

Schedule of Benefits Summary

Group Name: Sarpy County

Effective Date: July 01, 2012

Payment for Services	In-Network Provider	Out-of-Network Provider
<p>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.</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>Coinsurance Limit (the maximum Coinsurance the Covered Person must pay each Calendar Year.) (this amount does not include the deductible or copayments)</p> <ul style="list-style-type: none"> Individual Family (Embedded*) 	<p>\$450 \$900</p>	<p>\$3,900 \$7,800</p>
<p>Deductible and Coinsurance Limit (combination of the deductible and coinsurance amounts only; does not include any copayments or amounts not covered by the plan)</p> <ul style="list-style-type: none"> Individual Family 	<p>\$4,450 \$8,900</p>	<p>\$11,900 \$23,800</p>
<p>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.</p>		
<p>*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.</p>		

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

- Physician Office
- Urgent Care Facility
- Emergency Care
- Allergy Injections

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 <ul style="list-style-type: none"> Primary Care Physician Office Visit Specialist Physician Office Visit Other Covered Services and supplies provided in the Physicians Office (with or without an office visit billed) 	\$30 Copay \$60 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 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.</p> <p>Specialist Physician benefits include the office visits provided by 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>		
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)	\$30 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)	\$100 Copay then Coinsurance Coinsurance	In-Network level of benefits In-Network level of benefits
Outpatient Hospital or Facility Services 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 Service 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"> Health Care Reform (HCR) required preventive services (may be subject to limits that include, but are not limited to, age, gender, and frequency) HCR required covered preventive services (outside of limits) Other covered preventive services not required by HCR 	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"> Related to an illness Pediatric (up to age 7) Age 7 and older 	Same as any other illness Plan Pays 100% Plan Pays 100%	Same as any other illness Coinsurance Deductible and Coinsurance

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)	\$100 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 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
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
Family Planning <ul style="list-style-type: none"> • Contraceptive Services & Supplies • Elective Abortion • Elective Sterilization 	Deductible and Coinsurance Deductible and Coinsurance	Deductible and Coinsurance Deductible and Coinsurance
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 (limited to a total of 180 days)	Deductible and Coinsurance	Deductible and Coinsurance

Other Covered Services – Illness or Injury	In-Network Provider	Out-of-Network Provider
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, 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 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	Covered under Prescription Drugs	Covered under Prescription Drugs
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 and Maternity Services Payment for prenatal (excluding the initial visit to diagnosis pregnancy) and postnatal care is included in the payment for the delivery. Newborn care is payable at birth for Covered Services for the first 31 days 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

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 are applicable) <ul style="list-style-type: none"> • Individual • Family 		Not Applicable Not Applicable
Retail – per 30-day supply <ul style="list-style-type: none"> • Generic drugs • Formulary Brand Name Drugs • Non-formulary Brand Name Drugs 	\$10 Copay \$40 Copay \$60 Copay	\$10 Copay + 25% Penalty \$40 Copay + 25% Penalty \$60 Copay + 25% Penalty
Mail order – per 90-day supply <ul style="list-style-type: none"> • Generic drugs • Formulary Brand Name Drugs • Non-formulary Brand Name Drugs 	\$30 Copay \$120 Copay \$180 Copay	Not Covered Not Covered Not Covered
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%	Covered same as any other covered prescription drug
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.

Note: Please be advised that Blue Cross and Blue Shield of Nebraska does not perform plan discrimination testing. Such activities are the responsibility of the employer.