

Schedule of Benefits Summary

Group Name: Sarpy County

Effective Date: January 01,2016

Payment for Services	In-network Provider	Out-of-network Provider
<p>Covered Services are reimbursed based on the Allowable Charge. Blue Cross and Blue Shield of Nebraska In-network Providers have agreed to accept the benefit payment as payment in full, not including Deductible, Coinsurance and/or Copayment amounts and any charges for non-covered services, which are the Covered Person’s responsibility. That means that In-network providers, under the terms of their contract with Blue Cross and Blue Shield, can’t bill for amounts over the Contracted Amount. Out-of-network Providers can bill for amounts over the Out-of-network Allowance.</p>		
<p>Deductible (the amount the Covered Person pays each Calendar Year for Covered Services before the Coinsurance is payable)</p> <ul style="list-style-type: none"> Individual Family (Embedded*) 	<p>\$4,000 \$8,000</p>	<p>\$8,000 \$16,000</p>
<p>Coinsurance (the percentage amount the Covered Person must pay for most Covered Services after the Deductible has been met)</p> <ul style="list-style-type: none"> Covered Person Pays 	<p>30%</p>	<p>50%</p>
<p>Out-of-pocket Limit (does not include premium, penalty and amounts not covered by the plan)</p> <ul style="list-style-type: none"> Individual Family 	<p>\$6,000 \$12,000</p>	<p>\$11,900 \$23,800</p>
<p>Once the annual Out-of-pocket Limit is reached, most Covered Services are payable by the plan at 100% for the rest of the Calendar Year.</p>		
<p>In-network and Out-of-network Deductible and Out-of-pocket Limits are separate and do not cross accumulate. All other limits (days, visits, sessions, dollar amounts, etc.) do cross accumulate between In-network and Out-of-network, unless noted differently.</p>		
<p>*Embedded – If you have single coverage, you only need to satisfy the individual Deductible and Out-of-pocket Limit amounts. If you have family coverage, no one family member contributes more than the individual amount. Family members may combine their covered expenses to satisfy the required family Deductible and Out-of-pocket amounts.</p>		

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

- Physician Office
- Telehealth Services
- Urgent Care Facility
- Emergency Care
- Allergy Injections
- Ambulance
- Prescription Drugs

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

Out-of-pocket Limit includes:

- Deductible
- Coinsurance
- Medical Copays
- Prescription Drug Copays

Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Physician Office <ul style="list-style-type: none"> Primary Care Physician Office Visit Specialist Physician Office Visit Other Covered Services and supplies provided in the Physician’s Office (with or without an office visit billed) 	\$30 Copay \$75 Copay Applicable office visit Copay	Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance
<ul style="list-style-type: none"> Allergy Injections and Serum (only one copay applies per day per provider) 	\$10 Copay	Deductible and Coinsurance
<ul style="list-style-type: none"> Other Injections 	Deductible and Coinsurance	Deductible and Coinsurance
<p>Primary Care Physician is a physician who has a majority of his or her practice in internal or general medicine, obstetrics/gynecology, general pediatrics or family practice. A physician assistant is covered in the same manner as a Primary Care Physician.</p> <p>Specialist Physician is a physician who is not a Primary Care Physician.</p> <p>Office Visit Benefits for Primary Care and Specialist Physician Office Visit include office visits (including the initial visit to diagnose pregnancy) and consultations.</p> <p>Other Covered Services not part of the Physician Office Benefit (Refer to the appropriate category for benefit information) include: Allergy Injections & Serum; Other Injections; Advanced Diagnostic Imaging (CT, MRI, MRA, MRS, PET & SPECT scans and other Nuclear Medicine); Pregnancy Services; Preventive Services; Radiation Therapy & Chemotherapy; Surgery & Anesthesia; Therapy & Manipulations; Durable Medical Equipment; Sleep Studies; Biofeedback; Psychological Evaluations, Assessments, and Testing.</p>		
Telehealth Services (by a designated provider)	\$10 Copay	Not Covered
Convenient Care/Retail Clinics (Quick Care)	Same as a Primary Care Physician	Same as a Primary Care Physician
Urgent Care Facility Services (a single copay applies to each urgent care visit)	\$45 Copay	Deductible and Coinsurance
Emergency Care Services (services received in a Hospital emergency room setting) <ul style="list-style-type: none"> Facility Professional Services (Copayment is waived if admitted to the hospital within 24 hours for the same diagnosis)	\$250 Copay then Coinsurance Coinsurance	In-network level of benefits In-network level of benefits
Outpatient Hospital or Facility Services Services such as surgery, laboratory and radiology, cardiac and pulmonary rehabilitation, observation stays, and other services provided on an outpatient basis	Deductible and Coinsurance	Deductible and Coinsurance
Inpatient Hospital or Facility Services Charges for room and board, diagnostic testing, rehabilitation and other ancillary services provided on an inpatient basis	Deductible and Coinsurance	Deductible and Coinsurance

Preventive Services	In-network Provider	Out-of-network Provider
Preventive Services <ul style="list-style-type: none"> Affordable Care Act (ACA) required preventive services (may be subject to limits that include, but are not limited to, age, gender, and frequency) ACA required covered preventive services (outside of limits) Other covered preventive services not required by ACA 	Plan Pays 100% Plan Pays 100% Plan Pays 100%	Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance
Immunizations <ul style="list-style-type: none"> Pediatric (up to age 7) Age 7 and older Related to an illness 	Plan Pays 100% Plan Pays 100% Same as any other illness	Coinsurance Deductible and Coinsurance Same as any other illness

Mental Illness and/or Substance Dependence and Abuse covered services	In-network Provider	Out-of-network Provider
Inpatient Services	Deductible and Coinsurance	Deductible and Coinsurance
Outpatient Services <ul style="list-style-type: none"> Office Services All Other Outpatient Items & Services 	\$30 Copay Deductible and Coinsurance	Deductible and Coinsurance Deductible and Coinsurance
Emergency Care Services (services received in a Hospital emergency room setting) <ul style="list-style-type: none"> Facility Professional Services (Copayment is waived if admitted to the hospital within 24 hours for the same diagnosis)	\$250 Copay then Coinsurance Coinsurance	In-network level of benefits In-network level of benefits

Other Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Acupuncture	Not Covered	Not Covered
Advanced Diagnostic Imaging (CT, MRI, MRA, MRS, PET & SPECT scans and other Nuclear Medicine)	Deductible and Coinsurance	Deductible and Coinsurance
Ambulance (to the nearest facility for appropriate care) <ul style="list-style-type: none"> • Ground Ambulance • Air Ambulance 	\$100 Copay \$100 Copay	In-network level of benefits Deductible and Coinsurance (In-network level of benefits if due to an emergency)
Biofeedback	Deductible and Coinsurance	Deductible and Coinsurance
Cochlear implants	Deductible and Coinsurance	Deductible and Coinsurance
Dermatological Services	Same as any other illness	Same as any other illness
Diabetic Services Services include education, self-management training, podiatric appliances and equipment.	Deductible and Coinsurance	Deductible and Coinsurance
Drugs Administered in an Outpatient Setting (such as home, physician office and other outpatient settings)	Not Covered	Not Covered
<p>(NOTE: Some prescription drugs and covered services administered in an outpatient setting, other than a hospital emergency room, are only payable under the Prescription Drug category. A list of these drugs and covered services is available on the website www.nebraskablue.com or by contacting the Member Services Department.)</p>		
Durable Medical Equipment and Supplies (including Prosthetics) (rental or purchase, whichever is least costly; rental shall not exceed the cost of purchasing)	Deductible and Coinsurance	Deductible and Coinsurance
Eye Glasses or Contact Lenses 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 Home Health Aide (limited to 60 days per Calendar Year) Skilled Nursing Care (limited to 8 hours per day)	Deductible and Coinsurance	Deductible and Coinsurance
Home Infusion Therapy	Deductible and Coinsurance	Deductible and Coinsurance
Hospice Services	Deductible and Coinsurance	Deductible and Coinsurance
Independent Laboratory <ul style="list-style-type: none"> • Diagnostic • Preventive 	Plan Pays 100% Same as Preventive Services In-network level of benefits	In-network level of benefits Same as Preventive Services In-network level of benefits
Infertility <ul style="list-style-type: none"> • Services to diagnose • Treatment to promote fertility 	Same as any other illness Not Covered	Same as any other illness Not Covered
Nicotine Addiction <ul style="list-style-type: none"> • Medical services and therapy • Nicotine addiction classes & alternative therapy, such as acupuncture 	Same as Substance Dependence and Abuse Not Covered	Same as Substance Dependence and Abuse Not Covered
Obesity <ul style="list-style-type: none"> • Non-surgical treatment • Surgical Treatment 	Not Covered Not Covered	Not Covered Not Covered
Oral Surgery and Dentistry Services such as incision and drainage of abscesses and excision of tumors and cysts. Dental treatment when due to an accidental injury to naturally healthy teeth (treatment related to accidents must be provided within 12 months of the date of injury).	Deductible and Coinsurance	Deductible and Coinsurance
Organ and Tissue Transplantation	Deductible and Coinsurance	Deductible and Coinsurance
Ostomy Supplies	Deductible and Coinsurance	Deductible and Coinsurance

Other Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Physician Professional Services Inpatient and Outpatient services, such as, surgery, surgical assistant, anesthesia, inpatient hospital visits and other non-surgical services	Deductible and Coinsurance	Deductible and Coinsurance
Pregnancy, Maternity and Newborn Care <ul style="list-style-type: none"> • Pregnancy and maternity (Payment for prenatal and postnatal care is included in the payment for the delivery) • Newborn care NOTE: Newborns are covered at birth, subject to the plan’s enrollment provisions.	Deductible and Coinsurance Deductible and Coinsurance	Deductible and Coinsurance Deductible and Coinsurance
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 (must follow within 90 days of discharge from acute hospitalization)	Deductible and Coinsurance	Deductible and Coinsurance
Rehabilitation Services <ul style="list-style-type: none"> • Cardiac rehabilitation(limited to 18 sessions per diagnosis during the preceding four months of certain cardiac diagnosis) • Pulmonary Rehabilitation (Chronic lung disease is limited to 18 sessions per diagnosis, not to exceed 18 sessions per Calendar Year. Lung, heart-lung transplants and lung volume are limited to 18 sessions following referral and prior to surgery plus 18 sessions within six months of discharge from hospital following surgery.) 	Deductible and Coinsurance Deductible and Coinsurance	Deductible and Coinsurance Deductible and Coinsurance
Renal Dialysis	Deductible and Coinsurance	Deductible and Coinsurance
Respiratory Care (limited to 60 days per Calendar Year)	Deductible and Coinsurance	Deductible and Coinsurance

Other Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Sexual Dysfunction	Not Covered	Not Covered
Skilled Nursing Facility (limited to 60 days per Calendar Year)	Deductible and Coinsurance	Deductible and Coinsurance
Sleep Studies	Deductible and Coinsurance	Deductible and Coinsurance
Temporomandibular and Craniomandibular Joint Disorder	Deductible and Coinsurance	Deductible and Coinsurance
Therapy & Manipulations <ul style="list-style-type: none"> • Physical, occupational or speech therapy services, chiropractic or osteopathic physiotherapy (combined limit to 60 sessions per Calendar Year) • Chiropractic or osteopathic manipulative treatments or adjustments (combined limit to 30 sessions per Calendar Year) 	Deductible and Coinsurance Deductible and Coinsurance	Deductible and Coinsurance Deductible and Coinsurance
Vision Exams <ul style="list-style-type: none"> • Diagnostic (to diagnose an illness) • Preventive (routine exam including refraction) limited to one exam per Calendar Year 	See Physician Office Services See Preventive Services	See Physician Office Services See Preventive Services
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 (the amount the Covered Person pays each Calendar Year for Covered Prescription Drugs before the Prescription Drug Copayments and/or Coinsurance are applicable) <ul style="list-style-type: none"> • Individual • Family 		\$100 \$200
Retail – per 30-day supply <ul style="list-style-type: none"> • Generic drugs (including non-formulary contraceptives) • Formulary Brand Name Drugs • Non-formulary Brand Name Drugs 	\$10 Copay \$40 Copay \$75 Copay	\$10 Copay + 25% Penalty \$40 Copay + 25% Penalty \$75 Copay + 25% Penalty
NOTE: A 90-day supply is available at an Extended Supply Network pharmacy subject to 3 copays		
Mail order – per 90-day supply <ul style="list-style-type: none"> • Generic drugs (including non-formulary contraceptives) • Formulary Brand Name Drugs • Non-formulary Brand Name Drugs 	\$30 Copay \$120 Copay \$225 Copay	Not Covered Not Covered Not Covered
Specialty drugs (specialty drugs must be purchased through a designated specialty pharmacy after two fills)	\$100 Copay	Not Covered
Contraceptives <ul style="list-style-type: none"> • Formulary <ul style="list-style-type: none"> - Generic - Brand Name • Non-formulary <ul style="list-style-type: none"> - Generic - Brand Name 	Plan Pays 100% Plan Pays 100%	25% Penalty 25% Penalty
	Same as any other Generic Drugs Same as any other Non-formulary Brand Name	
Infertility FDA approved prescription drugs to promote fertility	Not Covered	Not Covered
Nicotine Addiction FDA approved prescription drugs and over-the-counter nicotine addiction drugs and deterrents	Plan Pays 100%	25% Penalty
Obesity FDA approved prescription drugs	Not Covered	Not Covered

Please note: This Schedule of Benefits Summary is intended to provide you with a brief overview of your benefits. It is not a contract and should not be regarded as one. For more complete information about your plan, including benefits, exclusions and contract limitations, please refer to the master group contract. In the event there are discrepancies between this document and the contract, the terms and conditions of the contract will govern.