and Services* (unless otherwise covered under the Rx Nebraska Prescription Drug Program and/or not covered under the medical plan);
- *Dialysis;*
- *Diabetic education* including self-management training and patient management;
- *Durable Medical Equipment (DME) rental or initial purchase (whichever costs less) of certain items of DME and supplies,* when prescribed by a Physician and determined by BCBSNE to be Medically Necessary. (See Durable Medical Equipment included in this section for additional information);
- *Emergency care;*
- *Eyeglasses or contact lenses when ordered by a Physician* because of a change in prescription as a direct result of a covered intraocular surgery or ocular injury (must be within 12 months of the surgery or injury);
- *Home health aide services* when ordered by a Physician and are part of a treatment plan developed by the home health agency and approved by BCBSNE (additional information about Home Health Aide services is included in this section);
- *Home infusion therapy;*
- *Hospice Services* when preauthorized by BCBSNE and provided primarily in the patient's home by a Medicare-Certified Hospice (additional information about Hospice Services can be found in this section);
- *Hospital Services* such as nursing care, drugs, medicines, therapies, x-rays (radiology) and laboratory (pathology) tests;
- *Immunizations;*
- *Inpatient Physician care;*
- *Inpatient Physical Rehabilitation* when the provider is accredited for comprehensive inpatient rehabilitation and the admission occurs within 90 days of discharge from the acute hospitalization for the injury, illness or condition causing the disability;
- *Mammography;*
- *Manipulative treatment or adjustments;*
- *Maternity care*, including services by a certified nurse midwife (see Maternity Care included in this section for additional information);
- *Mental Illness care on an Inpatient, Outpatient and Emergency Care basis*;
- *Newborn care,* (additional information about newborn care is included in this section);
- *Nursing services* requiring the skill, proficiency and training of a registered nurse (R.N.) or a licensed practical nurse (L.P.N.) (see Skilled Nursing Care included in this section for additional information);
- *Occupational therapy*;
- *Oral surgery, dental treatment and TMJ services* (see Oral Surgery and Dentistry included later in this section for more information);
- *Orthotics* for preventing complications associated with diabetes;
- *Osteopathic care;*
- *Outpatient (ambulatory) surgery;*
- *Outpatient x-ray, radiology, laboratory and pathology charges*;
- *Oxygen;*
- *Pacemakers;*
- *Pap smears*;
- *Physical therapy;*
- *Physician visits;*
- *Podiatric appliances necessary for the prevention of complications associated with diabetes;*
- *Preadmission testing;*
- *Prosthetic appliances;*
- *Pulmonary rehabilitation* when in an accredited program and when approved by BCBSNE;

- *Radiation therapy,* except as excluded (or not identified as covered) for or related to transplant procedures;
- *Renal dialysis*, including all charges for covered home dialysis equipment and covered disposable supplies. Benefits will also be provided for dialysis training or counseling pursuant to Medicare requirements for group health plans;
- *Respiratory care;*
- *Room and board*, including cardiac care and intensive care room for an Inpatient stay;
- *Sleep studies;*
- *Speech therapy or Cognitive Training;*
- *Sterilization;*
- *Substance Dependence and Abuse Treatment;*
- *Surgical care* (the Allowable Charge may include reductions for procedures involving multiple Physicians or multiple or bilateral surgical procedures);
- *Surgical dressings;*
- *Transplants* (for more information about Organ and Tissue Transplants see the additional information found in this section);
- *Urgent Care Facility Services.*

## ADDITIONAL INFORMATION ON COVERED SERVICES

### Ambulance Services

Benefits are available, subject to the Copay, Deductible and/or Coinsurance amounts outlined in the Schedule of Benefits Summary, when ambulance services are provided to a Covered Person for:

- transportation to the nearest facility for appropriate care for an Emergency Medical Condition.
- transportation from a facility where emergent care was obtained or from an Inpatient acute care facility to the nearest facility where appropriate care can be provided, whether it is a lesser or greater level of specific care. Benefits are also available for transporting the Covered Person who is bedridden, to a facility for treatment or to his or her place of residence.
- transporting a respirator-dependent person.
- transportation to and from the nearest appropriate facility for testing and/or procedures that are not available at the present facility.

### Durable Medical Equipment (DME)

In addition to rental or initial purchase, benefits will be available for subsequent purchases of covered DME when: there is a significant change in the Covered Person's condition; the Covered Person grows; the item is irreparable and/or the cost of repairs exceeds the expense of purchasing a second piece of equipment; the item is five or more years old (equipment may be replaced earlier if preauthorized by BCBSNE); or as otherwise determined to be reasonable and necessary. In addition, limited benefits may be available for repair, adjustment and maintenance of covered DME as determined appropriate by BCBSNE.

***NOTE: Oxygen and equipment for its administration, respiratory therapy, ventilation equipment, apnea monitors and continuous positive airway pressure devices (CPAP) may be subject to review of the rental versus purchase provision by BCBSNE.***

### Emergency Care

When you receive care in the emergency room, benefits will be provided subject to the applicable Copay, Deductible and/or Coinsurance shown on your Schedule of Benefits Summary. If you receive care at an Out-of-network Hospital emergency room or by an Out-of-network Provider, benefits for Covered Services may be provided at the In-network benefit level. You will still be responsible for amounts in excess of the Allowable Charge when you receive services from an Out-of-network Provider.

If Emergency Care results in a Covered Person being admitted to the Hospital, BCBSNE must be notified of the admission in accordance with the Certification requirements for emergencies. (Please refer to the section of this book titled "Certification Requirements.")

**EMERGENCY ROOMS ARE EXPENSIVE**

Hospital emergency rooms are very expensive because they are specifically staffed and equipped to handle accidents, injuries and other emergencies. Using them for preventive care (or as a substitute for the family physician) can cost you time and money.

## Home Health Aide, Skilled Nursing Care And Hospice

Benefits are available subject to the Copay, Deductible and/or Coinsurance and benefit limits outlined in the Schedule of Benefits Summary for the following Medically Necessary home health aide, skilled nursing care and hospice Services provided to a Covered Person.

### Home Health Aide

Benefits are available for Medically Necessary Physician ordered home health aide Services provided in the home by a licensed or Medicare-Certified home health agency. Covered Services include:

- bathing,
- feeding, and
- household cleaning duties.

Benefits are only available for personal care services when they are related to active and specific medical, surgical or psychiatric treatment of the Covered Person requiring the skills of a registered nurse.

### Skilled Nursing Care

Nursing care must be Physician ordered and the patient must need care which requires the skill, proficiency and training of a registered nurse (R.N.) or a Licensed practical nurse (L.P.N.).

Benefits will not be provided for:

- Nursing care in excess of the benefit limit.
- Nursing care which is primarily for the convenience of the patient or the patient's family.
- Time spent bathing, feeding, transporting, exercising or moving the patient, giving oral medication or acting as a companion, sitter, or homemaker.
- Care provided by a nurse who is an immediate relative by blood, marriage or adoption, or a member of the Covered Person's household.
- Care provided in a Hospital, a skilled nursing facility, intermediate care facility, or a sub-acute care or rehabilitation facility.

### Hospice Services

Hospice is a program of care provided for a person diagnosed as terminally ill and his/her family. The Covered Person must have a life expectancy of six months or less and the Physician ordered Services must be appropriate for palliative support or management of a terminal illness.

The following Services are covered under a hospice care program:

- Hospice nursing services provided in the home.
- Inpatient hospice care.
- Respite care, which is short-term Inpatient care necessary in order to give temporary relief to the person who regularly assists with the care at home.
- Medical social services, provided by a medical social worker employed by the hospice, which are directly related to the Covered Person's medical condition.
- Crisis care, which is extended skilled nursing care for up to 24 hours per day in lieu of a Medically Necessary Inpatient hospitalization.
- Bereavement counseling for a family member of the deceased Covered Person who was the recipient of Hospice Services. The counseling Services must be provided within six month of the death.

**Remember To Certify**
Skilled nursing care in the home and hospice care must be Certified by BCBSNE. Please refer to the section of the book titled "Certification Requirements" for more details.

## Maternity and Newborn Care

### Maternity Care

Maternity benefits are available to you, a covered spouse or an Eligible Dependent daughter unless otherwise indicated in the Master Group Contract between BCBSNE and your employer. Please contact your Human Resource Department for additional eligibility information.

Benefits for covered Hospital, surgical and medical care related to Pregnancy are subject to the Deductible, Coinsurance and/or Copay amounts outlined in the Schedule of Benefits Summary. This includes all related Services for prenatal care, postnatal care, delivery and complications of Pregnancy or interruptions of Pregnancy.

In addition, benefits are available for obstetrical care provided by and within the scope of practice of a certified nurse midwife.

*Postpartum depression, psychosis or any other Mental Illness are not considered complications of Pregnancy under this part. Benefits for this type of condition are provided in the same manner as all other Mental Illness Services.*

**Statement of Rights Under The Newborns' and Mothers' Health Protection Act**
Benefits may not, under Federal law, be restricted for any Hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, benefits may be paid for a shorter stay if the mother's or newborn's attending provider, after consulting with the mother, discharges the mother or newborn earlier.

Also, under Federal law, a plan may not set the level of benefits or out-of-pocket costs so that any later portion of the 48 hour (or 96 hour) stay is treated in a manner less favorable than any earlier portion of the stay. In addition, a plan may not require the provider to obtain authorization from the plan for prescribing a length of stay of up to 48 hours (or 96 hours).

**Newborn Care**
Benefits are available at birth for Covered Services for an eligible newborn infant. Your Schedule of Benefits Summary shows the applicable Copay, Deductible (the newborn infant will be subject to a separate, individual deductible) and/or Coinsurance amounts. Covered Services include:

- room and board, including any ancillary services;
- screening tests, including the initial newborn hearing exam;
- Physician Services for a newborn well infant while hospitalized, including circumcision;
- newborn screening Services for an infant born at home; and
- Medically Necessary definitive medical or surgical treatment.

For information on adding coverage for a newborn, please refer to your group specific eligibility and enrollment provisions.

## Mental Illness, Substance Dependence And Abuse Benefits

Benefits are payable for covered Hospital and Physician Services, including mental health Services, psychological or alcoholism and drug counseling Services by and within the scope of practice of a:

- qualified Physician or Licensed Psychologist;
- Licensed Special Psychologist, Licensed clinical social worker, Licensed professional counselor or Licensed mental health practitioner, or
- auxiliary providers who are supervised, and billed for, by a qualified Physician or Licensed Psychologist or as otherwise permitted by state law.

All licensing or certification shall be by the appropriate state authority. Appropriate supervision and consultation requirements also shall be provided by state law.

**Inpatient Care**
A person shall be considered to be receiving Inpatient treatment if he or she is confined to a Hospital or a Substance Dependence and Abuse treatment center that provides medical management including 24-hour nursing care. Services provided by a facility that does not meet this criteria are considered part of a residential treatment program, and are not covered under the group health plan.

Facilities must be Licensed by the Department of Health and Human Services, Regulation and Licensure (or equivalent state agency) or accredited by the Joint Commission on Accreditation of Rehabilitation Facilities (CARF) or Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Benefits for covered Inpatient Services are subject to the applicable Copay, Deductible and/or Coinsurance, as indicated on your Schedule of Benefits Summary.

**Remember To Certify**
Inpatient Services for Mental Illness or Substance Dependence and Abuse must be Certified by BCBSNE. Please refer to the section of the book titled "Certification Requirements" for more details.

**Outpatient Care**
Benefits are also available, subject to the applicable Copay, Deductible and/or Coinsurance amount indicated on your Schedule of Benefits Summary for Outpatient treatment of Mental Illness and Substance Dependence and Abuse.

A person who is not admitted for Inpatient care, but is receiving treatment in the Outpatient department of a Hospital, in an observation room, in an Ambulatory Surgical Facility, Urgent Care Facility, a Physician's office or home shall be considered to be receiving Outpatient Care.

Outpatient Covered Services include:

- psychological therapy and/or substance dependence and abuse counseling/rehabilitation provided by an Approved Provider.
- office visit or clinic visit, Consultation, or emergency room visit.
- an evaluation and assessment.
- medicine checks.
- an Outpatient day, or partial hospitalization program for Mental Illness or a Substance Dependence and Abuse treatment program, that offers all-inclusive services for each Outpatient treatment day.
- biofeedback training for treatment of Mental Illness.
- ambulance services provided for the treatment of Mental Illness and Substance Dependence and Abuse.
- laboratory and diagnostic Services.
- psychiatric/psychological testing.

Day treatment, partial care and Outpatient programs must be provided in a Hospital or facility which is Licensed by the Department of Health and Human Services Regulation and Licensure or accredited by the Commission on the Accreditation of Rehabilitation Facilities (CARF)

**Emergency Care**
Benefits are also available, subject to the applicable Emergency Care Copay, Deductible and/or Coinsurance indicated in your Schedule of Benefits Summary, for any Covered Services provided in a Hospital emergency room setting for the treatment of Mental Illness and Substance Dependence and Abuse.

## Oral Surgery and Dentistry

Limited benefits are available for oral surgery and dentistry. Benefits for Covered Services are available subject to any benefit maximums and the Copay, Deductible and/or Coinsurance as indicated on your Schedule of Benefits Summary.

**Covered Oral Surgery and Dentistry Benefits**
Unless otherwise indicated on your Schedule of Benefits Summary, the Plan provides benefits for the following Medically Necessary services:

- Evaluation and treatment of impacted teeth.
- Incision and drainage of abscesses, and other non-surgical treatment of infections *(excluding periodontic or endodontic treatment of infections)*.
- Excision of exostoses, tumors and cysts, *whether or not related to the temporomandibular joint of the jaw (TMJ)*.
- Services for the treatment of TMJ or craniomandibular disorder.
- Bone grafts to the jaw, including preparation of the mouth for dentures.
- Reduction of a complete dislocation or fracture of the TMJ required as a direct result of an accident. *Benefits are limited to treatment provided within 12 months of the injury*.
- Services, supplies or appliances for dental treatment of natural healthy teeth required as the direct result of an accidental injury. *Benefits are limited to treatment provided within 12 months of the injury*.
- Osteotomy performed for a gross congenital abnormality of the jaw which can not be treated solely by orthodontic treatment or appliances.
- Dental implants when related to trauma (*within one year of injury if osseous growth pattern has been completed, otherwise coverage will be extended for one year following completion of osseous growth pattern providing that coverage is still in effect at the time of treatment*), cancer and other tumor, benign cysts, and for persons from puberty through age 23 with two or more adjacent congenitally missing teeth.

Please note, damage to teeth that occurs as a result of eating, chewing or biting is not considered an "accident". Benefits are not available for these types of injuries.

**Dental Related Hospital Charges**
Benefits are also available for the following Services if determined by us to be Medically Necessary when related to Covered Services for oral surgery and dentistry or when the Services are essential to safeguard the health of the patient who has a specific nondental physical and/or organic impairment:

- Hospital Inpatient Services.
- Hospital Outpatient Services.
- Ambulatory facility Services.
- Anesthesia.

## Organ and Tissue Transplants

Benefits are available to a Covered Person who is a transplant recipient for Medically Necessary Covered Services relating to or resulting from a transplant of these body organs or tissues:

- liver,
- heart,
- single and double lung,
- lobar lung,
- heart-lung,
- heart valve (heterograft),
- kidney,
- kidney-pancreas,
- pancreas,
- bone graft,
- cornea,
- parathyroid,
- small intestine,
- small intestine and liver,
- small intestine and multiple viscera,
- bone marrow transplants, including autologous and allogeneic stem cell transplants.

The applicable Copay, Deductible and/or Coinsurance are indicated on your Schedule of Benefits Summary.

**Remember To Certify**
All transplants must be Certified by BCBSNE prior to the procedure being performed. Please refer to the section of the book titled "Certification Requirements" for more details.

### Additional Covered Transplant Services

Benefits are also available for the following Medically Necessary Covered Services directly related to or resulting from a covered transplant:

- Hospital, medical, surgical or other Covered Services provided to a donor are included as part of the recipient's coverage.
- Services provided for the evaluation of organs or tissue including, but not limited to, the determination of tissue matches.
- Services provided for the removal of organs or tissue from nonliving donors.
- Service provided for the transportation and storage of donated human organs or tissues.

## Outpatient Hospital Or Facility Services

Benefits are available, subject to the Copay, Deductible and/or Coinsurance and benefit limits shown in your Schedule of Benefits Summary for covered Outpatient Services provided by a Hospital, Ambulatory Surgical Facility, Urgent Care Facility or other Outpatient facility.

## Outpatient Rehabilitation Services

**Cardiac or Pulmonary Rehabilitation** is defined as the use of various modalities of treatment to improve cardiac or pulmonary function as well as tissue perfusion and oxygenation through which selected patients are restored to and maintained at either a pre-illness level of activity or a new and appropriate level of adjustment.

### Covered Outpatient Cardiac or Pulmonary Rehabilitation

The following Services are covered when provided as part of a rehabilitation program:

- Initial rehabilitation evaluation.
- Exercise sessions.
- Concurrent monitoring during the exercise session for high risk patients.
- Physician services which are otherwise defined as Covered Services.

### Cardiac Rehabilitation Criteria

The patient must have one of the following diagnoses occurring during the preceding four months:

- an acute myocardial infarction;
- coronary artery angioplasty, with or without stent placement, or other Scientifically Validated procedure to clear blocked vessels;
- heart surgery, or coronary artery surgery;
- heart transplant;
- heart-lung transplant; or
- cardiac rehabilitation for treatment of congestive heart failure and stable angina initially and after significant changes in clinical status as determined by BCBSNE.

### Cardiac Rehabilitation Limits

Benefits for Covered Services are subject to any limits indicated on your Schedule of Benefits Summary

**Pulmonary Rehabilitation Criteria**
Benefits are available when Services are provided prior to and following lung transplant, heart-lung transplant, lung volume reduction surgery and for severe chronic lung disease patients as reviewed and determined by BCBSNE. In addition, pulmonary rehabilitation Services must be under the continuing supervision of a Physician and in a Hospital environment.

**Pulmonary Rehabilitation Limits**
Benefits for Covered Services are subject to any limits indicated on your Schedule of Benefits Summary

**Remember To Certify**
Pulmonary Rehabilitation Services must be Certified by BCBSNE prior to the Services being provided. Please refer to the section of the book titled "Certification Requirements" for more details.

## Physician Office
Benefits are available, subject to the applicable Copay, Deductible and/or Coinsurance shown in the Schedule of Benefits Summary, for Medically Necessary Covered Services provided in a Physician's office.

**Covered Physician Office Visits**
The office visit provision of this plan includes:
- The Physician office visit.
- The initial visit to diagnose Pregnancy.
- Consultations.
- Psychological therapy and/or Substance Dependence and Abuse counseling/rehabilitation.
- Medication checks.

**Covered Office Services**
Unless otherwise stated in this SPD or an amendment to this SPD, Services and supplies covered under the office services provisions of this plan include:
- X-ray, laboratory and pathology services performed in the Physician's office.
- Supplies used to treat the patient during the office visit.
- Drugs administered to the patient during the office visit.
- Hearing examination due to illness performed in the office.
- Vision examination due to illness performed in the office.
- Allergy testing.

**Non-Covered Under Office Service Benefit**
Although these Services may be covered elsewhere, generally the office services provision does not include:
- Services provided by Out-of-network Providers.
- Preventive services.
- Services for Pregnancy, except the initial office visit to diagnose Pregnancy.
- Injections.
- Chemotherapy.
- Radiation therapy and/or Advanced Diagnostic Imaging.
- Manipulations and adjustments.
- Physical, occupational or speech therapy, including cognitive training, chiropractic or osteopathic physiotherapy.
- Surgical procedures and anesthesia.
- Sleep studies.
- Durable Medical Equipment.
- Biofeedback.
- Psychological evaluations, assessments and testing.
- Outpatient Services received at a place of service other than a Physician's office.

## Preventive/Routine Services
Health Care Reform (HCR) required Preventive Services, including any age, gender or frequency limits, are not subject to a Copayment, Deductible and/or Coinsurance amount when provided by an In-network Provider. A list of these Preventive Services may be obtained by contacting the BCBSNE Member Services Department.

When the same HCR required Preventive Services are provided by an Out-of-network Provider and are otherwise covered Services, benefits will be provided as indicated on your Schedule of Benefits Summary.

In addition, benefits for covered Services provided by either an In-network or an Out-of-network Provider that fall outside the age, gender, and frequency limits for HCR required Preventive Services, and other covered Preventive Services (such as laboratory Services and radiology Services) will be provided as indicated on your Schedule of Benefits Summary.

## Therapy and Manipulations

The following outpatient and/or home therapies and manipulative treatments or adjustments are covered subject to the applicable Copay, Deductible and/or Coinsurance amounts and benefit maximums shown on your Schedule of Benefits Summary:

- Chiropractic or osteopathic manipulative treatments or adjustments by an Approved Provider.
- Occupational therapy by a Licensed occupational therapist or Licensed occupational therapist assistant under the supervision and billing of a Licensed occupational therapist.
- Physical therapy by a Licensed physical therapist or Licensed physical therapist assistant who is an Approved Provider.
- Chiropractic or osteopathic physiotherapy.
- Speech therapy or Cognitive Training provided by a Licensed speech-language pathologist or registered communication assistant practicing under the supervision of a Licensed speech-language pathologist.

**NOTE: A benefit maximum can apply to all the above Services or any combination of these Services. Be sure to check your Schedule of Benefits Summary to determine how any applicable benefit maximum will be calculated.**

A session is defined as one visit. Ongoing preventative/maintenance therapy sessions and ongoing preventative/maintenance treatments or adjustments are not covered once the maximum therapeutic benefit has been achieved for a given condition and continued therapy or continued treatments or adjustments no longer result in some functional or restorative improvement.

## Women's Health Act

The Women's Health and Cancer Rights Act of 1998 (Women's Health Act) includes protections for breast cancer patients who elect to have breast reconstruction in connection with a mastectomy.

The law requires that certain coverage be provided, and that notice be given to Covered Persons regarding coverage for this care under the group health plan. The Women's Health Act requires that:

A group health plan which provides medical and surgical benefits for mastectomies shall also provide, in the case of a Covered Person who is receiving benefits in connection with a mastectomy, and who elects breast reconstruction in connection with such mastectomy, coverage for:

- Reconstruction of the breast on which the mastectomy has been performed,
- surgery and reconstruction of the other breast to produce a symmetrical appearance,
- prostheses, and
- physical complications resulting from all stages of the mastectomy, including lymphedemas

in a manner determined in consultation with the attending Physician and patient.

This group health plan is in compliance with the Women's Health Act, and provides benefits as required by the Act, subject to the Copay, Deductible and Coinsurance amounts applicable to other benefits under the plan.

# EXCLUSIONS—WHAT'S NOT COVERED

Section 5

Although this plan provides benefits for a wide variety of Services, there are some expenses that are not covered. This section gives you examples of some Services and supplies that are not covered by the plan.

## Using Headings In This Section

To help you find specific exclusions more easily, we have provided headings for types of Services, treatments or supplies that fall into a similar category. The actual exclusion appears under the heading.

### Plan Exclusions

Benefits are not available for the Services, treatments or supplies described in this section, even if:

- recommended or prescribed by a Physician.
- the only treatment available for the Covered Person's condition.

**The Services, treatments and supplies listed as exclusions in this section are not covered, except when specifically provided for under another section of this SPD; or by an amendment to this SPD.**

### A. Alternative Treatments

- Alternative therapies:
  - Massage therapy, including rolfing;
  - Acupuncture;
  - Aromatherapy;
  - Light therapy;
  - Naturopathy;
  - Vax-D therapy (vertebral axial decompression).
- Services, drugs, medical supplies, devices or equipment which are not cost effective compared to established alternatives or which are provided for the convenience or personal use of the Covered Person.

### B. Comfort or Convenience

- Batteries and battery chargers unless the device is covered by BCBSNE.
- Beauty/barber service.
- Breast pumps.
- Equipment for purifying, heating, cooling or otherwise treating air or water.
- Exercise Equipment.
- Guest meals.
- Hot tubs.
- Humidifiers.
- Jacuzzis.
- Medical alert systems.
- Music devices.
- Personal computers.
- Pillows.
- Radios.
- Safety equipment.
- Saunas.
- Strollers.
- Television.
- The building, remodeling or alteration of a residence.
- The purchasing or customizing of vans or other vehicles.
- Video players.
- Whirlpools.

### C. Dental

Except as specifically described as covered, benefits are not available for:

- Dental care in connection with the treatment, filling, removal, repositioning or replacement of teeth, including orthodontics or implants.
- Preparation of the mouth for dentures.
- Root canal therapy or care.
- Treatment of the dental occlusion by any means or for any reason.
- Other procedures involving the teeth or structures directly related to or supporting the teeth, including a) the gums and b) the alveolar processes.
- Treatment of sleep disorders by a dentist, including sleep apnea, except for the fabrication of an orthotic for treatment of a sleep disorder.

### D. Durable Medical Equipment (DME) and Supplies

- Automated external defibrillator.
- Enuresis alarm, even if prescribed by a Physician.
- Mouth guard, even if prescribed by a Physician.
- Non-wearable external defibrillator.
- Rental or purchase from or use of DME while the patient is confined to a Hospital, skilled nursing facility, an intermediate care facility, a nursing home or any other licensed residential facility if such equipment is usually supplied by the facility.
- Repair, maintenance or adjustment of DME, except as specifically identified as covered, provided by other than a DME or medical supply company.
- Repair or replacement of an item of DME due to misuse, malicious damage, gross neglect or to replace lost or stolen items.

**E. Experimental or Investigative**

- Services considered by BCBSNE to be Investigative, or for any directly related Services.
- Services for medical treatment and/or drugs, whether compensated or not, that are directly related to, or resulting from the Covered Person's participation in a voluntary, investigative test or research program or study, unless authorized by BCBSNE.

**F. Foot Care**

- Orthotic appliances that straighten or re-shape a body part.
- Orthopedic shoes.
- Orthotics for the foot, except when such podiatric appliances are necessary for the prevention of complications associated with diabetes, or when necessary to treat a congenital anomaly, as determined by BCBSNE.
- Treatment or removal of corns, callosities, or the cutting or trimming of nails.

**G. Mental Illness and Substance Dependency/Abuse**

- Custodial care.
- Programs for co-dependency; employee assistance; probation; prevention; educational or self-help.
- Programs ordered by the Court that are determined by BCBSNE to be not Medically Necessary.
- Programs that treat obesity or gambling, except when specifically identified elsewhere as a Covered Service.
- Residential treatment programs.
- Services by a non-approved provider.
- Services not within the scope of practice of the provider. (Licensing or certification is by the appropriate state authority. Supervision and consultation requirements are governed by the state law.)
- Services, supplies, equipment, procedures, drugs or programs for treatment of nicotine addiction, except when identified elsewhere as a Covered Service.

**H. Nutrition**

- Dietary counseling, except diabetes management as provided by the plan.
- Enteral feedings, even if the sole source of nutrition.
- Nutrition care, nutritional supplements, FDA-exempt infant formulas, supplies, electrolytes or other nutritional substances, including but not limited to Neocate, Vivonex, Elecare, Cyclinex-1, ProPhree, vitamins, minerals, elements, foods of any kind (including high protein and low carbohydrate foods) and other over-the-counter nutritional substances.

**I. Physical Appearance**

- Cosmetic Services, or any complications thereof. Examples include:
  - Dermabrasion.
  - Liposuction.
  - Protruding ears.
  - Spider veins.
  - Tattoo removal or revision.
  - Telangiectasias.

*NOTE: Benefits for treatment of complications of cosmetic Services are only payable if such treatment is normally covered under the plan. In addition, when the cosmetic Services are required as a direct result of a traumatic injury; to correct a congenital abnormality when the defect severely impairs or impedes normal essential functions; to correct a scar or deformity resulting from cancer or from non-cosmetic surgery, benefits are available for Services that are normally covered under the plan.*

- Treatment and monitoring for obesity or weight reduction, regardless of diagnosis. Examples include:
  - Health and athletic club memberships.
  - Physical conditioning programs such as athletic training, body-building exercise, fitness, flexibility and diversion or general motivation.
  - Weight loss programs.
- Weight reduction surgery.

**J. Preexisting Conditions**

- Services provided to a Covered Person for treatment of a Pre-existing condition during the period of time Waiting Periods are in effect.

*NOTE: A Pre-existing condition does not include Pregnancy.*

**K. Providers**

- Canceled appointment: Charges for failure to cancel a scheduled appointment.
- Claim forms/records/administrative fees: Charges made for filling out claim forms or furnishing any records or information; special charges such as dispensing fees; admission charges. Physician's charges for Hospital discharge Services; after-hour charges over and above the routine charge; administrative fees; technical support or utilization review charges which are normally considered to be within the charge for a Service.
- Custodial care, domiciliary care, rest cures, or Services provided by personal care attendants.
- Immediate family: Charges for Services provided by a person who is a member of the Covered Person's immediate family by blood, marriage or adoption.
- Hospital/institution Services provided in or by:
  a) a Veterans Administration Hospital where the care is for a condition related to military service, or
  b) any non-Participating Hospital or other institution which is owned, operated or controlled by any federal government agency, except where care is provided to nonactive duty Covered Persons in medical facilities.
- Inadequate documentation: Charges received when there is inadequate documentation that a Service was provided.
- Non-approved facility: A health care facility that does not meet the licensing or Accreditation Standards required by BCBSNE.
- Non-approved provider: Charges for Services by a non-approved provider.
- Out-of-Hospital: Charges made while the patient is temporarily out of the Hospital.
- Overhead expenses: Charges for any office or facility overhead expenses including, but not limited to, staff charges, copying fees, facsimile fees and office supplies.
- Scope of practice: Charges for Services by a health care provider which are not within the scope of practice of such provider.
- Standby: Hospital or Physician charges for standby availability.

**L. Reproductive Services**

- Pregnancy assistance treatments, which include but are not limited to, infertility treatment and related Services, in addition to:
  - Assisted Reproductive Technology (ART), such as artificial insemination, sperm washing, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), and in vitro fertilization;
  - Embryo transfer procedures;
  - Drug and/or hormonal therapy for fertility enhancement;
  - Ultrasounds, lab work and other testing in conjunction with infertility treatment;
  - Reversal of voluntary sterilization;
  - Surrogate parenting, donor eggs, donor sperm and host uterus; and
  - Storage and retrieval of all reproductive materials.

**M. Services Payable Under Another Plan**

- Services available at government expense, except as follows:
  If payment is required by state or federal law, the obligation to provide benefits will be reduced by the amount of payments the patient is eligible for under such program (except Medicaid).

  With respect to person entitled to Medicare Part A and eligible for Part B benefits, the obligation to provide benefits will be reduced by the amount of payment or benefits such person receives from Medicare. This provision will not apply if the patient is still actively at work or is an Eligible Dependent of a Subscriber who is actively at work and has elected this Plan as primary. Services provided for renal dialysis and kidney transplant Services will be provided pursuant to federal law.

- Services arising out of the course of employment, whether or not the patient fails to assert or waives his or her right to Workers' Compensation or Employers' Liability Law. This includes Services determined to be work-related under a Workers' compensation law, or under a Workers' compensation Managed Care Plan, but which are not payable because of noncompliance with such law or Plan. Any charges incurred as a result of or in the course of employment for a group that is not legally required to carry Workers' Compensation coverage and that does not cover Workers' Compensation coverage will be covered.

**N. Transplants**

- Donor charges other than those identified as covered under "Organ and Tissue Transplants" in the section titled "Benefit Descriptions."
- Purchased human organs or tissue.
- Implantation of an artificial/mechanical organ into a human recipient, excluding pacemakers, LVADs, or other devices when specifically approved by BCBSNE.
- Transplantation of any nonhuman organ or tissue to a human recipient.

**O. Travel**

- Lodging or travel expenses incurred by the patient or the provider, even though directed by a Physician for the purpose of obtaining medical treatment, except covered ambulance Services or other expenses specifically identified as covered by the plan.

**P. Vision and Hearing**

- Eyeglasses or contact lenses, eye exercises or visual training (orthoptics), except when specifically identified elsewhere as a Covered Service.
- Preventive vision examinations or care and screening eye examinations, including eye refractions, except when specifically identified elsewhere as a Covered Service.
- Screening audiological tests (except as covered under Preventive Services); external and surgically implantable devices (except cochlear implants as otherwise covered under this plan) and combination external/implantable devices to improve hearing, including audiant bone conductors or hearing aids and their fitting.
- Surgical, laser or nonsurgical procedures or alterations of the refractive character of the cornea including but not limited to correction of myopia, hyperopia or astigmatism. In addition, benefits are not available for:
  - Charges for related Services.
  - Eyeglasses or contact lenses following the surgery.

**Q. Other Exclusions and Limitations**

- Services not covered by the plan.
- Services which are determined by BCBSNE to be not Medically Necessary.
- Services, including related diagnostic testing, which are primarily:
  - recreational, such as music or art therapy.
  - educational.
  - Work-hardening Therapy; vocational training.
  - self-help training.
- Sex transformation surgery and related Services.
- Interest, sales or other taxes or surcharges on Covered Services, drugs, supplies or DME, other than those surcharges or assessments made directly upon employers or third party payers.
- Genetic treatment or engineering. Any service performed to alter or create changes in genetic structure.
- Genetic testing, unless scientifically validated by BCBSNE medical policy.
- Food antigens and/or sublingual therapy.
- Snoring, the reduction or elimination of, when that is the primary purpose of treatment.
- Calls or consults by telephone or other electronic means, video or internet transmissions, and telemedicine, except in conformance with BCBSNE policies and procedures.
- Blood, blood plasma or blood derivatives or fractionates, or Services by or for blood donors, except administrative and processing charges for blood used for a Covered Person furnished to a Hospital by the American Red Cross, county blood bank, or other organization that does not charge for blood.
- Wigs, hair prostheses and hair transplants, regardless of the reason for the hair loss.
- Hair analysis, including evaluation of alopecia or age-related hair loss.
- Services provided to or for:
  - Any dependent when coverage is provided by a single membership, except when benefits are specifically provided by the plan for a newborn or adopted child.
  - Any person who does not qualify as an Eligible Dependent.
  - Any Covered Person before or after his or her effective date of coverage, or after the effective date of cancellation or termination of coverage.
- Military service related Illness or Injury.

- Services for which there is no legal obligation to pay, including:
  - Services for which no charge would be made if coverage did not exist;
  - any charge above the charge that would have been made if no coverage existed, or
  - any service which is normally furnished without charge.
- Charges in excess of the Contracted Amount.
- Charges made separately for Services and/or procedures, supplies and materials when they are considered to be included within the charge for a total Service payable, or if the charge is payable to another provider.

  *EXCEPTION: If such charges are made separately when they are considered to be included within the charge for a total Service performed by a BCBSNE In-network Provider, then this amount is not the patient's liability.*
- Employer required Services as a condition of employment including, but not limited to immunizations, blood testing, work physicals and drug tests.
- Illegal occupation or commission/attempt to commit a felony. Charges made pursuant to a Covered Person's engagement in an illegal occupation or felony.
- Electron beam computed tomography for vascular screening, including but not limited to screening for cardiovascular, cerebrovascular and peripheral vascular disease.
- Private duty nursing.
- Respite care when not covered as part of a covered Hospice benefit.
- Home health aide, Skilled Nursing Care or Hospice related Services as follows:
  - Services performed by volunteers;
  - pastoral Services, or legal or financial counseling Services;
  - Services primarily for the convenience of the patient, or a person other than the patient;
  - home delivered meals.
- Shipping and handling charges.
- Places of Service as follows, excluding Covered Services provided at a health fair approved by BCBSNE:
  - day care;
  - school;
  - library; or
  - church.
- Otherwise Covered Services when:
  - Required solely for purposes of camp, travel, career, employment, insurance, marriage or adoption;
  - Related to judicial or administrative proceedings or orders;
  - Conducted for the purpose of medical research;
  - Required to obtain or maintain a license of any type.
- Foreign language and sign language Services.
- Driving tests or exams.
- Autopsies.

# PRESCRIPTION DRUG BENEFITS

**Section 6**

Prescription Drug Benefits are subject to the applicable Copay, Deductible and/or Coinsurance amounts shown in the Schedule of Benefits Summary for covered drugs dispensed by a registered pharmacist requiring a physician's or dentist's prescription and bearing a label, "Caution — Federal law prohibits dispensing without a prescription." A Copay, Deductible and/or Coinsurance will be assessed for each prescribed drug, supply and/or unit.

All covered prescriptions must be FDA approved with a valid National Drug Code (NDC) number. Compounded prescriptions must contain at least one FDA approved ingredient. Injectables are limited to claims from providers who are contracting with Prime Therapeutics, and filed as a pharmacy claim.

Your prescription drug benefit is based on a tiered benefit design that helps control your out-of-pocket prescription drug costs by encouraging the use of generic medications. A drug formulary, which is a list of medications divided into tiers or categories, is used to determine what you must pay for each covered prescription medication. The formulary list classifies drugs as generic and formulary brand-name. A brand-name drug that does not appear on the list is classified as a non-formulary brand name drug. Specialty medications are typically self-administered injectable drugs used to treat serious or chronic medical conditions such as multiple sclerosis, hemophilia, hepatitis and rheumatoid arthritis. The formulary list is available at www.nebraskablue.com, or you may contact the BCBSNE Member Services Department.

Whenever appropriate, generic drugs will be used to fill prescriptions. If a generic version is available and the ordering physician did not specify a brand name drug, but the Covered Person requests a brand name drug, he or she may be required to pay the difference in cost between the brand name drug and the generic drug.

## Accessing Benefits

If the prescription or supply is purchased at a Rx Nebraska participating pharmacy, and you present your BCBSNE identification card to the pharmacist at the time of purchase, you will only be required to pay your financial liability at the time the prescription is filled. The Schedule of Benefits Summary shows your financial liability and the dispensing amount for each benefit tier.

***NOTE: Prepackaging by the manufacturer may limit the quantity dispensed to an amount which is less than the maximum dispensing amount available under your coverage. If that happens, benefits will be provided in compliance with the manufacturer's packaging guidelines.***

If the covered prescription is filled at a pharmacy not participating with Rx Nebraska, or if you do not present your I.D. card at the time of purchase, you will be required to pay the pharmacy's usual retail price. You must file a claim with BCBSNE. Eligible claims will be reimbursed based on the Allowance for the drug less the applicable Copay, Deductible and/or Coinsurance and a penalty.

**To locate participating Rx Nebraska pharmacies nationwide, call toll-free 1-877-800-0746.**

## Services Covered Under the Rx Nebraska Drug Coverage Program

- Anti-rejection drugs (immunosuppressants);
- Compounded prescriptions;
- Dexedrine;
- Diabetic Medication or oral agents other than Insulin including Diazoixide, glucagon, glipizide, glucophage or Glucose Chewable;
- Erectile dysfunction agents, including but not limited to Viagra, Caverject, Muse, Cialis, Levitra and Alprostadil. *(Viagra, Cialis and Levitra are limited to 8 pills per 30 days, and are excluded for males under the age of 19);*
- FluMist;
- Human Immunodeficiency Virus (HIV) medications;
- Oral, intravaginal and transdermal contraceptives; Emergency contraceptive *(limited to one regimen per prescription)*;
- Ostomy Supplies;
- Prescription Prenatal Vitamins;
- Prescription Vitamins;
- Self injectable medications, including insulin;
- Topical acne agents; and
- Preventive Services as required by Health Care Reform *(see Preventive Services on Schedule of Benefits Summary).*

Benefits are also available, subject to the applicable Copay, Deductible and/or Coinsurance amount, for covered diabetic supplies including acetone testing agents, alcohol swabs, antiseptic pads, glucose monitor, insulin pump supplies, lancets, lancet device, needles, glucose tablets, syringes, and test strips.

**Generic Drugs Can Save You Money**
Generic drugs are drugs that are labeled by their chemical name rather than by a brand name. However, all drugs, whether generic or brand, must meet the same government standards for safety and effectiveness. Why pay more for a brand name drug if its generic twin is available at a lower cost? Ask your physician to prescribe generic drugs whenever possible.

**Services NOT Covered Under the Rx Nebraska Drug Coverage Program**

- Androgel and Testim for females;
- Cosmetic alteration drugs, health and beauty aids for such things as the promotion of hair growth/restoration, control perspiration, to enhance athletic performance or improve natural appearance;
- Diet or appetite suppressant drugs (Anorexics), dietary and herbal or nutritional supplements;
- Drugs or medicinals for treatment of fertility/infertility *unless such drugs are covered under an amendment for infertility treatment and related services*;
- DME or devices of any type including, but not limited to therapeutic devices or artificial appliances;
- General anesthetic;
- Home infusion therapy;
- Investigative drugs or drugs classified by the FDA as experimental;
- Mifeprex;
- Nutrition care, nutritional supplements and substances;
- Over-the-counter medications, including non-prescription medications, unless certain over-the-counter/non-prescription medications are covered under an amendment;
- Prescription medications determined by the FDA as having no clinical value (ex: DESI indicator class 06);
- Supplies other than ostomy, designated injectable, diabetic and insulin pump supplies. Insulin pump batteries are not covered under your prescription drug benefits;
- Insulin pumps and continuous glucose monitoring devices;
- Services, drugs and medical supplies which are not cost effective compared to established alternatives or which are provided for convenience or personal use;
- Prescription medications purchased in a foreign country, unless the covered person is living in another country or needs prescription medications to treat an emergency medical condition arising while he or she is traveling in a foreign country or otherwise mandated by federal legislation. (Evidence of residency or emergency medical condition must be provided with the claim); and
- Other drugs and/or injectables that are not covered as determined by BCBSNE.

## Limitations

- Lost, destroyed or stolen medications are limited to one replacement per prescription per calendar year.
- Excessive pattern of drug usage.

  In the event a Covered Person's usage of prescription drugs during a six month period indicates an excessive pattern of drug usage that is not Medically Necessary (as determined by BCBSNE's Drug Utilization Review Program), the Covered Person will be limited to one Participating Pharmacy of his/her choice for obtaining covered prescription drugs. If such a limitation applies to the Covered Person, benefits will not be available for prescription drugs obtained from any other pharmacy.

**Preauthorization:** Under the Rx Nebraska Drug Coverage Program preauthorization is required for some prescriptions as determined by BCBSNE. For more information on prescription medications requiring preauthorization, visit the BCBSNE website (www.nebraskablue.com) or call the Member Services Department at the phone number shown on the back of your I.D. card.

**Requesting Preauthorization:** A written request to BCBSNE must be made prior to the initial purchase of the prescription. This request must be accompanied by appropriate documentation from the covered person's physician, dentist or other medical provider demonstrating the medical necessity of the drug. This written request should be directed to:

Blue Cross and Blue Shield of Nebraska
Attention: Pharmacy
P.O. Box 3248
Omaha, Nebraska 68180-0001

Preauthorization forms can be found on the BCBSNE website at www.nebraskablue.com.

Upon receipt of the necessary information, BCBSNE will respond in writing advising the provider and the covered person whether or not benefits are available.

## Pre-existing Conditions

Benefits under the Rx Nebraska Drug Prescription Drug Program are not subject to any exclusion or limitation for pre-existing conditions. Payment of benefits under this program will not, however, waive such exclusions and limitations as they apply to other benefits.

**NOTE:** *The limitation, preauthorization and formulary lists may be updated at any time without notice. Additional information about your RX Nebraska pharmacy benefits can be found on the BCBSNE website at www.nebraskablue.com.*

## Definitions

The following terms are specifically used in conjunction with your Prescription Drug Benefits.

**Allowance:** The amount determined by BCBSNE to be payable to the Covered Person who has used a Nonparticipating Pharmacy for a Covered Service. The Allowance may be one of the following:

1. the lesser of the usual retail price or the applicable Contract Amount payable for similar Services by similar Participating Pharmacies; or
2. as otherwise determined by BCBSNE or our Pharmacy Benefit Manager to be appropriate based on industry standards for similar Covered Services.

**Brand Name Drug:** Single source and multisource brand drugs as set forth in the Medi-Span Master Drug Database File or such nationally recognized source relied upon by the Pharmacy Benefit Manager or BCBSNE.

**Generic Drug:** A Generic Drug as set forth in the Medi-Span Master Drug Database File or such nationally recognized source relied upon by the Pharmacy Benefit Manager or BCBSNE.

**Nonparticipating Pharmacies:** Licensed pharmacies that have not entered into written agreements with the Pharmacy Benefit Manager as designated by BCBSNE.

**Participating Pharmacies:** Licensed pharmacies that have entered into written agreements with the Pharmacy Benefit Manager as designated by BCBSNE.

**Pharmacy Benefit Manager:** Prime Therapeutics, LLC, (Prime) has been retained by BCBSNE to administer the Rx Nebraska Prescription Drug Program.

# ELIGIBILITY AND ENROLLMENT

Section 7

**For group specific eligibility and enrollment provisions, including information, when applicable, on initial enrollment, special enrollment, late enrollment, open enrollment, and adding a dependent, please refer to the amendment in the back of this book.**

## Who's Eligible

The Plan's eligibility requirements are specified in the Master Group Contract between BCBSNE and the Group applicant. We refer to the individual who enrolls for the coverage or the "employee" as a Subscriber. Dependents are generally your spouse and children; however, in order to be an Eligible Dependent, they must meet the definition of an Eligible Dependent.

*NOTE: If two eligible persons in the same employer group are married to each other, each person and/or their Eligible Dependents may not enroll under more than one Membership Unit.*

## Waiting Period For Pre-existing Conditions

You will be notified if a Waiting Period for Pre-existing Conditions applies to your (or your Eligible Dependent's) coverage. The Waiting Period for Pre-existing Conditions does not apply to a person who is 18 years of age or younger. If an individual's coverage is subject to a waiting period, no benefits will be paid for pre-existing conditions during the period of time the Waiting Period for Pre-existing Conditions is in effect.

### Creditable Coverage

The Waiting Period for Pre-existing Conditions may be reduced or waived by periods of prior Creditable Coverage if there is not a significant break in coverage. A significant break in coverage is a period of 63 days during which the individual does not have any Creditable Coverage. Days of Creditable Coverage that occur before a significant break in coverage will not be counted toward the reduction of a Waiting Period. Neither an Eligibility Waiting Period nor an HMO affiliation period is taken into account in determining a significant break in coverage.

The individual is responsible for providing satisfactory evidence of Creditable Coverage in order to reduce the Waiting Period. You may request a "certificate of creditable coverage" from your prior plan(s) or health insurer(s). If necessary, you may contact the BCBSNE Member Services Department and we will help you obtain it from them.

## Qualified Medical Child Support Orders (QMCSO)

A QMCSO is a court order that requires an employee to provide medical coverage for his or her children (called alternate recipients) in situations involving divorce, legal separation, or paternity disputes. The order may direct the group health plan to enroll the child(ren), and also creates a right for the alternate recipient to receive plan information, submit claims, and receive benefits for services.

QMCSOs are specifically defined under the law, and are required to include certain information in order to be considered "qualified." A National Medical Support Notice received by the employer or plan from a state agency, regarding coverage for a child, will also be treated as a QMCSO. The Plan Administrator or its designee, will review the Order or Notice to determine whether it is qualified, and make a coverage determination. The Plan Administrator or its designee will notify affected employees and the alternate recipient(s) if a QMCSO is received.

You have the right to request a copy of the Plan's procedures governing QMCSO determinations from the Plan Administrator, at no charge.

## Active Employees Age 65 And Over

Federal law affects the way employers provide coverage to eligible active employees and their spouses who are 65 and over. These active employees and their spouses ages 65 and over may elect to continue full benefits under the employer group benefit plan or choose Medicare as their primary coverage. If the group plan is elected as the primary carrier (the plan which pays first), Medicare becomes the secondary coverage. If Medicare is elected as the primary carrier, coverage under the group plan will be terminated. This law applies to employers with 20 or more employees. Please check with your employer regarding whether your group is subject to this federal law.

## Family Medical Leave Act (FMLA)

The Family Medical Leave Act of 1993, as amended, requires that subject to certain limitations, most employers of 50 or more persons must offer continued coverage to eligible employees and their covered dependents, while the employee is on an approved FMLA leave of absence. In addition, an employee who has terminated his/her group health coverage while on an approved FMLA leave is entitled to reenroll for group health coverage upon return to work. Please check with your employer for details regarding your eligibility under FMLA.

### If You Receive Covered Services From An In-Network Provider

Contracting Providers and many other Hospitals and Physicians will file the claim to BCBSNE on your behalf. Out-of-state Contracting Providers will file a claim with their local Blue Cross and Blue Shield plan for processing through the BlueCard Program. When we receive a claim from a Contracting Provider, payment will be made directly to the provider, unless otherwise provided under state or federal law. Even when you use a Contracting Provider, you are responsible for meeting any applicable Deductible and paying any applicable Copay and/or Coinsurance amounts. You may be asked to pay amounts that are your liability at the time of service, or the provider may bill you for those amounts.

### Filing A Claim

You must file your own claim if your health care provider is not a Contracting Provider and does not file for you. You can obtain a claim form by contacting BCBSNE's Member Services Department, or you can find a form on the website: www.bcbsne.com.

All submitted claims must include:

- Correct BCBSNE ID number, including the alpha prefix.
- Name of patient.
- The date and time of an accident or onset of an illness, and whether or not it occurred at work.
- Diagnosis.
- An itemized statement of services, including the date of service, description and charge for the service.
- Complete name, address and professional status (M.D., R.N., etc.) of the health care provider.
- Prescription number, if applicable.
- The name and identification number of other insurance, including Medicare.
- The primary plan's explanation of benefits (EOB), if applicable.

Claims cannot be processed if they are incomplete, and may be denied for "lack of information" if required information is not received.

Claims should be filed as soon as possible. If a claim is not filed within 15 months of the date of service, benefits will not be allowed.

In Nebraska, claim forms should be sent to:

Blue Cross and Blue Shield of Nebraska
P.O. Box 3248
Omaha, Nebraska 68180-0001

If health care services are provided in a state other than Nebraska, claims should be filed to the Blue Cross and Blue Shield plan servicing the area where the services were received. If you need assistance in locating the plan, please contact BCBSNE's Member Services Department.

### Payment Of Benefits For Non-Contracting Provider Claims

Payment will be made, at BCBSNE's option, to the Covered Person, to his or her estate, to the provider or as required by state or federal law. Benefits may also be paid to an alternate recipient or custodial parent, if pursuant to a QMCSO.

No assignment, whether made before or after Services are provided, of any amount payable according to this group benefit plan shall be recognized or accepted as binding upon BCBSNE, unless otherwise provided by state or federal law.

### Payment For Services That Are The Covered Person's Responsibility

Under certain circumstances, if BCBSNE pays the provider amounts that are your responsibility, such as Deductibles, Copays or Coinsurance, we may collect such amounts from you. You agree that BCBSNE has the right to collect such amounts from you.

### Claim Determinations

A "Claim" may be classified as a "Preservice" or "Postservice."

**Preservice Claims** — In some cases, under the terms of the health plan, the Covered Person is required to certify benefits in advance of a Service being provided, or benefits for the Service may be reduced or denied. This required request for a benefit is a "Preservice Claim." Preservice Claim determinations that are not Urgent Care Claims will be made with 15 calendar days of receipt, unless an extension is needed to obtain necessary information. If additional information is requested, the Covered Person or his or her provider may be given up to 45 calendar days from receipt of notice to submit the specified information. A Claim determination will be made within 15 days of receipt of the information, or the end of the 45 day extension period.

*(See the section of this book titled "Certification Requirements" for more information on certifying benefits.)*

**Urgent Care** – If your Pre-Service Claim is one for Urgent Care, the determination will be made within 72 hours of receipt of the claim, unless further information is needed. If additional information is necessary, the Covered Person or his or her provider will be given no less than 48 hours to provide the specified information. Notification of the decision will be provided not later than 48 hours after the earlier of: our receipt of the information, or the end of the period allowed to submit the information.

**Postservice Claims –** A Postservice Claim is any Claim that is not a Preservice Claim. In most cased, a Postservice Claim is a request for benefits or reimbursement of expenses for medical care that has been provided to a Covered Person. The instructions for filing a Postservice Claim are outlined earlier in this section. Upon receipt of a completed claim form, a Postservice Claim will be processed within 30 days, unless additional information is needed. If additional information is requested, the Covered Person may be given not less than 45 days to submit the necessary information. A Claim determination will be made within 15 days of receipt of the information, or the expiration of the 45-day extension period. You will receive an EOB when a Claim is processed which explains the manner in which your Claim was handled.

**Concurrent Care** – If you request to extend a course of treatment beyond the care previously approved and it involves urgent care, a decision will be made within 24 hours of the request, if you submitted the request at least 24 hours before the course of treatment expires. In all other cases, the request for an extension will be decided as appropriate for Preservice or Postservice Claims.

## Explanation Of Benefits

Every time a claim is processed for you, an Explanation of Benefits (EOB) form will be sent. The front page of the EOB provides you with a summary of the payment including:

- The patient's name and the claim number.
- The name of the individual or institution that was paid for the service.
- The total charge associated with the claim.
- The covered amount.
- Any amount previously processed by this plan, Medicare or another insurance company.
- The amount(s) that you are responsible to pay the Provider.
- The total Deductible, Coinsurance and/or Copay that you have accumulated to date.
- Other general messages.

A more detailed breakdown of the charges including provider discounts, amount paid and cost sharing amounts (e.g. noncovered charges, Deductible, Coinsurance and Copays) are shown on the back of your EOB.

Also included on your EOB is information regarding your right to appeal a benefit determination.

Save your EOBs in the event that you need them for other insurance or for tax purposes.

# APPEAL PROCEDURES

Section 9

BCBSNE has the discretionary authority to determine eligibility for benefits under the health plan, and to construe and interpret the terms of the plan, consistent with the terms of the master group contract.

You have the right to seek and obtain a review of "adverse benefit determinations" arising under this health plan.

## Appeal Procedure Definitions

**Adverse Benefit Determination:** A determination by BCBSNE or its Utilization Review designee, of the denial, reduction, or termination of a benefit, or a failure to provide or make payment (in whole or in part) of a benefit. This includes any such determination that is based on:

- the application of Utilization Review;
- a determination that the Service is Investigative;
- a determination that the Service is not Medically Necessary or appropriate;
- an individual's eligibility for coverage or to participate in a plan.

An Adverse Benefit Determination also includes any rescission of coverage, which is defined as a cancellation or discontinuance of coverage that has a retroactive effect, except if for failure to timely pay required premiums or contribution for coverage.

**Final Internal Adverse Benefit Determination:** An Adverse Benefit Determination that has been upheld by BCBSNE, or its Utilization Review designee, at the completion of the internal appeal process as described in this document.

**Preservice Claim(s):** Any claim for a benefit under the plan with respect to which the terms of the Contract require approval of the benefit in advance of obtaining medical care, and failure to do so will cause benefits to be denied or reduced.

**Postservice Claim(s):** Any claim that is not a Preservice Claim.

**Urgent Care Claim:** A claim for medical care or treatment for which the application of the time periods for making non-urgent care determinations:

- could seriously jeopardize the life or health of the Covered Person or the ability of the Covered Person to regain maximum function; or
- would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

## How To Appeal An Adverse Benefit Determination

A Covered Person or a person acting on his/her behalf (the "claimant") is entitled to an opportunity to appeal initial or final Adverse Benefit Determinations.

## First Level Appeal

A request for a first level appeal must be submitted within 6 months of the date the claim was processed, or Adverse Benefit Determination was made. The written request for an appeal should state that it is a request for an appeal and, if possible, include a copy of the Explanation of Benefits (EOB). The appeal should also include:

- the name of the person submitting the appeal and his/her relationship to the patient;
- the reason for the appeal;
- any information that might help resolve the issue; and
- the date of service/claim.

The written appeal should be sent to:

Blue Cross and Blue Shield of Nebraska
P.O. Box 3248
Omaha, Nebraska 68180-0001

**Preservice or Postservice Claim Appeal:** A written notice of the appeal determination will be provided to the claimant as follows:

- Preservice Claims (other than Urgent Care), within 15 calendar days after receipt.
- Postservice Claims, within 30 calendar days after receipt.

**Expedited Appeal:** When the appeal is related to an Urgent Care Claim, an expedited appeal may be requested. In the case of an expedited appeal, the request may be submitted in writing or orally. All information, including the decision, will be submitted by the most expeditious method available. BCBSNE will make an expedited review decision within 72 hours after the appeal is requested. Written notification of the decision will be sent within the 72-hour period.

Concurrent Care denials must be appealed within 24 hours of the denial. A Concurrent Care denial will be handled as an expedited appeal. If the appeal is requested within the 24-hour time period, coverage will continue for health care services pending notification of the review decision.

**NOTE: When an adverse appeal determination involves medical judgment, upon receipt of a written request, the identity of the health care professionals who reviewed the appeal will be provided to the claimant.**

## Second Level Appeal

If the claimant is not satisfied with the first level appeal determination, a written request for a second level appeal may be submitted within 60 calendar days of receipt of the first level appeal decision. Unless otherwise indicated on the back of the Covered Person's I.D. card, the written request must be mailed to:

Blue Cross and Blue Shield of Nebraska
Second Review Unit
P.O. Box 3248
Omaha, Nebraska 68180-0001

The Covered Person and/or a representative have the right to appear in person to present the case before an appeal panel appointed by BCBSNE. The panel will include health care professionals with appropriate expertise when the case being reviewed requires a medical judgment. No deference will be given to either the initial determination or the first level review. The second level review and decision will be made by individuals who were not involved in the prior determinations.

**Preservice or Postservice Claim Appeal:** Upon receipt of a second level appeal, written notification of the decision will be made as follows:

- Preservice Claims, within 15 calendar days after receipt.
- Postservice Claims, within 30 calendar days after receipt.

The second level determination will be considered the Final Internal Adverse Benefit Decision.

## Rights to Documentation

Documentation relevant to the claim and Adverse Benefit Determination(s) can be accessed or copies requested by the claimant. In addition, supporting material may be submitted by the claimant both before and during the appeal process.

## External Review

If the claimant has exhausted all levels of internal appeal review, an external review by an Independent Review Organization (IRO) may be requested. The request must be submitted in writing within four months after receipt of the Final Internal Adverse Benefit Determination. (An Adverse Benefit Determination based on an individual's eligibility for coverage or to participate in a plan is not eligible for External Review.)

The request for an External Review may be submitted electronically, by facsimile, or U.S. mail, as stated on the Final Internal Adverse Benefit Determination notice (letter). Request may be e-mailed to DisputedClaim@opm.gov; fax to (202)-606-0036; mail to P.O. Box 791, Washington, D.C. 20044.

The IRO and/or BCBSNE shall review the request and will provide the claimant written notification whether the request is eligible for External Review. If the request is not complete, or is not eligible for External Review, the claimant will be notified of the reason for ineligibility, or advised of the information needed to make the request complete.

If the External Review request is eligible, all documentation and information considered in making the initial Adverse or Final Adverse Benefit Determination will be forwarded to the IRO. If the claimant wishes to submit additional information to the IRO for consideration, they will be given an opportunity to do so.

The IRO will provide the claimant with written notification of its decision within 45 calendar days of receipt. No deference shall be given to the prior internal appeal determinations made by BCBSNE.

**Expedited External Review:** An expedited External Review of an Adverse Benefit Determination for an Urgent Care Claim may be request at the same time a claimant requests an expedited internal first level appeal. However, the claimant must first exhaust the internal appeal process unless BCBSNE agrees to waive this requirement.

An expedited External Review may also be requested following a Final Internal Adverse Benefit Determination, if:

- the Covered Person has a medical condition where the timeframe for completion of a standard External Review would seriously jeopardize his/her life, health, or ability to regain maximum function would be jeopardized.
- the Final Internal Adverse Benefit Determination concerns an admission; availability of care; continued stay, or heath care service for which the Covered Person has received emergency services, but has not been discharged from a facility.

The expedited External Review decision will be made by the IRO within 72 hours after receipt of the request.

Once an External Review decision has been made, the Covered Person or his/her representative may not file a subsequent request for an External Review involving the same Adverse Benefit Determination. The decision of the IRO is the final review decision and is binding on BCBSNE and the claimant, except to the extent that federal or state law may provide the claimant with other remedies.

# COORDINATION OF BENEFITS

Section 10

## When You Have Coverage Under More Than One Plan

This Plan includes a Coordination of Benefits (COB) provision. This provision establishes a uniform order in which the Plans pay their claims, limits duplication of benefits and provides for transfer of information between the Plans.

## When Coordination Of Benefits Applies

COB provisions apply when a Covered Person has coverage under more than one health Plan. The order of benefit determination rules described in this section determine which Plan will pay as the primary Plan without regard to any benefits that might be payable by another Plan.

## Definitions

For the purpose of this section, the terms are defined as:

**Allowable Expense:** A health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of Services, the reasonable cash value of each Service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense.

The amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical options, precertification of admissions, and Preferred Provider arrangements.

**Closed Panel Plan:** A Plan that provides health care benefits to Covered Persons primarily in the form of Services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for Services provided by other providers, except in cases of emergency or referral by a panel member.

**Custodial Parent:** The parent awarded custody by a court decree or, in the absence of a court decree, the parent with whom the child resides more than one half of the calendar year excluding temporary visitation.

**Plan:** Any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

a. Plan includes: group insurance contracts, health maintenance organization (HMO) contracts, Closed Panel Plans or other forms of group or group-type coverage (whether insured or uninsured); individual underwritten coverage including HMO coverage or Subscriber contracts; medical care components of long-term care contracts, such as Skilled Nursing Care; and Medicare or any other federal governmental plan, as permitted by law.

b. Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage other than the medical benefits coverage in automobile "no fault" and traditional "fault" contracts; specified disease or specified accident coverage; limited benefit health coverage; school accident coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; and coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under a. or b. is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

**Primary Plan:** The Plan that will determine payment for its benefits first before those of any other Plan without considering any other Plan's benefits.

**Secondary Plan:** The Plan that will determine its benefits after those of another Plan and may reduce the benefits so that all Plan benefits do not exceed 100% of the total Allowable Expense.

**This Plan:** The part of the contract providing health care benefits to which the COB provision applies and which may be reduced because of the benefits of other Plans. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

## Order Of Benefit Determination Rules

1. The Primary Plan pays or provides its benefits according to its terms or coverage and without regard to the benefits under any other Plan.
2. If one of the Plans has drug card coverage, the coverage first used by the Covered Person becomes the primary coverage. In this instance, Blue Cross and Blue Shield of Nebraska under its health coverage will become the secondary payer, and will calculate Allowable Expenses pursuant to this Part.
3. A Plan that does not contain a coordination of benefits provision that is consistent with this Part is always primary unless the provisions of both Plans stated that the complying Plan is primary.
4. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.
5. Each Plan determines its order of benefits using the first of the following rules that apply:

**Subscriber And Dependent.** The Plan that covers the person as the Subscriber is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent and primary to the Plan covering the person as a Subscriber, then the order of benefits between the two Plans is reversed so that the Plan covering the person as a Subscriber is the Secondary Plan and the other Plan is the Primary Plan.

**Dependent Child Covered Under More Than One Plan.** Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:

For a dependent child whose parents are married or are living together, whether or not they have ever been married, the Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan. If both parents have the same birthday, the Plan that has covered the parents the longest is the Primary Plan (birthday rule).

For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married, if a court decree states that one of the parents is responsible for the child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, the Plan of that parent's spouse is primary. This rule applies to Plan years beginning after the Plan is given notice of the court decree.

If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the order of benefits shall be determined by the "birthday rule" stated above.

If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the order of benefits shall be determined by the "birthday rule" stated above.

If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

- The Plan covering the Custodial Parent;
- The Plan covering the spouse of the Custodial Parent;
- The Plan covering the non-custodial parent; and then
- The Plan covering the spouse of the non-custodial parent.

For a dependent child covered under more than one Plan of individuals who are not parents of the child, the above provisions shall apply as if those individuals were the parents.

**Active Employee, Retired Or Laid-Off Employee.** The Plan that covers a person as an active employee, that is, an employee who is neither retired nor laid off, is the Primary Plan. The Plan covering that same person as a retired or laid-off employee is the Secondary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the first rule (Subscriber and Dependent) can determine the order of benefits.

**COBRA Or State Continuation Coverage.** If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as a Subscriber or covering the person as a dependent of a Subscriber is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the first rule (Subscriber and Dependent) can determine the order of benefits.

**Longer Or Shorter Length Of Coverage.** The Plan that covered the person as a Subscriber longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan. The start of a new Plan does not include a change in the amount or scope of a Plan's benefits; a change in the entity that pays, provides or administers the Plan's benefits; or a change from one type of Plan to another, such as from a single employer Plan to a multiple employer Plan.

If the above rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the Primary Plan.

## Administration Of Coordination Of Benefits

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Plan that pays after the Primary Plan is called the Secondary Plan.

If this Plan is the Primary Plan, there shall be no reduction of benefits. Benefits will be paid without regard to the benefits of any other Plan.

If this Plan is the Secondary Plan, it may reduce its benefits so that the total benefits paid or provided by all Plans for any claim are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its Plan Deductible any amounts it would have credited to its Deductible in the absence of other health coverage.

## Miscellaneous Provisions

If these COB rules do not specifically address a particular situation, we may, at our discretion, rely on the National Association of Insurance Commissioners Coordination of Benefits Model Regulation as an interpretive guide.

To properly administer these COB rules, certain facts are needed. This Plan may obtain or release information to any insurance company, organization or person. Any person who claims benefits under this Plan agrees to furnish the information that may be necessary to apply COB rules and determine benefits.

If another Plan pays benefits that should have been paid under this Plan, this Plan may reimburse the other Plan amounts determined to be necessary. Amounts paid to other Plans in this manner will be considered benefits paid under this Plan and this Plan is released from liability for any such amounts.

If the amount of the benefits paid by this Plan exceeds the amount it should have paid, this Plan has the right to recover any excess from any other insurer, any other organization, or any person to or for whom such amounts were paid, including Covered Persons under this plan.

**For group specific information on the date your coverage will terminate, please refer to the amendment in the back of this book.**

You and/or your Eligible Dependents may be eligible to continue coverage under the group health plan as detailed in this section.

## Continuation Of Coverage Under The Federal Continuation Law

If you terminate your employment, or if a dependent loses coverage due to certain "Qualifying Events," continued coverage under the group health plan may be available. Payment for continued coverage under the federal continuation law is at the employee's or dependent's own expense. Please contact your employer for details regarding eligibility.

## What Is The Federal Continuation Law?

The Consolidated Omnibus Budget Reconciliation Act (COBRA), is a federal law which provides that a Covered Person who would lose coverage due to the occurrence of a "Qualifying Event," may elect to continue coverage under the group health plan. A person who is eligible to continue coverage is called a "Qualified Beneficiary." A Qualified Beneficiary also includes a child born to, or placed for adoption with the Covered Person during the period of COBRA coverage. Please share the information found in this section with your Eligible Dependents.

*NOTE: To protect your rights under COBRA, please keep your employer informed of your current address.*

**Termination Of Employment Or Reduction In Hours –** COBRA provides that if you should lose coverage due to:

- termination of employment;
- a lay-off for economic reasons;
- discharge for misconduct (other than gross misconduct); or
- a reduction in work hours,

you and your covered dependents may be able to continue the group coverage at your own expense for up to 18 months. Your employer is required to notify the Plan Administrator of the event. The Plan Administrator will send the Qualified Beneficiaries a COBRA notification within the time period required by law.

**Special Provisions —** If an employer files Chapter 11 bankruptcy, special provisions regarding COBRA continuation coverage may apply for the retiree or deceased retiree's surviving spouse and dependent children. Please check with your employer for details.

**Disability –** If a Qualified Beneficiary is determined by the Social Security Administration to have been disabled any time during the first 60 days of COBRA continuation coverage, the COBRA coverage period for the disabled individual and his or her related beneficiaries may be extended to 29 months instead of 18 months when loss of coverage is due to termination or reduction in hours of employment. You must provide written notice of the disability determination to the plan within 18 months of becoming eligible for COBRA and no later than 60 days after the date of the Social Security Administration's determination.

If the Social Security Administration determines that you or the dependent are no longer disabled, the extended continuation of coverage period (19th through 29th month) will be terminated the month that begins more than 30 days after the determination. You must notify the plan within 30 days of a determination that an individual is no longer disabled.

**Change In Dependent Status, Divorce/Separation Or Medicare Entitlement –** If your covered spouse and eligible children would otherwise lose coverage as a result of:

- divorce or legal separation;
- a child losing dependent status; or
- the employee becoming entitled to Medicare,

COBRA requires that they be allowed to continue coverage at their own expense for up to 36 months.

In the case of divorce or legal separation, or a child's loss of dependent status, you or the dependent are obligated to notify the Plan Administrator within 60 days of the later of the event or the date coverage would be lost. The notice must include sufficient information to enable the Plan Administrator to determine the group health plan to which the notice applies; the covered employee and qualified beneficiary(ies); the qualifying event; and the date the qualifying event occurred. Failure to provide timely and proper notice may result in the loss of the right to COBRA.

After receiving a timely notice of such an event, if eligible, the Plan Administrator will send the Qualified Beneficiary an election form and the information needed to apply for coverage within 14 days of the date the notice is received.

**Your Death –** If you should die while you are covered under this group health plan, continued coverage is available to your spouse and Eligible Dependents.

COBRA provides that subject to certain limitations, your surviving spouse and children may continue the group health coverage at their own expense for up to 36 months. Federal law requires your Plan Administrator to send the surviving family members instructions as to how to apply for continued coverage if they are eligible.

## Electing COBRA Coverage

Within 14 days after notice of a Qualifying Event is received by the Plan Administrator, you and/or your dependents will be sent a written notice of the right to continue health coverage and an election form(s).

***Reminder:*** *In the case of a divorce or legal separation, or if a child loses dependent status, you must notify your employer or Plan Administrator of this Qualifying Event within 60 days. Failure to provide timely and proper notice may result in the loss of the right to COBRA coverage.*

Qualified Beneficiaries must complete and return the COBRA election form in order to continue coverage. The notice will include instructions for completing and returning the form. The election form must be received by the later of:

- 60 days after the day health coverage would otherwise end, or
- 60 days after the notice is sent to you by the employer or Plan Administrator.

COBRA continuation coverage may only begin on the day after coverage under the group plan would otherwise end. The required premium, including any retroactive premium, must be paid from the day coverage would have otherwise ended. The initial premium must be paid within 45 days after the day continued coverage is elected. Succeeding premiums must be paid monthly within 30 days of the premium due date. The COBRA notice and election form will inform you or your dependents of the monthly premium amount, and to whom such premium should be paid.

**Second Qualifying Event** — In the event your family experiences a second Qualifying Event while receiving an 18-month period of COBRA coverage (or the extended 29-month period), your covered spouse and dependents are eligible to extend the original COBRA coverage period to a maximum of 36 months if notice of the second event is properly given to the Plan Administrator. This extension may be available to the spouse and children receiving continuation coverage if: a) you die, b) you become entitled to Medicare, c) you get divorced or legally separated, or d) the dependent child is no longer eligible as a dependent, but only if the second event would have caused the spouse or child to lose coverage under the plan had the first Qualifying Event not occurred. In all of these cases, you or the dependent must notify the Plan Administrator, in writing, within 60 days of the second Qualifying Event. The notice must include sufficient information to enable the Plan Administrator to determine the group health plan to which the notice applies; the covered employee and qualified beneficiary(ies); the second qualifying event; and the date the qualifying event occurred. Failure to provide timely and proper notice may result in the loss of the right to extend COBRA coverage.

## Termination Of COBRA Coverage

A Qualified Beneficiary's COBRA continuation coverage may be terminated at midnight on the earliest of:

- the day your employer ceases to provide any group health plan to any employee;
- the day the premium is due and unpaid;
- the day the individual first becomes covered under any other group health plan (after the COBRA election), which does not exclude or limit any pre-existing conditions or to whom such an exclusion is not applicable due to creditable coverage;
- the day the individual again becomes covered as an employee or dependent under the policy;
- the day an insured person becomes entitled to benefits under Medicare (after COBRA election); or
- the day health insurance has been continued for the maximum period of time allowed (18, 29 or 36 months).

***NOTE:*** *In the event more than one continuous provision applies, the periods of continued coverage may run concurrently, but never for more than 36 months.*

## Trade Adjustment Assistance (TAA) Reform Act of 2002

The Trade Adjustment Assistance (TAA) Reform Act provides benefits to individuals eligible for trade adjustment assistance because international trade has adversely affected their employment. The Act provides that a TAA eligible individual who did not elect continuation coverage during the initial COBRA election period is entitled to a second 60-day election period. This election must take place no later than six months after the date of the TAA related loss of coverage. The Act also includes a federal tax credit for a percentage of premiums paid for qualified private health insurance coverage, including COBRA coverage.

Additional information regarding requirements and benefits under the TAA Reform Act may be obtained from the U.S. Department of Labor or the Nebraska Workforce Development, Department of Labor.

## Uniformed Services Employment And Reemployment Rights (Military Leave)

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) requires that continued coverage under an employer group health plan be offered to an employee and covered dependents if coverage would otherwise be lost due to a military leave.

**Continuation Of Group Health Coverage:**
If coverage under your employee group health plan ends because of service in the uniformed services, you may elect to continue health coverage for yourself and your covered dependents, until the earlier of:

- 24 consecutive months from the date active duty began; or
- the day after the date on which you fail to apply for, or return to employment, in accordance with USERRA.

You are responsible for payment of the required premium to continue coverage. If the leave for military service is less than 31 days, your required premium is the standard employee share of the applicable premium; for a leave in excess of 30 days, the required premium shall be no more than 102% of the total premium applicable for your membership option. Your employer will inform you of the amount and procedure for payment of premiums.

A Covered Person's continued coverage under these USERRA provisions will end at midnight on the earliest of:

- the day the employer ceases to provide any group health plan for its employees;
- the day premium is due and unpaid;
- the day a Covered Person again becomes covered under the plan; or
- the day coverage has been continued for the period of time stated above.

**Reemployment**
Following service in the uniformed services, an employee may be eligible to apply for reemployment with the employer in accordance with USERRA. Such reemployment includes the right to reenroll for group health coverage provided by the employer, with no new waiting periods imposed.

Please contact your employer for further information regarding your rights under USERRA.

### Benefit Plan Document

This document provides an overview of your benefits. It is not intended to be a complete description of every detail of the Plan. All coverage and benefit determinations are governed by the Benefit Plan Document, which consists of the Master Group Application, any Subgroup applications, the enrollment information, the Master Group Contract, addenda, attachments, or endorsements. If there is a discrepancy or conflict between this document and the Benefit Plan documents, the Benefit Plan documents will govern.

### Fraud Or Misrepresentation

A Covered Person's coverage may be canceled or rescinded for fraud or intentional misrepresentation about a claim or eligibility for this coverage.

If coverage is rescinded, the amount of premium paid will be reduced by any benefits that were paid, and will be refunded. If benefits paid exceed the premium received, we may recover the difference.

### Subrogation

Subrogation is the right to recover benefits paid for Covered Services provided as the result of Injury or Illness which was caused by another person or organization. When benefits are paid under the Master Group Contract, the Plan shall be subrogated to all of the Covered Person's right of recovery against any person or organization to the extent of the benefits paid. The Subscriber, the Covered Person or the person who has the right to recover for a Covered Person (usually a parent or spouse), agrees to make reimbursement to the plan if payment is received from the person who caused the Illness or Injury or from that person's liability carrier.

This subrogation shall be a first priority lien on the full or partial proceeds of any settlement, judgment, or other payment recovered by or on behalf of the Covered Person, whether or not there has been full compensation for all his or her losses or as provided by applicable state law. BCBSNE's rights shall not be defeated by allocating the proceeds in whole or in part to nonmedical damages.

### Contractual Right To Reimbursement

If a Covered Person receives full or partial proceeds from any other source for Covered Services for an Illness or Injury, the Plan has a contractual right of reimbursement to the extent benefits were paid under the Contract for the same Illness or Injury. This contractual right to reimbursement shall be a first priority lien against any proceeds recovered by the Covered Person, whether or not the Covered Person has been fully compensated for all his or her losses, or as provided by applicable state law.

Such proceeds may include any settlement; judgment; payments made under group auto insurance; individual or group no fault auto insurance; another person's uninsured, underinsured or medical payment insurance; or proceeds otherwise paid by a third party. This contractual right to reimbursement is in addition to and separate from the subrogation right. Our rights shall not be defeated by allocating the proceeds in whole or in part, to nonmedical damages.

When BCBSNE recovers proceeds under this contractual right to reimbursement for all or a part of the Claim, amounts previously credited to a Covered Person's Deductible or Coinsurance liability may be removed. Future Claims will be subject to the reinstated Deductible or Coinsurance.

No adult Subscriber may assign any rights to recover medical expenses from any third party to any minor or other dependent of the adult Subscriber or to any other person, without the express written consent of the Plan. The right to recover, whether by subrogation or reimbursement, shall apply to settlements or recoveries of deceased persons, incompetent or disabled Subscribers, or their incompetent or disabled Eligible Dependents.

The Subscriber agrees to fully cooperate and assist in any way necessary to recover such payments, including but not limited to notifying BCBSNE of a claim or lawsuit filed on his or her behalf, or on behalf of any Eligible Dependent for an Injury or Illness. The Subscriber, Eligible Dependent or an authorized representative shall contact BCBSNE prior to settling any claim or lawsuit to obtain an updated itemization of its subrogation Claim or reimbursement amount due. Upon receiving any proceeds, the Subscriber, Eligible Dependent or an authorized representative must hold such proceeds in trust until such time as the proceeds can be transferred to the Plan. The party holding the funds that rightfully belong to the Plan shall not interrupt or prejudice the Plan's recovery of such payments.

If the Subscriber refuses or fails to comply with these provisions, coverage can be canceled, including that of any covered dependents. Costs incurred in enforcing these provisions shall also be recovered, including, but not limited to, attorneys' fees, litigation and court costs, and other expenses.

## Workers' Compensation

Benefits are not available for Services provided for Injuries or Illnesses arising out of and in the course of employment, whether or not the Covered Person fails to assert or waives his or her right to Workers' Compensation or Employer Liability Law. The employer is required to furnish or pay for such Services or a settlement can be made, pursuant to Workers' Compensation laws. (See also the section of this book titled "Exclusions – What's Not Covered.")

If a Covered Person enters into a lump-sum settlement which includes compensation for past or future medical expenses for an Injury or Illness, payment will not be made under the group plan for Services related to that Injury or Illness.

Benefits are not payable for services determined to be not compensable due to noncompliance with terms, rules and conditions under Workers' Compensation laws, or in a Certified or otherwise Licensed Workers' Compensation Managed Care Plan. In addition, benefits are not payable for Services that are related to the work Injury or Illness, but are determined to be not necessary or reasonable by the employer or Workers' Compensation carrier.

In certain instances, benefits for such Services are paid in error under the group plan. If payment is received by the Covered Person for such Services, reimbursement must be made. This reimbursement may be refunded from any recovery made from the employer, or the employer's Workers' Compensation carrier, as permitted by law. Reimbursement must be made directly by the Subscriber when benefits are paid in error due to his or her failure to comply with the terms, rules and conditions of Workers' Compensation laws, or a Certified or Licensed Workers' Compensation Managed Care Plan.

## Your ERISA Rights

If your group health plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), you are entitled to certain rights and protections under this law.

ERISA provides that all plan participants shall be entitled to:

**Receive Information About Your Plan And Benefits**

- Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the plan, including insurance contracts, and collective bargaining agreements, and a copy of the latest annual report filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts, collective bargaining agreements, copies of the latest annual report and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

**COBRA And HIPAA Rights**

- Continue health coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event (COBRA). You or your dependents may have to pay for such coverage. Review your Summary Plan Description and the documents governing the Plan for the rules regarding your COBRA continuation rights.
- Reduction or elimination of Pre-existing Condition Waiting Periods under your group health plan, if you have Creditable Coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of Creditable Coverage, you may be subject to a Pre-existing Condition exclusion.

**Prudent Actions By Plan Fiduciaries**
In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

**Enforce Your Rights**

- If your Claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.
- Under ERISA, there are steps you can take to enforce your rights. For instance, if you request a copy of the plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file a lawsuit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.
- If you have a Claim for benefits which is denied or ignored in whole or in part, you may file a lawsuit in state or federal court. If you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file a lawsuit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file a lawsuit in federal court. The court will decide who should pay the costs and fees associated with a lawsuit. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs or fees, for example, if it finds your Claim is frivolous.

**Assistance With Your Questions**
If you have any questions about your plan, you should contact the Plan Administrator. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

**Advanced Diagnostics Imaging:** Highly developed technologies that use computerized imaging or radio isotropic enhancements to play a decisive role in diagnostics, such as computed tomography (CT) scans, magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), MRI of the breast, magnetic resonance spectroscopy (MRS),functional brain MRI (MRI), positron emission tomography (PET) scans, single photon emission computed tomography (SPECT) scans and other nuclear medicines.

**Allowable Charge:** An amount we use to calculate our payment of Covered Services. This amount will be based on either the Contracted Amount for In-network Providers or the Out-of-network Allowance for Out-of-network Providers.

**Ambulatory Surgical Facility:** A Certified facility that provides surgical treatment to patients not requiring inpatient hospitalization. Such facility must be Licensed as a health clinic as defined by state statutes, but shall not include the offices of private Physicians or dentists whether for individual or group practice.

**Approved Provider:** A Licensed practitioner of the healing arts who provides Covered Services within the scope of his or her License or a Licensed or Certified facility or other health care provider, payable according to the terms of the Contract, Nebraska law or pursuant to the direction of BCBSNE.

**Auxiliary Provider:** A Certified social worker, psychiatric registered nurse, provisional Licensed Mental Health Practitioner, provisional PhD, provisional Certified master social worker, provisional Certified alcohol and drug counselor or other Approved Provider who is performing Services within his or her scope of practice and who is supervised, and billed for, by a qualified Physician or Licensed clinical Psychologist, or as otherwise permitted by state law. Certified master social workers or Certified professional counselors performing mental health Services who are not Licensed Mental Health Practitioners are included in this definition.

**BlueCard Program:** This Blue Cross and Blue Shield Association (BCBSA) program is a collection of policies, provisions and guidelines that enables Us to process Claims incurred by Covered Persons residing or traveling outside Our Service Area by utilizing the discounts negotiated by the On-site plan and its Contracting Providers.

**Certificate of Coverage:** A summary of the terms of this Contract provided to the Subscriber by BCBSNE.

**Certification (Certify and Certified):** A determination by BCBSNE or Our designee, that an admission, extension of stay or other health care service has been reviewed and, based on the information provided, meets the clinical requirements for Medical Necessity, appropriateness, level of care, or effectiveness under the auspices of the applicable health benefit plan.

Certification also refers to successful voluntary compliance with certain prerequisite qualifications specified by regulatory entities. Agencies and programs may be deemed to be in compliance when they are accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Commission on the Accreditation of Rehabilitation Facilities (CARF), American Association for Ambulatory Health Care (AAAHC), American Association for Accreditation of Ambulatory Plastic Surgery Facilities (AAAAPSF), Medicare or as otherwise provided in the Contract provisions or state law.

**Claim:** A request for benefits under this Plan.

**Cognitive Training:** A rehabilitative intervention aimed at retraining or facilitating the recovery of mental and information processing skills including perception, problem-solving, memory storage and retrieval, language organization and expression.

**Coinsurance:** The percentage amount the Covered Person must pay for Covered Services which is based on the lesser of the Contracted Amount or the billed charge.

**Coinsurance Limit:** The maximum Coinsurance the Covered Person must pay during each calendar year.

**Congenital Abnormality:** A condition existing at birth which is outside the broad range of normal, such as cleft palate, birthmarks, webbed fingers or toes. Normal variations in size and shape of the organ such as protruding ears are not considered a Congenital Abnormality.

**Consultations:** Physician's Services for a patient in need of specialized care requested by the attending Physician who does not have that expertise or knowledge.

**Contract:** The agreement between BCBSNE and the Group Applicant which includes the Contract and any endorsements; the Master Group Application, any Subgroup Application, addenda, the individual enrollment information of Subscribers and any financial agreements.

**Contracted Amount:** The payment agreed to by BCBSNE or an On-site Plan and Contracting Providers for Covered Services received by a Covered Person.

**Contracting Provider:** An In-Network Provider or an On-site BlueCard Program Preferred or Participating Provider.

**Convenient Care/Retail Clinic:** A medical clinic located in a retail location such as a grocery or drug store, where a Provider offers treatment of minor medical conditions, immunizations and physicals without an appointment.

**Copayment (Copay):** A fixed dollar amount of the Contracted Amount, payable by the Covered Person for a Covered Service, as indicated in the Master Group Application.

**Cosmetic:** Any Services provided to improve the patient's physical appearance, from which no significant improvement in physiologic function can be expected, regardless of emotional or psychological factors.

**Covered Person:** Any person entitled to benefits for Covered Services pursuant to the Contract administered by BCBSNE.

**Covered Services:** Hospital, medical or surgical procedures, treatments, drugs, supplies, Durable Medical Equipment, or other health, mental health or dental care, including any single Service or combination of Services, for which benefits are payable, while the Contract is in effect.

**Creditable Coverage:** Coverage of the individual under any of the following: (a) a group health plan, as defined by HIPAA; (b) health insurance coverage consisting of medical care offered by a health insurance issuer in the group or individual market; (c) Part A or Part B of Medicare; (d) Medicaid, other than coverage consisting solely of benefits under section 1928 (for pediatric immunizations); (e) Title 10 U.S.C. Chapter 55 (medical and dental care of the uniformed services); (f) a medical care program of the Indian Health Service or a tribal organization; (g) a State health benefits risk pool; (h) the Federal Employees Health Benefits Program; (i) a public health plan, which means a plan providing health coverage that is established by a State, the U.S. government, or a foreign country, or a political subdivision thereof; (j) a health plan of the Peace Corps, or (k) a State Children's Health Insurance Program (SCHIP).

Creditable Coverage does not include coverage described in HIPAA as "excepted benefits," including: coverage only for accidents; disability income coverage; liability insurance, including general liability and automobile liability and any supplement thereto; credit only insurance; or coverage for on site medical clinics.

Other excepted benefits include: limited scope dental or vision coverage or long term care coverage; non coordinated coverages offered separately, such as specified disease or illness policies, hospital or other fixed indemnity insurance; and supplemental benefits such as Medicare Supplemental health insurance, TRICARE supplemental programs or other similar supplemental coverage.

**Custodial Care:** The level of care that consists primarily of assisting with the activities of daily living such as bathing, continence, dressing, transferring and eating. The purpose of such care is to maintain and support the existing level of care and preserve health from further decline.

Custodial Care includes:

1. care given to a patient who:
   a. is mentally or physically disabled: and
   b. needs a protected, monitored or controlled environment or assistance to support the basics of daily living, in an institution or at home, and
   c. may be ventilator dependent or require routine catheter maintenance.
2. health-related Services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific Services are considered to be skilled Services), as opposed to improving that function to an extent that might allow for a more independent existence;
3. Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively, such as recording pulse, temperature, and respiration; supervising medications that can usually be self-administered; or administration and monitoring of feeding systems.

**Deductible:** An amount which the Covered Person must pay each calendar year for Covered Services before benefits are payable by the Contract.

**Durable Medical Equipment:** Equipment and supplies which treat an Illness or Injury, to improve the functioning of a particular body part, or to prevent further deterioration of the patient's medical condition. Such equipment and supplies must be designed and used primarily to treat conditions which are medical in nature, and able to withstand repeated use. Durable Medical Equipment includes such items as prosthetic devices that replace a limb or body part, orthopedic braces, crutches and wheelchairs. It does not include sporting or athletic equipment or items purchased for the convenience of the family.

**Eligibility Date:** The date an employee's coverage becomes effective on the Group Contract after meeting the eligibility requirements, including any applicable probationary period indicated in the Group's Master Group Application.

**Eligibility Waiting Period:** Applicable to new Subscribers only, the period between the first day of employment and the first date of coverage under the Contract. This period may include the probationary period indicated in the Master Group Application.

**Eligible Dependent:**

1. The spouse of the Subscriber unless the marriage has been ended by a legal, effective decree of dissolution, divorce or separation.
2. Children to age 26.

"Children" means the Subscriber's biological and adopted sons and daughters, a grandchild who lives with the Subscriber in a regular child-parent relationship where the grandchild receives no support or maintenance from the parent and where the Subscriber is a court-appointed guardian of the grandchild, a stepchild (i.e. the son or daughter of the Subscriber's current spouse), or a child, other than a grandchild or stepchild, for whom the Subscriber is a court-appointed guardianship, but does not include a foster child.

3. Reaching age 26 will not end the covered child's coverage under the plan as long as the child is, and remains both incapable of self-sustaining employment, or of returning to school as a full-time student, by reason of mental or physical handicap; and dependent upon the Subscriber for support and maintenance.

Proof of the requirements stated above must be received from the Subscriber within 31 days of the child's reaching age 26 and after that, as required (but not more often than yearly after two years of such handicap). Determination of eligibility under this provision will be made by BCBSNE. Any extended coverage under this paragraph 3. will be subject to all other provisions of the Contract.

**Emergency Care:** Any Covered Services provided in a Hospital emergency room setting.

**Emergency Medical Condition:** A medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including, but not limited to, severe pain that a prudent lay person, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in: 1) placing the health of the person afflicted with such condition in serious jeopardy or, in the case of a behavioral condition, placing the health of such persons or others in serious jeopardy, 2) serious impairment to such person's bodily functions, 3) serious impairment of any bodily organ or part of such person, or 4) serious disfigurement of such person.

**Group:** The employer or association providing health coverage under the Contract.

**Hospice:** A program of care provided for persons diagnosed as terminally ill and their families.

**Hospital:** A Hospital is an institution or facility duly Licensed by the State of Nebraska or the state in which it is located, which provides medical, surgical, diagnostic and treatment Services with 24 hour per day nursing Services,to two or more nonrelated persons with an Illness, Injury or Pregnancy, under the supervision of a staff of Physicians Licensed to practice medicine and surgery.

**Illness:** A condition which deviates from or disrupts normal bodily functions or body tissues in an abnormal way, and is manifested by a characteristic set of signs or symptoms.

**Independent Laboratory:** A freestanding facility offering radiology and pathology Services which is not part of a Hospital and is Licensed by the proper authority in the state in which it is located.

**Injury:** Physical harm or damage inflicted to the body from an external force.

**In-network Hospital, Physician Or Other Provider:** A Licensed practitioner of the healing arts, a Licensed facility or other qualified provider of health care Services who has contracted with Us to provide Services as a part of a Preferred Provider network in Nebraska.

**Inpatient:** A patient admitted to a Hospital or other institutional facility for bed occupancy to receive Services consisting of active medical and nursing care to treat conditions requiring continuous nursing intervention of such an intensity that it cannot be safely or effectively provided in any other setting.

**Investigative:** A technology, a drug, biological product, device, diagnostic, treatment or procedure that has not been Scientifically Validated. We will determine whether a technology is Investigative.

**Late Enrollee:** An individual who does not enroll for coverage during the first period in which he or she is eligible, or during a Special Enrollment Period.

**Licensure (Licensed):** Permission to engage in a health profession that would otherwise be unlawful in the state where Services are performed, and which is granted to individuals who meet prerequisite qualifications. Licensure protects a given scope of practice and the title.

**Long Term Acute Care (LTAC):** Specialized acute Hospital care for medically complex patients who are critically ill, have multi-system complications and/or failures, and require hospitalization in a facility offering specialized treatment programs and aggressive clinical and therapeutic intervention on a 24-hour/seven-day-a-week basis.

**Master Group Application:** A form completed by the Group which indicates the health coverage options and provisions chosen by the Group.

**Medicaid:** Grants to states for Medical Assistance Programs, Title XIX of the Social Security Act, as amended.

**Medically Necessary Or Medical Necessity:** Health care Services ordered by a Treating Physician exercising prudent clinical judgment, provided to a Covered Person for the purposes of prevention, evaluation, diagnosis or treatment of that Covered Person's Illness, Injury or Pregnancy, that are:

1. consistent with the prevailing professionally recognized standards of medical practice; and, known to be effective in improving health care outcomes for the condition for which it is recommended or prescribed. Effectiveness will be determined by validation based upon scientific evidence, professional standards and consideration of expert opinion; and
2. clinically appropriate in terms of type, frequency, extent, site and duration for the prevention, diagnosis or treatment of the Covered Person's Illness, Injury or Pregnancy. The most appropriate setting and the most appropriate level of Service is that setting and that level of Service, considering the potential benefits and harms to the patient. When this test is applied to the care of an Inpatient, the Covered Person's medical symptoms and conditions must require that treatment cannot be safely provided in a less intensive medical setting; and
3. not more costly than alternative interventions, including no intervention, and are at least as likely to produce equivalent therapeutic or diagnostic results as to the prevention, diagnosis or treatment of the patient's Illness, Injury or Pregnancy, without adversely affecting the Covered Person's medical condition; and
4. not provided primarily for the convenience of the following:
   a. the Covered Person;
   b. the Physician;
   c. the Covered Person 's family;
   d. any other person or health care provider; and
5. not considered unnecessarily repetitive when performed in combination with other prevention, evaluation, diagnoses or treatment procedures.

BCBSNE will determine whether Services are Medically Necessary. Services will not automatically be considered Medically Necessary because they have been ordered or provided by a Treating Physician.

**Medicare:** Health Insurance for the Aged and Disabled, Title XVIII of the Social Security Act, as amended.

**Membership Unit:** The category of persons to be provided benefits, pursuant to the Subscriber's enrollment. The Subscriber may select one of the following types of Membership Units:

1. Single Membership: This option provides benefits for Covered Services provided to the Subscriber only.
2. Subscriber-Spouse Membership: This option provides benefits for Covered Services provided to the Subscriber and his or her spouse.
3. Single Parent Membership: This option provides benefits for Covered Services provided to the Subscriber and his or her Eligible Dependent children, but not to a spouse.
4. Family Membership: This option provides benefits for Covered Services provided to the Subscriber and his or her Eligible Dependents.

Other Membership Units may be chosen by the Group and will be defined in the Master Group Application. If other Membership Units are chosen, a Subscriber may select from those Membership Units as defined by the Group.

**Mental Health Services Provider:** A qualified Physician, Licensed psychologist, Licensed Special Psychologist, and Licensed Mental Health Practitioners are payable providers under the Contract. A Mental Health Practitioner may also be a Licensed Professional Counselor or a Licensed Clinical Social Worker who is duly Certified/Licensed for such practice by state law. It also includes, for purposes of the Contract, Auxiliary Providers supervised, and billed for, by a professional as permitted by state law. All mental health Services must be provided under appropriate supervision and consultation requirements as set forth by state law.

**Licenses Psychologist:** Psychologist shall mean a person Licensed to engage in the practice of psychology in this or another jurisdiction. The terms Certified, registered, chartered, or any other term chosen by a jurisdiction to authorize the autonomous practice of psychology shall be considered equivalent terms.

**Licensed Special Psychologist:** A person who has a doctoral degree in psychology from an institution of higher education accredited by the American Psychological Association but who is not Certified in clinical psychology. Such person shall be issued a special License to practice psychology that continues to require supervision by a Licensed Psychologist or qualified Physician for any practice that involves major mental and emotional disorders. This psychologist may provide mental health Services without supervision.

**Licensed Mental Health Practitioner:** A person Licensed to provide treatment, assessment, psychotherapy, counseling, or equivalent activities to individuals, families or groups for behavioral, cognitive, social, mental, or emotional disorders, including interpersonal or personal situations. Mental health practice shall include the initial assessment of organic mental or emotional disorders (as defined by state law), for the purpose of referral to, or consultation with a qualified Physician or a Licensed Psychologist.

Mental health practice shall not include the practice of psychology or medicine, prescribing drugs or electroconvulsive therapy, treating physical disease, Injury, or deformity, diagnosing major Mental Illness or disorder except in consultation with a qualified Physician or a Licensed Psychologist, measuring personality or intelligence for the purpose of diagnosis or treatment planning, using psychotherapy with individuals suspected of having major mental or emotional disorders except in consultation with a qualified Physician or Licensed Psychologist, or using psychotherapy to treat the concomitants of organic Illness except in consultation with a qualified Physician or Licensed Psychologist.

**Mental Illness:** A pathological state of mind producing clinically significant psychological or physiological symptoms (distress) together with impairment in one or more major areas of functioning (disability) wherein improvement can reasonably be anticipated with therapy, and which is a condition listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM IV or any subsequent version).

**Noncovered Services:** Services that are not payable under the Contract.

**On-site or Host Plan:** A Blue Cross and/or a Blue Shield Plan in another Blue Cross and Blue Shield Association Service Area, which administers Claims through the BlueCard Program for Nebraska Covered Persons residing or traveling in that Service Area.

**Out-of-network Allowance:** An amount BCBSNE uses to calculate payment for Covered Services to an Out-of-network Provider. This amount will be based on the Contracted Amount for Nebraska Providers or an amount determined by the On-site Plan for out-of-area Providers.

**Out-of-network Provider:** A provider of health care Services who has not contracted with BCBSNE to provide Services as a part of a Preferred Provider network in Nebraska.

**Outpatient:** A person who is not admitted for Inpatient care, but is treated in the Outpatient department of a Hospital, in an observation room, in an Ambulatory Surgical Facility, Urgent Care Facility, a Physician's office, or at home. Ambulance Services are also considered Outpatient.

**Outpatient Program:** An organized set of resources and Services for a Substance Abusive or mentally ill population, administered by a Certified provider, which is directed toward the accomplishment of a designed set of objectives. Day treatment, partial care and Outpatient Programs which provide primary treatment for Mental Illness or Substance Dependence and Abuse must be provided in a facility which is Licensed by the Department of Health and Human Services Regulation and Licensure, (or equivalent state agency) or accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the Commission on the Accreditation of Rehabilitation Facilities (CARF).

This definition does not include programs of co-dependency, family intervention, employee assistance, probation, prevention, educational or self-help programs, or programs which treat obesity, gambling, or nicotine addiction. It also does not include Residential Treatment Programs or day rehabilitation programs for Mental Illness, or Residential Treatment Programs, halfway house or methadone maintenance programs for Substance Dependence and Abuse. Benefits will not be provided for programs or services ordered by the Court that are not Medically Necessary as determined by BCBSNE.

**Participating Provider:** A Licensed practitioner of the healing arts, or qualified provider of health care Services, who is a Participating Provider in the BlueCard Program.

**Physical Rehabilitation:** The restoration of a person who was disabled as the result of an Injury or an acute physical impairment to a level of function which allows that person to live as independently as possible. A person is disabled when such person has physical disabilities and needs active assistance to perform the normal activities of daily living, such as eating, dressing, personal hygiene, ambulation and changing body position.

**Physician:** Any person holding a License and duly authorized to practice medicine and surgery.

**Plan Administrator** The administrator of the Plan as defined by ERISA.

**Postservice Claim:** Any Claim which is not a Preservice Claim. The information required to process a Postservice Claim includes: first and last name of the claimant, identification number, date of Service, itemized statement describing the service, the diagnosis, the amount charged for the care and the provider's full name.

**Preferred Provider Organization:** A panel of Hospitals, Physicians and other health care providers who belong to a network of Preferred Providers, which agrees to more effectively manage health care costs.

**Preferred Provider:** A health care provider (Hospital, Physician or other health care provider) who has contracted to provide Services as a part of the network in Nebraska, or if in another state, who is a Preferred Provider with the BlueCard Program PPO network.

**Pregnancy:** Includes obstetrics, abortions, threatened abortions, miscarriages, premature deliveries, ectopic pregnancies, cesarean sections or other conditions or complications caused by Pregnancy. For purposes of this Plan, Pregnancy also includes a condition or complication caused by Pregnancy, but separate from, and not part of the Pregnancy. It occurs prior to the end of the Pregnancy, and is adversely affected by it. Postpartum depression and similar diagnoses are not considered complications of Pregnancy.

**Preservice Claim:** Any Claim for a benefit under the Contract with respect to which the terms of the Contract require approval of the benefit in advance of obtaining medical care and failure to do so will cause benefits to be denied or reduced.

**Pre-existing Condition:** A condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the first day of coverage, or if there is an Eligibility Waiting Period, the first day of such Waiting Period. A Pre-existing Condition does not include a Pregnancy. Genetic information shall not be treated as a condition for which a Pre-existing Condition Waiting Period must be imposed in the absence of a diagnosis of a condition related to such information.

**Primary Care Physician:** A Physician who has a majority of his or her practice in the fields of internal or general medicine, obstetrics/gynecology, general pediatrics or family practice.

**Private Duty Nursing:** Continuous nursing care (beyond the accepted BCBSNE definition of a skilled nursing visit) in homes or facilities. Private Duty Nursing is primarily non-skilled in nature but may include skilled Services and is generally provided to chronically ill patients over the long term.

**Qualified Beneficiary:** Under COBRA, an individual who must in certain circumstances, be offered the opportunity to elect COBRA coverage under a group health plan. The term generally includes a covered employee's spouse or dependent children who were covered under the group health plan on the day before a Qualifying Event, as well as a covered employee who was covered under the group health plan on the day before a Qualifying Event that is a termination of employment or a reduction in hours. The term also includes a child born to or adopted by a covered employee during a period of COBRA coverage.

**Qualifying Event:** The circumstances that entitle persons to elect COBRA coverage.

**Residential Treatment Program:** Services or a program for persons with behavioral health disorders organized and staffed to provide both general and specialized nonhospital-based interdisciplinary Inpatient services 24 hours a day, seven days a week with oversight by a Physician. Residential treatment may be provided in freestanding, nonhospital-based facilities or in units of larger entities, such as a wing of a Hospital. Residential Treatment Programs may include nonhospital addiction treatment centers, intermediate care facilities, psychiatric treatment centers, or other nonmedical settings.

**Schedule of Benefits:** A summarized personal document which provides information such as Copayments, Deductibles, percentages payable, special benefits, maximums and limitations of coverage, and the type of Membership Unit selected. This term also includes the Schedule of Benefits Summary.

**Scientifically Validated:** A technology, a drug, biological product, device, diagnostic, treatment or procedure is Scientifically Validated if it meets all of the factors set forth below:

1. Technologies, drugs, biological products, devices and diagnostics must have final approval from the appropriate government regulatory bodies. A drug or biological product must have final approval from the Food and Drug Administration (FDA). A device must have final approval from the FDA for those specific indications and methods of use that is being evaluated. FDA or other governmental approval is only one of the factors necessary to determine Scientific Validity.
2. The Scientific Evidence must permit conclusions concerning the effect of the technology on health outcomes. The evidence should consist of well-designed and well-conducted investigations published in peer-reviewed journals. The quality of the body of studies and the consistency of the results are considered in evaluating the evidence.

   The evidence should demonstrate that the technology can measure or alter the physiological changes related to a disease, injury, Illness or condition. In addition there should be evidence based on established medical facts that such measurement or alteration affects the health outcomes.

   Opinions and evaluations by national medical associations, consensus panels or other technology evaluation bodies are evaluated according to the scientific quality of the supporting evidence and rationale. Our evidence includes, but is not limited to: Blue Cross and Blue Shield Association Technology Evaluation Center technology evaluations; Hayes Directory of New Medical Technologies' Status; Centers for Medicare and Medicaid Services (CMS) Technology Assessments and United States Food and Drug Administration (FDA) approvals.

3. The technology must improve the health outcome.
4. The technology must improve the health outcome as much as or more than established alternatives.
5. The improvement must be attainable outside the investigational settings.

BCBSNE will determine whether a technology is Scientifically Validated.

**Services:** Hospital, medical or surgical procedures, treatments, drugs, supplies, Durable Medical Equipment, or other health, mental health or dental care, including any single service or combination of such services.

**Service Area:** The geographic area in which a Blue Cross and Blue Shield plan is authorized to use the Blue Cross and Blue Shield brands pursuant to its license agreement with Blue Cross and Blue Shield Association.

**Skilled Nursing Care:** A level of care that includes services that can only be performed safely and correctly by either a registered nurse or a Licensed practical nurse.

**Special Enrollee:** An eligible person who enrolls for coverage during a Special Enrollment Period, as further described in the Contract.

**Special Enrollment Period:** A period of time during which a Special Enrollee is allowed to enroll because of a loss of coverage, an adoption, placement for adoption, birth or marriage, without being considered a Late Enrollee, subject to certain criteria as further described in the Contract.

**Specialist:** A Physician who has a majority of his or her practice in fields other than internal or general medicine, obstetrics/gynecology, general pediatrics or family practice.

**Subscriber:** An individual who enrolls for health coverage and is named on an identification card issued pursuant to the Contract, and who is:

1. An employee hired by an employer who makes application for health coverage for its employee.
2. A member of an association that makes application for health coverage for its members.
3. A retiree qualified to receive benefits as defined in the Master Group Application.

**Substance Dependence and Abuse:** Alcoholism, drug abuse and nicotine dependence or addiction.

**Substance Dependence And Abuse Treatment Center:** A facility Licensed by the Department of Health and Human Services Regulation and Licensure, (or equivalent state agency), accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the Commission on the Accreditation of Rehabilitation Facilities (CARF). Such facility is not Licensed as a Hospital, but provides Inpatient or Outpatient care, treatment, Services, maintenance, accommodation or board in a group setting primarily and exclusively for individuals having any type of Substance Dependence or Abuse.

**Treating Physician:** A Physician who has personally evaluated the patient. This may include a Physician or oral surgeon, a Certified nurse midwife, a Certified nurse practitioner or Certified Physician's assistant, within the practitioner's scope of practice.

**Urgent Care Claim:** A Claim for medical care or treatment for which the application of time periods for making non-urgent care determinations:

1. could seriously jeopordize the life of health of the claimant or the ability of the claimant to regain maximum function; or
2. would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Claim.

**Urgent Care Facility:** A facility, other than a Hospital, that provides covered health Services that are required to prevent serious deterioration of Your health, and that are required as a result of an unforeseen sickness, Injury or the onset of acute or severe symptoms.

**Waiting Period for Pre-existing Conditions:** The period of time during which no benefit payment will be made for Services provided for a Pre-existing Condition.

**We, Our or Us:** Blue Cross and Blue Shield of Nebraska (BCBSNE).

**Work-hardening Therapy:** Physical therapy or similar Services provided primarily for strengthening an individual for purposes of his or her employment.

# AMENDMENT

**THIS SECTION INCLUDES AMENDMENTS TO THE PREVIOUS SECTIONS OF THIS DOCUMENT WHICH ARE SPECIFIC TO YOUR GROUP HEALTH PLAN. PLEASE REVIEW THIS SECTION CAREFULLY.**

## ELIGIBILITY

**Who's Eligible**
The Plan's eligibility requirements are as follows: an employee working a minimum of 30 hours per week on a regular calendar year basis will be eligible for coverage. Employees will either be effective the first of the month following their date of hire, or the first of the month following a 90-day probationary period (90 consecutive days), as determined by the City of Lincoln.

**Initial Enrollment**
The application for coverage (for both the employee and his/her eligible dependents) must be submitted to the City County Personnel Department within 31 days of eligibility; otherwise, late enrollment provisions will apply.

### Special Enrollment

A period of 31 days is allowed for:

- enrollment of eligible persons due to marriage, birth, adoption or placement for adoption;
- enrollment of eligible persons not previously covered under this plan due to having had other coverage at the time it was previously offered, and who have lost that other coverage due to:
  - exhaustion of COBRA continuation coverage; or
  - a loss of eligibility, including loss due to death, divorce, legal separation, termination of employment or reduction in hours, or due to the plan no longer offering benefits to the class of individuals that includes the person (when the other coverage was not COBRA); or
  - moving out of the service area of an HMO or other arrangement that only provides benefits to individuals who reside, live or work in the service area; or
  - the lifetime limit on all benefits is exhausted; or
  - the employer ceasing to make contribution for the other coverage (when the other coverage was not COBRA).

A special enrollment period of 60 days is allowed for:

- Enrollment of eligible persons who were covered under Medicaid or State Child Health Insurance Program (SCHIP), which has been terminated due to loss of eligibility.
- Enrollment of eligible persons who have become eligible for premium assistance for this group health plan coverage under Medicaid or SCHIP.

The Subscriber must enroll (or already be enrolled ) in order to enroll his or her dependents in this plan. In the case of a marriage, birth or adoption, a Subscriber who is eligible, but who has not previously enrolled, may enroll at this time with or without the newly Eligible Dependent. Likewise an eligible spouse who has not previously enrolled, may enroll as a Special Enrollee with or without a new dependent child. Please contact your Human Resource Department for additional information.

**Late Enrollment**
A "late enrollee" is defined as a subscriber or dependent who does not timely enroll, or does not enroll for coverage within the first period in which he or she is eligible to enroll. Late enrollment is only allowed during the open enrollment period. A person who enrolls for coverage during a "special enrollment period" is not considered a "late enrollee".

### Open Enrollment

Eligible persons who did not enroll for coverage during the initial enrollment period or special enrollment period ("late enrollee"), may do so during an open enrollment period. For additional information on open enrollment, please contact your Human Resource Department.

### Adding A Dependent

Dependents cannot enroll unless you, the eligible employee, are covered under the Plan. In order to add a dependent, he or she must meet the definition of an Eligible Dependent.

**Effective Date of Coverage**
Provided that an appropriate membership option is in place and, if applicable, any additional premium is paid, the effective date of coverage will be as follows:

**Marriage:** The first day of the month following receipt of the enrollment form or the date the group advises BCBSNE to make coverage effective.

**Newborn Children:** Coverage will be provided from the date of birth for a child who meets the definition of an Eligible Dependent provided that the group is notified of the birth of the child and enrollment is made within 31 days of the birth.

For additional information on adding newborn children, including any requirements that are specific to your group, please contact your Human Resource Department.

**Adopted Children:** Coverage will be provided from the earlier of the date the child is placed for adoption or the date a court order grants custody to the adoptive parents provided that any enrollment procedures required by the group are met. You must enroll the child within 31 days of the adoption or placement.

*NOTE: When adding a dependent, you must be enrolled under a membership option that provides coverage for your dependents.*

## WHEN COVERAGE ENDS

Coverage under your group health plan will terminate on the earliest of the following dates:

- The date the entire Contract is terminated.
- The date the City County Personnel Department advises BCBSNE to terminate your coverage.
- The date the City County Personnel Department advises BCBSNE to terminate the coverage of a dependent because the dependent has ceased to be eligible under the health plan.
- The last day of the month in which BCBSNE receives a request from you to terminate coverage or the date you requested in the notice, if later.
- The last date for which premium is paid.

Unless otherwise specified for your health plan, the termination date will be the date of the event. Please contact your employer or Blue Cross and Blue Shield of Nebraska for information.

## GENERAL LEGAL PROVISIONS

Workers' Compensation is amended to add:

If payment is received by the Covered Person for services provided for Illness or Injury arising out of and/or in the course of employment, reimbursement to the Plan will be required without reduction for attorney fees, costs or other deductions.

Claims administration by:

Blue Cross and Blue Shield of Nebraska is an independent licensee of the Blue Cross and Blue Shield Association.

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