

Schedule of Benefits Summary

Gold Standard 2000 EPO

Effective Date: January 1, 2026

Payment for Services	In-network Provider	Out-of-network Provider
Covered Services are reimbursed based on the Allowable Charge. Blue Cross and Blue Shield of Nebraska (BCBSNE) 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 Noncovered Services, which are the Covered Person's responsibility. That means In-network Providers, under the terms of their contract with BCBSNE, can't bill for amounts over the Contracted Amount. Cost-sharing and reimbursement amounts for categories showing "Same as any other Illness" may vary based on where Services are rendered. There is no Out-of-network coverage under this plan.		
In-network Provider: The provider network is shown on your I.D. card. For help locating In-network Providers, visit NebraskaBlue.com/DoctorFinder . For certain Durable Medical Equipment, Independent Laboratory and Specialty Drug Services, the Doctor Finder may display providers that are considered Out-of-network for these types of Services. Please refer to your benefit book for additional information.		
Deductible (the amount the Covered Person pays each Calendar Year for Covered Services before the Coinsurance is payable) - Individual - Family (Embedded*)	\$2,000 \$4,000	Not Covered Not Covered
Coinsurance (the percentage amount the Covered Person must pay for most Covered Services after the Deductible has been met) - Covered Person Pays - Plan Pays	25% 75%	Not Covered Not Covered
Out-of-pocket Limit (includes Deductible, Coinsurance and Copayments) - Individual - Family (Embedded*)	\$8,200 \$16,400	Not Covered Not Covered
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.) cross accumulate between In-network and Out-of-network, unless noted differently. Day, session or visit limits for certain Services shown on this summary are not applicable to Mental Health and/or Substance Use Disorder Services. 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.		
*Embedded – If you have single coverage, you only need to satisfy the individual Deductible and Out-of-pocket Limit. 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 Limit.		
Copayment(s) (Copay(s)) apply to: - Physician Office - Physical, Occupational, Speech Therapy - Telehealth/Virtual Care - Prescription Drugs - Urgent Care Facility The Copay amount varies by the type of Covered Services. Refer to the appropriate category for benefit information.		
Services may require Preauthorization. Failure to obtain Preauthorization will result in denial of benefits. For additional information regarding Preauthorization procedures visit NebraskaBlue.com/PreAuth.		

Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Primary Care Physician Office Visit	\$30 Copay	Not Covered
Specialist Physician Office Visit	\$60 Copay	Not Covered
Benefits for Primary Care Physician or Specialist Physician office visit include the office visit (including the initial visit to diagnose Pregnancy), consultations and medication checks.		
Physician Office Services	Deductible and Coinsurance	Not Covered
The following Physician Office Services are available when provided in a Primary Care Physician or Specialist Physician's office, with or without an office visit; X-rays, laboratory and pathology Services, allergy testing, injections and serums, supplies and/or drugs administered during the office visit, hearing exams or eye exams (excluding refractions) due to Illness or Injury. Other Services provided in the office but NOT included in the Physician's office visit or Physician office Services benefit listed above, include but are not limited to; Preventive Services, Mental Health and/or Substance Use Disorder Services, Biofeedback, Advanced Diagnostic Imaging (CT, MRI, MRA, MRS, PET and SPECT scans and other Nuclear Medicine), Durable Medical Equipment, Pregnancy, Maternity and Newborn Care, Radiation Therapy and Chemotherapy, Sleep Studies, Therapy and Manipulations and Surgery and Anesthesia. <i>(Refer to the appropriate categories below and your benefit book for additional information.)</i>		
Telehealth/Virtual Care Services		
• Medical	\$0 Copay	Not Covered
• Mental Health	See Mental Health and/or Substance Use Disorder Services	Not Covered
Convenient Care/Retail Clinics/Quick Care	Same as a Primary Care Physician	Not Covered
Urgent Care Facility Services (a single Copay applies to each urgent care visit)	\$45 Copay	Not Covered
Emergency Room Services		
• Facility	Deductible and Coinsurance	In-network level of benefits
• Professional Services	Deductible and Coinsurance	In-network level of benefits
Outpatient Hospital or Facility Services Services include but are not limited to surgery, laboratory and radiology, observation stays, and other Services provided on an Outpatient basis.	Deductible and Coinsurance	Not Covered
Inpatient Hospital or Facility Services Services include but are not limited to charges for room and board, diagnostic testing, rehabilitation Services and other ancillary Services provided on an Inpatient basis.	Deductible and Coinsurance	Not Covered
Orthopedic Specialty Hospital or Facility Services	Deductible and Coinsurance	Not Covered
NOTE: Deductibles and Coinsurance may be waived if Covered Services are provided at a designated Preferred Center. See NebraskaBlue.com/PreferredCenters for a list of Covered Services and designated Hospitals.		

Preventive Services	In-network Provider	Out-of-network Provider
Preventive Services - Affordable Care Act (ACA) required Preventive Services (may be subject to limits that include but are not limited to age, gender, and frequency) - ACA-required covered Preventive Services (outside of limits) - Other covered Preventive Services not required by ACA For additional information visit NebraskaBlue.com/PreventiveCare	Plan Pays 100% Same as any other Illness Same as any other Illness	Not Covered Not Covered Not Covered
Immunizations - Pediatric (up to age 7) - Age 7 and older - Related to an Illness	Plan Pays 100% Plan Pays 100% Same as any other Illness	Not Covered Not Covered Not Covered
Colorectal Cancer Screenings (starting at age 45) - Colonoscopy Screening - Diagnostic or Preventive Screening (one every five years) - Screenings outside the age or frequency limit - Sigmoidoscopy/Proctoscopy Screening and CT of the Colon - Preventive Screening (one every five years) - Screenings outside the age or frequency limit - FIT DNA - Preventive Screening (one every three years) - Screenings outside the age or frequency limit - Fecal Occult Blood Test - Preventive Screening (one per year) - Screenings outside the age or frequency limit - Barium Enema, and other tests as determined under ACA Preventive Services - Preventive Screenings - Diagnostic Screenings	Plan Pays 100% Same as any other Illness Plan Pays 100% Same as any other Illness Plan Pays 100% Same as any other Illness Plan Pays 100% Same as any other Illness Plan Pays 100% Same as any other Illness	Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered
NOTE: Related Services will pay in the same manner as the Colorectal Cancer Screening when performed on the same date of service. Screening limits accumulate based on a Calendar Year.		

Mental Health and/or Substance Use Disorder Services		In-network Provider	Out-of-network Provider
Office Visit		\$30 Copay	Not Covered
Benefits for office visit include the office visit , medication checks, psychological therapy and/or Substance Use Disorder counseling.			
Office Services		\$30 Copay	Not Covered
The following office Services are available when provided in the office; X-rays, laboratory tests, supplies and/or drugs administered during the office visit .			
All Other Outpatient Items and Services		Deductible and Coinsurance	Not Covered
Other Services provided in the office but NOT included in the office visit or office Services benefit listed above include, but are not limited to; psychological evaluations, assessments, testing, physical therapy, occupational therapy, speech therapy or any other covered Mental Health and/or Substance Use Disorder Services.			
Telehealth/Virtual Care Services		\$0 Copay	Not Covered
Emergency Room Services			
- Facility - Professional Services		Deductible and Coinsurance Deductible and Coinsurance	In-network level of benefits In-network level of benefits
Inpatient Services		Deductible and Coinsurance	Not Covered
For additional resources and support visit NebraskaBlue.com/MentalHealth			
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	Not Covered
Ambulance (to the nearest facility for appropriate care)			
- Ground Ambulance - Air Ambulance		Deductible and Coinsurance Deductible and Coinsurance	In-network level of benefits In-network level of benefits
Autism Spectrum Disorder			
- Testing and Diagnosis - Treatment		Same as Mental Health Not Covered	Not Covered Not Covered
Biofeedback			
- Medical - Mental Health		Deductible and Coinsurance Same as Mental Health	Not Covered Not Covered
Dermatological Services		Same as any other Illness	Not Covered
Diabetic Services			
Services include education, self-management training, podiatric appliances, and equipment.		Same as any other Illness	Not Covered
Drugs Administered in an Outpatient Setting (such as home, physician office and other Outpatient settings)		Same as any other Illness	Not Covered
NOTE: Benefits for specific prescription drugs are covered under the prescription drug plan and not payable under medical, other than in an emergency room. A list of these specific drugs is available at NebraskaBlue.com/Pharmacy or by contacting the Member Services department.			
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	Not Covered
Hearing Services			
- Bone Anchored Hearing Aids - Cochlear Implants - Hearing Aids and related Services (up to age 19, limited to \$3,000 every 48 months)		Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance	Not Covered Not Covered Not Covered

Other Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Home Health Care Services - Home Health Aide (limited to 60 days per Calendar Year) - Home Infusion Therapy - Respiratory Care (limited to 60 days per Calendar Year) - Skilled Nursing Care (limited to 8 hours per day)	Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance	Not Covered Not Covered Not Covered Not Covered
Hospice Services	Deductible and Coinsurance	Not Covered
Independent Laboratory - Diagnostic - Preventive	Plan Pays 100% Same as Preventive Services In-network level of benefits	Not Covered Not Covered
Infertility - Services to Diagnose - Treatment to Promote Fertility	Same as any other Illness Not Covered	Not Covered Not Covered
Nicotine Addiction - Medical Services and Therapy - Nicotine Addiction Classes & Alternative Therapy, such as Acupuncture	Same as Substance Use Disorder Services Not Covered	Not Covered Not Covered
Obesity - 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) NOTE: For Pediatric Oral Surgery and Dentistry Services see Pediatric Services.	Same as any other Illness	Not Covered
Organ and Tissue Transplantation	Same as any other Illness	Not Covered
Ostomy Supplies	Deductible and Coinsurance	Not Covered
Physician Professional Services include but is not limited to Inpatient and Outpatient professional Services for surgery, surgical assistant, anesthesia, Inpatient Hospital visits and other non-surgical Services.	Deductible and Coinsurance	Not Covered
Pregnancy, Maternity and Newborn Care - Pregnancy and Maternity (payment for prenatal and postnatal care is included in the payment for the delivery) - Newborn Care (newborns are covered at birth, subject to the plans enrollment provisions) NOTE: The plan pays 100% for the initial postpartum depression screening up to one year following a Pregnancy or childbirth.	Deductible and Coinsurance Deductible and Coinsurance	Not Covered Not Covered

Pediatric Services	In-network Provider	Out-of-network Provider
Pediatric Dental Services (up to age 19) - Preventive and Diagnostic - Maintenance and Simple Restorative - Oral Surgery and Complex Restorative - Orthodontic Services NOTE: Age and frequency limits apply.	Plan Pays 100% Deductible and Coinsurance Deductible and Coinsurance Deductible and 70% Coinsurance	Not Covered Not Covered Not Covered Not Covered
Pediatric Vision Services (up to age 19) - Vision Exam (including refraction and dilation, limited to one per Calendar Year) - Eyeglass frames/lenses or contact lenses (limited to one set of frames/lenses or one purchase of contact lenses, which includes evaluation and fitting, per Calendar Year) - Medically Necessary contact lenses in lieu of eyeglasses for specific medical conditions (preauthorization required for charges in excess of \$600) - Low vision services and aids (preauthorization required) - Comprehensive low vision evaluation (limited to one every 5 Calendar Years) - Follow-up low vision care (limited to four visits every 5 Calendar Years) - Low vision aids	Plan Pays 100% Deductible and 50% Coinsurance Deductible and 50% Coinsurance Deductible and Coinsurance Deductible and Coinsurance Deductible and 50% Coinsurance	Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered

Prescription Drugs		In-network Provider	Out-of-network Provider
Retail – per 30-day supply			
• Preferred Generic Drugs		\$15 Copay	Not Covered
• Non-Preferred Generic Drugs		\$15 Copay	Not Covered
• Preferred Brand Name Drugs		\$30 Copay	Not Covered
• Non-Preferred Brand Name Drugs		\$60 Copay	Not Covered
NOTE: A 90-day supply is available at an Extended Supply Network pharmacy.			
Home Delivery – per 90-day supply			
• Preferred Generic Drugs		\$45 Copay	Not Covered
• Non-Preferred Generic Drugs		\$45 Copay	Not Covered
• Preferred Brand Name Drugs		\$90 Copay	Not Covered
• Non-Preferred Brand Name Drugs		\$180 Copay	Not Covered
Specialty Drugs (Specialty Drugs must be purchased through a designated Specialty Pharmacy)			
• Preferred Specialty Drugs		\$250 Copay	Not Covered
• Non-Preferred Specialty Drugs		\$250 Copay	Not Covered
Contraceptive Drugs			
• Contraceptive Drugs and Methods in accordance with Federal Guidelines		Plan Pays 100%	Not Covered
• All other Contraceptive Drugs and Methods		Same as any other Generic or Brand Name Drugs	Not Covered
For additional information please see Women's Services listed on NebraskaBlue.com/PreventiveCare			
Diabetic Insulin			
• Preferred Generic Drugs		Plan Pays 100%	Not Covered
• Non-Preferred Generic Drugs		Same as any other Generic Drugs	Not Covered
• Preferred Brand Name Drugs		Plan Pays 100%	Not Covered
• Non-Preferred Brand Name Drugs		Same as any other Non-Preferred Brand Name Drugs	Not Covered
This plan utilizes the Limited Network and Value Prescription Drug List (PDL71). You can find this PDL and network listing on NebraskaBlue.com/Pharmacy or you may contact Member Services at the phone number on the back of your I.D. card.			

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 limitations, refer to the Contract. In the event there are discrepancies between this document and the Contract, the terms and conditions of the Contract will govern.

**EXCLUSIVE PROVIDER ORGANIZATION
HEALTH BENEFIT CONTRACT
FOR INDIVIDUALS**



This Contract is an Exclusive Provider Organization health benefits plan offered by Blue Cross and Blue Shield of Nebraska, Inc. (BCBSNE), a domestic insurance company, licensed by the State of Nebraska. This Contract is made in and governed by the laws of the State of Nebraska. Defined terms are capitalized throughout.

This Contract is underwritten and administered by Us. The Contract provides In-network benefits for specific health Services provided to Covered Persons by In-network Physicians, Hospitals and other health care providers. These providers have agreed to furnish Services to Covered Persons in a manner reasonably expected to effectively manage health care costs. **This Contract does not provide benefits for health care Services performed by Out-of-network or Out-of-area Providers, unless otherwise specified by this Contract.**

We agree to make payment for the health Services described, defined and limited herein during the term of this Contract. This Contract is effective beginning 12:01 a.m. at Your principal place of residence, on the effective date stated in Your Schedule of Benefits, and in consideration of the Application and payment of premiums.

This Contract is guaranteed renewable subject to payment of premium each month. We may cancel this Contract if you fail to pay Your premium or for the other reasons stated in Part I.

The entire Contract consists of the Application, Your Schedule of Benefits, Your Schedule of Benefits Summary, this document and any attachments or endorsements hereto.

Only We can approve a change to this Contract and that change must be in writing. Any change will affect all Covered Persons and no agent may change the Contract in any way.

Throughout this Contract, Blue Cross and Blue Shield of Nebraska will be referred to by the personal pronouns "We," "Our," and "Us." The person making application for coverage will be referred to as the Subscriber or by the personal pronouns "You" or "Your." Defined terms are capitalized throughout this Contract.

BLUE CROSS AND BLUE SHIELD OF NEBRASKA

Jeff Russell, President and
Chief Executive Officer

Blue Cross and Blue Shield of Nebraska
1919 Aksarben Drive
Omaha, NE 68180
(402) 982-7000

NOTICE

If, after examination of this Contract, You are not satisfied for any reason, it may be returned to Blue Cross and Blue Shield of Nebraska or its agent within ten days of its delivery to You. If returned, any premium paid will be refunded, the Contract will be void from the beginning, and all parties will be in the same position as if no Contract had been issued.

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PART I. SUBSCRIBERS ENROLLED THROUGH A HEALTH INSURANCE MARKETPLACE OR DIRECTLY WITH BLUE CROSS AND BLUE SHIELD OF NEBRASKA

This Contract is available to Subscribers and their Eligible Dependents who are enrolled through the Health Insurance Marketplace (Marketplace) or enrolled for coverage directly with BCBSNE. Please refer to this Part of the Contract for information regarding eligibility, effective dates, charges for coverage, grace periods, and termination of coverage.

A. ELIGIBILITY, EFFECTIVE DATE OF COVERAGE, CONTINUATION OF COVERAGE, EVIDENCE OF COVERAGE

1. ELIGIBILITY:

- a. You must be, and remain, a resident of the State of Nebraska. If You move from the State of Nebraska, We may cancel Your coverage. If We cancel Your coverage under these circumstances, We will provide You with 31 days written notice.
- b. You must complete an Application and elect a Membership Unit. If you do not complete Your Application truthfully, and we discover that fact, We may cancel coverage. All dependents for whom coverage is requested must meet the definition of an Eligible Dependent.
- c. You must pay the premium by the due date.
- d. For coverage obtained through the Marketplace, the Marketplace must determine that You and Your Eligible Dependents are qualified individuals for coverage. Coverage is not available for You or Your Eligible Dependents if the Marketplace determines that You and/or Your Eligible Dependents are ineligible for enrollment in a QHP.
- e. Child Support Order: If a Subscriber is subject to a court order to provide medical coverage for a child or children as a result of a divorce, legal separation or paternity determination, a copy of the child support order must be submitted to BCBSNE. This order may direct the health plan to enroll the child and create a right for an alternate recipient to receive plan information, submit Claims and receive benefits for services.
- f. BCBSNE does not discriminate on the basis of race, color, national origin, disability, age, sex or gender identity, sexual orientation, or a health related factor. In addition, BCBSNE does not discriminate against any Covered Person for having received a federal Advance Premium Tax Credit and or cost-sharing subsidy through the Health Insurance Marketplace, or for taking any other action to enforce his or her rights under applicable law.
- g. Coverage under this Contract is not subject to any pre-existing condition exclusions.
- h. Payments made by a Third Party Payer for premiums or cost-share amounts on behalf of Covered Persons will not be accepted, unless otherwise stated on the Subscriber's enrollment application or by agreement with Us, or as otherwise required by law. "Third Party Payer" is defined as any person or entity not covered by this Contract remitting payment(s) for premiums or applicable cost-share amounts on behalf of the Subscriber.
- i. Child-only policies are available for children under 19 years of age.

- j. Any person who is enrolled in Medicare may not apply for this Contract, unless otherwise allowed by law. Coverage for Persons enrolling in Medicare or turning 65 years of age during the Benefit Year who enrolled through the Marketplace or directly with BCBSNE will continue until coverage is terminated by You, or until December 31 of the same year.

2. **EFFECTIVE DATE OF COVERAGE:** Enrollment for coverage under this plan is limited to initial or annual enrollment through an Open Enrollment Period or a Special Enrollment Period as stated below. Upon acceptance by Us of Your Application and payment of applicable premiums, coverage shall commence as follows:

a. **Initial or Annual Enrollment:** Coverage for You and any Eligible Dependents shall begin the first day of the month or the first of the second month following Our approval of Your Application, or as determined by the Marketplace. Your effective date will be shown on Your Schedule of Benefits.

b. **Special Enrollment:** An eligible person who has not previously enrolled for coverage may be able to enroll during a Special Enrollment Period. A Special Enrollment Period of 60 days is available for:

- 1) An eligible person who loses minimum essential coverage.
- 2) The Subscriber who acquires an Eligible Dependent through birth, adoption or marriage. An eligible person who has not previously enrolled may enroll at this time, whether or not the new Eligible Dependent(s) is enrolled. Likewise, an eligible spouse who has not previously enrolled may enroll at this time, whether or not the new Eligible Dependent child is enrolled.
- 3) The Subscriber or an Eligible Dependent who experiences an error in enrollment as determined by the Marketplace.
- 4) The Subscriber or Eligible Dependent who demonstrates to the Marketplace that BCBSNE substantially violated a material provision of this Contract in relation to the individual.
- 5) The Subscriber or Eligible Dependent who becomes newly eligible or ineligible for advance payment of premium tax credits or cost-sharing reductions as determined by the Marketplace.
- 6) The Subscriber or Eligible Dependent who gains access to new coverage or QHP options as a result of a permanent move to a new residence.
- 7) The Subscriber becomes a U.S. citizen, U.S. national, or lawfully present resident.
- 8) The Subscriber gains membership in a federally recognized tribe or status as an Alaska Native Claims Settlement Act Corporate shareholder. Subscribers who are Native American or Alaska Native enrolled for coverage through the Marketplace may enroll or change from one QHP to another one time per month.

For Marketplace enrollees, Special Enrollment Period coverage effective dates will be determined by the Marketplace and will depend on the type of event, the date of request for special enrollment, and the date of plan selection. Other qualifying events triggering a Special Enrollment Period may be available. The Marketplace will determine eligibility for special enrollment. Enrollment is conditioned upon timely payment of premium.

c. **Newborn or Adopted Children:** Coverage will begin at birth for a Subscriber's child born after the effective date of the Subscriber's coverage. This includes coverage for Injury

or Illness (including the necessary care and treatment of medically diagnosed Congenital Abnormalities). This coverage will be provided for 31 days from the date of birth. To continue coverage for the child beyond the 31-day period, a special enrollment request must be made to Us within 60 days of the birth and payment of premium must be received by BCBSNE.

Coverage will begin at birth for the newborn child of an Eligible Dependent of a Subscriber with an existing Family Membership, for a period of 31 days. To continue coverage the child must meet the definition of an Eligible Dependent and a special enrollment request must be made to Us within 60 days of birth and payment of premium must be received by BCBSNE.

Coverage for a newly adopted child of the Subscriber shall begin on the earlier of the date of placement for adoption or the date of entry of an order granting custody to the adoptive parents for purposes of adoption. To continue coverage for the child beyond an initial 31-day period, a special enrollment request must be made to Us within 60 days of the placement or order and payment of premium must be received by BCBSNE.

d. Any requests for a coverage change must be submitted to Us in writing on a form designated by Us.

e. If You or an Eligible Dependent are hospitalized on the date this Contract is transferred to another Contract issued or administered by Us, the benefits for Hospital Covered Services for that admission will be provided by this Contract.

3. CONTINUATIONS OF COVERAGE

a. If Your coverage is discontinued while having a Family Membership, We will offer to continue a Single or Family Membership, as appropriate, to Your covered dependents. We must be notified of such an event in order for coverage to continue. Payment must be made within 31 days for continued coverage enrolled in directly with BCBSNE.

b. If a person ceases to be an Eligible Dependent, We will provide a comparable Single Membership for that person, provided eligibility requirements are met. For such coverage to become effective, however, that person must make application and pay the initial premium within 31 days of the date dependent eligibility ceases.

c. The coverage offered under this section will be the most recent version of this Individual Contract. If we do not receive application for coverage or payment of premium within the time limits stated above, all rights and privileges to continue coverage will lapse.

d. If You are no longer a Nebraska resident, You may request that We assist You in a transfer by notifying the Blue Cross and Blue Shield Plan servicing the state of Your new residence. The plan in the other state will make a contract available, but will not be identical to this Contract.

4. CONTINUATION OF COVERAGE FOR CHILDREN TO AGE 30:

a. A Subscriber may elect to continue coverage for an Eligible Dependent child to age 30 who attains the limiting age at which all coverage ceases under this Contract and who remains financially dependent upon the Subscriber. In order to receive coverage pursuant to this provision, the child must have been covered as an Eligible Dependent under this Contract at the time such coverage would have otherwise terminated.

b. In order to elect such coverage, the Subscriber must request an election form from Us, complete the form and return it to Us no sooner than 31 days prior to or later than 31 days after the date on which the Eligible Dependent would otherwise lose coverage under the Contract. Payment of premiums for continuation coverage is the responsibility of the Subscriber. Premium for the continuation coverage will be equal to a single adult premium. For coverage enrolled in directly with BCBSNE, the Subscriber must pay the first month's premium to Us no later than 31 days after the date on which the Eligible Dependent would otherwise lose coverage under the Contract.

c. If coverage is elected pursuant to this provision, such coverage will terminate if:

- 1) We do not receive premium payment on a timely basis in any month;
- 2) the Subscriber requests termination of the continuation coverage;
- 3) the Subscriber's coverage terminates for any reason; or
- 4) the child covered under this provision:
 - a) marries;
 - b) ceases to be a resident of Nebraska, unless the child is under 19 years of age or is enrolled on a full-time basis in any college, university or trade school;
 - c) receives coverage under another health benefit plan or self-funded employee benefit plan; or
 - d) attains thirty years of age.

The continuation coverage will terminate at the end of the month in which any event listed above occurs. Once coverage terminates pursuant to this provision, it may not be reinstated.

5. EVIDENCE OF COVERAGE: When Your coverage becomes effective, We will provide You with this Contract, a Schedule of Benefits, and an identification card. The Schedule of Benefits is a personalized document that provides information as to Deductibles, Copayments, Coinsurance percentages, and the Out-of-Pocket Maximum.

The identification card identifies You as a Subscriber who has coverage under this Contract. The Covered Person must present the identification card(s) to the provider when receiving Services.

B. CHARGES FOR COVERAGE

1. The charges for this coverage are called premiums. Premiums are payable in advance at Our office in Omaha, Nebraska or online at www.myNebraskaBlue.com. This Contract will be renewed each month when You pay Your premium, unless canceled (as stated below).

2. The premium is based on factors such as age, family size, geographic area, tobacco or nontobacco use, as well as the Membership Unit and coverage option selected. Premiums may

be adjusted as of January 1 of each year. You will be notified in writing at the most recent address appearing in Our records of any change in premium.

3. We will refund any premium paid if We are provided with proof in writing that such premium was collected as the result of Our error. If We determine the reason for a valid refund request was not the result of Our error, any refund of premium is limited to the 12-month period before Our receipt of such written request.

C. GRACE PERIOD; REINSTATEMENT; CANCELLATION; TERMINATION

1. GRACE PERIOD: Failure to pay premiums will result in cancellation of this Contract as stated below:

- a. **Subscribers enrolled through the Health Insurance Marketplace and receiving advance payment of premium tax credits.** A grace period of three (3) months from the due date will be granted for the payment of monthly premiums and Your Contract will continue in force during this grace period as described in this paragraph. To be entitled to this grace period, the Subscriber must have paid his/her share of at least one (1) full month's premium. Payment of all outstanding premiums must be paid in full during the grace period. If payment in full is not received, this Contract will terminate as of the last day of the first month of the 3-month grace period. If the Contract is terminated, benefits will be provided for Covered Services rendered during the first month of such grace period; benefits will not be provided for Covered Services rendered during the second and third months of the grace period. If coverage is terminated as stated in this paragraph, You and Your Eligible Dependents will lose coverage and may be required to pay any outstanding premium debt owed to BCBSNE.
- b. **Subscribers enrolled either directly with BCBSNE or through the Health Insurance Marketplace but NOT receiving advance payment of premium tax credits.** A grace period of ten days from the due date will be granted for the payment of monthly premiums. Your Contract will continue in force during this grace period. Cancellation of coverage for failure to pay premiums within the grace period shall be effective at midnight on the last day for which the premium has been paid.

2. CANCELLATION: We may cancel this Contract for any of the following reasons:

- a. If You fail to pay premiums, subject to the grace period, above.
- b. If You, or someone acting on Your behalf, or acting under Your Membership, commits an act of fraud or makes an intentional misrepresentation of material fact involving the application for this Contract, or benefits payable under this Contract.
- c. If a fraudulent or intentional misrepresentation is made on an application for coverage and that fact is discovered within two years of the application, coverage may be rescinded to the initial effective date of coverage for the Subscriber and/or Eligible Dependents, subject to Our provision of a 30-day advance notice of such rescission. The amount of premiums paid for coverage will be reduced by any benefits that were paid and will be refunded to You. If benefits paid exceed premiums received, BCBSNE may recover the difference. Neither the acceptance of premiums nor the processing of Claims will constitute a waiver of Our rights under this paragraph.

- d. If You no longer meet eligibility or residency requirements.
- e. If We cancel all Contracts of the same contract form number and date.
- f. If We receive notification from the Marketplace that this Contract should be cancelled, or that any Covered Person's enrollment in this Contract should be cancelled.

Notice: We will provide written notice of cancellation to You by mail at Your last known address, as shown by Our records, or by email if You elected to receive electronic communications. Notice will be given at least 30 days prior to the effective date of cancellation, except in those cases where cancellation is due to Your failure to pay premiums, Your request for cancellation, or Marketplace-directed cancellations.

If this Contract is canceled, cancellation will not affect any valid Claim for services provided prior to the effective date of cancellation.

3. TERMINATION BY YOU: For persons who enrolled in coverage directly with BCBSNE, You may terminate this Contract by notifying Us in writing, via email, or telephone. Coverage enrolled in through the Marketplace must be terminated through the Marketplace. Following Our receipt of Your notification, the Contract will terminate on either the earlier of the end of the month in which the notice is received or the end of the period for which premiums have been paid. For Marketplace coverage, the contract will terminate on the date specified by the Marketplace. If You specify an earlier termination date when You send the notice of termination, the earlier date will be effective. Coverage may not, however, be terminated in this manner on a date earlier than Our receipt of notification. In the event of termination by You, We will return the prorated unearned premium to You. Termination will not affect any Claim for Services provided prior to the date of termination.

4. UNPAID PREMIUM: Upon the payment of a Claim under this plan, any premium due and unpaid or covered by any note or written order may be deducted therefrom unless prohibited by law.

PART II. PAYMENT FOR SERVICES

OVERVIEW: This Contract provides benefits for Covered Services provided to Covered Persons from In-network Providers only within the State of Nebraska, unless otherwise specified. The Deductible, Coinsurance and Copayments are indicated in the Schedule of Benefits Summary.

A. PROVIDER PAYMENTS: We and Blue Cross and/or Blue Shield Plans in other states have contracted with Physicians, Hospitals, and other health care providers who have agreed to furnish Services to Covered Persons. These Contracting Providers have agreed to be reimbursed a Contracted Amount for Covered Services. Providers will not be discriminated against within the scope of his or her license to practice.

1. In-Network Provider Payment: In-Network Providers agree to accept Our payment plus the Covered Person's payment of any In-network Deductible, Coinsurance and/or a Copayment as payment in full for Covered Services. The Covered Person is responsible for charges for Noncovered Services. Payment will be made to the In-network Provider. When an In-Network Provider is used, the Covered Person is not responsible for any amount in excess of the Contracted Amount. A directory of In-network Providers is available upon request, or may be found online at NebraskaBlue.com/Find-a-Doctor. The In-network Provider network name is shown on the Identification Card.

For certain Durable Medical Equipment, Independent Laboratory, and specialty Pharmacy Services, the Doctor Finder at NebraskaBlue.com/Find-A-Doctor may show out-of-state providers that could be Out-of-network for these Services. To receive In-Network cost-sharing, individuals should request their ordering provider use an in-state In-network supplier, Independent Laboratory, or Specialty Pharmacy. The Member Services Department can confirm network status.

2. Out-of-network Provider Payment: Benefits for Services received from an Out-of-network Provider will not be covered, except for Emergency Services received to treat an Emergency Medical Condition. The Covered Person is responsible for all charges and payments for Services received from an Out-of-network Provider, unless such charges are related to Emergency Services received to treat an Emergency Medical Condition.

EXCEPTION: Emergency Services and post-stabilization Services provided at an Out-of-network health care facility, limited to a hospital emergency department, general acute hospital, satellite emergency department, or Ambulatory Surgical Facility, or by an ancillary individual Out-of-network health care professional or air ambulance provider, will be considered as having been provided by an In-network Provider, and the Covered Person will not be responsible for amounts over the Allowable Charge, as required by law. Benefits for Inpatient care will continue to be paid subject to the In-network cost-sharing level, as long as the Services are for an Emergency Medical Condition.

For non-emergency Services, if a Covered Person receives Services at an In-network health care facility but the Physician or other provider is Out-of-network, benefits for those Covered Services will be subject to the In-network Deductible, Coinsurance, and/or Copayment. Providers may not bill the Covered Person for charges over the Allowable Charge payable under this Contract, unless otherwise allowed by law.

If a Covered Person receives a bill from an Out-of-network Provider, and the Covered Person did not provide consent to the Out-of-network Provider to receive such Services, the Covered Person should send the bill to the Member Services Department for further review by either sending a secure email through myNebraskaBlue.com or by mail at the following address:

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

3. Out-of-area Services

Blue Cross and Blue Shield of Nebraska (BCBSNE) has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called “Inter-Plan Arrangements.” These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association (“Association”). Whenever You access health care services outside the geographic area BCBSNE serves, the claim for those services may be processed through one of these Inter-Plan Arrangements.

When you receive care outside BCBSNE’s service area, You will receive it from one of two kinds of providers. Most providers (“participating providers”) contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area (“Host Blue”). Some providers (“non-participating providers”) don’t contract with the Host Blue. We explain below how We pay both kinds of providers.

BCBSNE covers only limited health care services received outside of Our service area. As used in this section, “Out-of-area Covered Health care Services” only include Emergency Services for an Emergency Medical Condition and Services received at an Urgent Care Facility obtained outside the geographic area We serve. Any other Services will not be covered when processed through any Inter-Plan Arrangements.

a. BlueCard® Program

Under the BlueCard® Program, when You receive Out-of-area Covered Services within the geographic area served by a Host Blue, BCBSNE will remain responsible for doing what We agreed to in the Contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating providers.

The BlueCard Program enables you to obtain Out-of-area Covered Health care Services, as defined above, from a health care provider participating with a Host Blue, where available. The participating provider will automatically file a claim for the Out-of-area Covered Health care Services provided to you, so there are no claim forms for you to fill out. You will be responsible for the member Copayment amount, as stated in Your Schedule of Benefits Summary.

Emergency Services: If you experience a Medical Emergency while traveling outside the BCBSNE service area, go to the nearest Emergency or Urgent Care Facility.

When you receive Out-of-area Covered Services outside BCBSNE’s service area and the claim is processed through the BlueCard Program, the amount you pay for Covered Services is calculated based on the lower of:

- The billed charges for Covered Services; or
- The negotiated price that the Host Blue makes available to BCBSNE.

Often, this “negotiated price” will be a simple discount that reflects an actual price that the Host Blue pays to your health care provider. Sometimes, it is an estimated price that takes into account special arrangements with your health care provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of health care providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price BCBSNE used for your claim because they will not be applied after a claim has already been paid.

b. Non-Participating Providers Outside Our Service Area

(1) Subscriber Liability Calculation

Federal or state law, as applicable, will govern payments for Out-of-Network Emergency Services.

(2) Exceptions

In certain situations, BCBSNE may use other payment bases, such as billed charges for Covered Services, the payment BCBSNE would make if the health care services had been obtained within BCBSNE's service area, or a special negotiated payment to determine the amount BCBSNE will pay for services provided by non-participating providers. In these situations, You may be liable for the difference between the amount that the non-participating provider bills and the payment BCBSNE will make for the Covered Services as set forth in this paragraph, unless otherwise prohibited by law.

c. Blue Cross Blue Shield Global® Core

If You are outside the United States, You may be able to take advantage of Blue Cross Blue Shield Global Core when accessing Covered Emergency Services to treat an Emergency Medical Condition. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although Blue Cross Blue Shield Global Core assists You with accessing a network of inpatient, outpatient and professional providers, the network is not served by Host Blue. As such, when You receive care from providers outside the BlueCard service area, You will typically have to pay the providers and submit the claims yourself to obtain reimbursement for these services.

If You need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, You should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

Inpatient Services

In most cases, if You contact the service center for assistance, hospitals will not require You to pay for covered inpatient services, except for Your cost-share amounts. In such cases, the hospital will submit your claim to the service center to begin claims processing. However, if You paid in full at the time of service, you must submit a claim to receive reimbursement for Covered Emergency Services. **Covered Persons must contact BCBSNE to obtain Preauthorization for non-emergency Inpatient Services.**

Outpatient Services

Emergency Services providers and Urgent Care Facilities located outside the BlueCard service area will typically require You to pay in full at the time of service. You must submit a claim to obtain reimbursement for Covered Emergency Services.

Submitting a Blue Cross Blue Shield Global Core Claim

When You pay for Covered Emergency Services outside the BlueCard service area, You must submit a claim to obtain reimbursement. For institutional and professional claims, You should complete a Blue Cross Blue Shield Global Core claim form and send the claim form with the provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of Your claim. The claim form is

available from BCBSNE, the service center or online at www.bcbsglobalcore.com. If You need assistance with Your claim submission, You should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week.

5. Right to Change Providers or Benefit Payment Procedures: Agreements with health care providers may be changed or terminated and benefit payment procedures to In-network Providers may be altered. Benefit payments may be calculated on a charge basis, a Contracted Amount or similar charge, global fee basis, through an Exclusive Provider Organization, or in any other manner agreed upon between Us or the on-site plan and the provider. However, any payment method agreed upon, will not affect the method of calculating the Deductible and Coinsurance.

6. Direct Payment: All payments for Covered Services by In-network Providers will be made directly to such providers. In all other cases, payments will be made, at Our option, to the Subscriber, to his or her estate, to the provider or as required under state or federal law, including qualified medical child support orders. No assignment whether made before or after Services are provided, of any amount payable according to this Contract shall be recognized or accepted as binding upon Us, unless otherwise required by state or federal law.

7. Continuity of Care: In the event a Covered Person is receiving an active course of treatment for certain types of care from an In-network Provider on the date that Our contracting agreement with the provider is terminated, the provider will continue to render Covered Services to the Covered Person, and the contracting agreement shall continue to apply to those Covered Services after the termination takes effect, for the earlier of 90 days or until the Covered Person is no longer a continuing care patient. The types of care that qualify, and the length of time that the contracting agreement shall continue to apply are stated in the BCBSNE Provider Policies and Procedures Manual. The terms of the Provider Policies and Procedures Manual may be updated by BCBSNE from time to time.

8. Access to In-Network Providers: In the event Covered Services are not available from an In-network Provider, BCBSNE may authorize coverage. Services will be authorized only if an In-network Provider is unavailable in a service area. A referral from an In-network Provider may be required. BCBSNE reserves the right to direct a member to an Out-of-network Provider with whom we have a negotiated rate.

Prior to receiving Services from an Out-of-network Provider, Covered Persons should contact Member Services at the telephone number listed on their ID card, or referring In-network Providers should contact their BCBSNE provider executive. Unless otherwise specified in this Contract, approval by BCBSNE is required prior to receiving Services from an Out-of-network Provider.

B. PAYMENT: All benefits payable under this Contract will be paid as soon as possible after the Claim has been filed. Payments made in error may be recovered as provided by law. Duplicate or erroneous payments not recovered will be considered as benefits paid under the Contract.

Payment for a specific service or an erroneous payment made under this Contract shall not make Us liable for further payment for the same condition.

Under certain circumstances, if We pay a Provider amounts that are the responsibility of the Covered Person under this Contract, such as Copays, Deductibles, or Coinsurance, BCBSNE may collect such amounts from the Covered Person.

C. **CASE MANAGEMENT:** The case management program is a program designed to help manage the care of a Covered Person who has special or extended care Illnesses or Injuries. Case management is a collaborative process that is used to identify and coordinate cost-effective medical care, monitor the care of the Covered Person, offer emotional support to the Covered Person's family, and coordinate communication among Providers, the Covered Person, and others.

D. **UTILIZATION MANAGEMENT:** The utilization management program is an evaluation of the Medical Necessity, appropriateness, and efficiency of the use of health care Services. Services performed by all health care providers are subject to utilization review. We will determine whether the Covered Services are Medically Necessary or Scientifically Validated under the terms of the Contract and benefits available.

E. **NOT MEDICALLY NECESSARY SERVICES:** When an In-network Provider is used, the Covered Person is not responsible for payment for Services determined by Us to be not Medically Necessary. The In-network Provider may collect from the Covered Person; however, for any specific Service determined to be not Medically Necessary, including ongoing preventive or maintenance therapy, if prior to the Service being provided, the provider has advised the Covered Person in writing of his or her responsibility for payment, and the Covered Person has agreed in writing to be responsible. If written agreement cannot be obtained, prior verbal notification may be given by the provider and must be documented in the Covered Person's medical record at the time such notification is given.

F. **EXPANSION OF BENEFITS:** The scope of benefits in an individual case may be expanded solely on a concurrent/prospective basis as determined by Us, to include payment for specific Services which would not ordinarily be included as Covered Services. It must appear that use of such Services will:

1. equal or reduce costs,
2. improve the quality of medical care; or
3. be medically more appropriate than an alternate Covered Service.

We will advise the Covered Person and the provider in writing when, and to what extent, payment for such Services will be made. Such expansion of the scope of benefits will not constitute an amendment to this Contract, nor provide a continuing right to receive such Services. Expansion of benefits under this clause is solely at Our discretion.

G. **OUT-OF-POCKET LIMIT:** This limit is the maximum amount of cost-sharing each Covered Person and/or Membership Unit must pay in a calendar year before benefits are payable without application of a cost-share amount. The Out-of-pocket Limit includes Deductible, Coinsurance and Copayment amounts for medical and pharmacy services. The Out-of-pocket Limit does not include premium amounts, amounts over the Allowable Charge, charges for Noncovered Services or penalties for failure to comply with Preauthorization requirements or as imposed under the Rx Nebraska Prescription Drug Program. Also, any cost-sharing for prescription drugs paid with a pharmaceutical discount, drug coupon or Copay card may be excluded from the Out-of-pocket Limit. The Out-of-pocket Limit is stated on the Schedule of Benefits Summary.

1. **Deductible:** The Deductible for a calendar year will be met when Allowable Charges for Covered Services incurred in that calendar year equal the Deductible stated in the

Subscriber's Schedule of Benefits Summary. The first calendar year begins on the effective date of coverage and ends on December 31 of that same year. Copayments do not accumulate to the Deductible Charges for prescription drugs paid by the Covered Person with a pharmaceutical discount, drug coupon or Copay card may not accumulate to the Deductible.

The applicable Deductible must be met each calendar year before benefits are paid, unless otherwise indicated. If there is a change in the Deductible during a calendar year, the Covered Person(s) may be given credit for any applied Deductible amounts prior to the change. However, as of the date of the change, the new Deductible amount will be applicable to the Covered Person(s) before benefits are available for the remainder of the year.

2. **Coinsurance:** Each Covered Person is responsible for payment of any applicable Coinsurance for Covered Services as stated on the Schedule of Benefits Summary.
3. **Copayments:** Each Covered Person must pay all required Copayments for Covered Services, as shown on the Schedule of Benefits Summary. Multiple Copayments may apply to one Claim, depending on the Covered Services submitted on the Claim.

Qualified High Deductible Health Plans: If you have a Health Savings Account (HSA)-eligible high deductible health plan, the Deductible and Out-of-pocket Limit may be adjusted annually pursuant to the cost-of-living adjustment to qualified high deductible health plan deductible and out-of-pocket limits and HSA contribution limits announced by the IRS, as found in I.R.C. §223. All Copays and Coinsurance amounts will apply after the Deductible is met.

H. **WAIVER OF COINSURANCE OR DEDUCTIBLE:** If a provider routinely waives (does not require the Covered Person to pay) or reduces the Coinsurance or Deductible for Covered Services, he or she is misstating the actual charge. Blue Cross and Blue Shield of Nebraska is not obligated to pay the full percentage of the Provider's original charge, but instead, will pay benefits based on the lower fee actually charged.

I. **COST SHARING REDUCTIONS:** As required by the ACA, Covered Persons enrolled for certain Qualified Health Plans through the Health Insurance Marketplace may be eligible for cost-sharing reductions, as determined by the Marketplace. Such cost-sharing reductions include:

1. Native American and Alaska Natives who are enrolled through the Marketplace and receive Covered Services directly from Indian Health Service providers, an Indian tribe, tribal organization, Urban Indian Health Program or referral for contract health services, will have no cost-sharing such as Copayment, Coinsurance or Deductible for such Covered Services.

In addition, Native American/Alaska Natives enrolled through the Marketplace who are determined to be eligible for Advance Premium Tax Credits, may be eligible for cost-sharing reductions.

2. Covered Persons enrolled for specific Qualified Health Plans through the Marketplace who are determined to be eligible Advance Premium Tax Credits, may be eligible for cost-sharing reductions.

Eligibility for such cost sharing reductions is determined by the Health Insurance Marketplace, pursuant to the guidelines set forth in the ACA.

J. **MEMBER INCENTIVES:** Subscribers may be offered financial incentives for enrolling in or obtaining preventive care, direct primary care, maternity care, health assessments, disease

management, evaluation and monitoring visits for certain chronic conditions in order to improve health conditions, and use of electronic communications, tools or online accounts.

PART III. PREAUTHORIZATION REQUIREMENTS

OVERVIEW: Our Preauthorization procedures are intended to determine if health care Services or supplies are appropriate under the terms of the Contract.

Before the Services or supplies are received, all Hospital stays, certain surgical procedures and specialized Services and supplies identified in these provisions must be Preauthorized by Us. The Subscriber is responsible for making sure Preauthorization occurs. However, a Hospital or Provider may initiate the Preauthorization.

Preauthorization of a proposed service or supply through the Preauthorization process does not necessarily mean that benefits are payable. Eligibility for coverage for a particular service or supply, and fulfillment of all other Contract requirements, are also necessary for benefits to be payable.

Under all circumstances, the Covered Person and his or her providers bear the ultimate responsibility for the medical decisions regarding treatment of the Covered Person. We are not responsible for treatment or diagnosis of a Covered Person, regardless of any case Preauthorization, review or management.

A. PREAUTHORIZATION PROCESS: Prior to receiving any of the Services, supplies or drugs listed below in this Part (or as otherwise specified in the Contract or Endorsements thereto), the Covered Person or a person or facility acting on their behalf must contact Us by telephone or in writing and notify Us of the intended receipt of services. We may require that the Preauthorization request include written documentation from the Covered Person's Physician, dentist or other medical provider demonstrating the Medical Necessity of the procedure or service and should indicate the location of the service.

During an ongoing inpatient admission, care should be Preauthorized to assure that it is being provided in the most appropriate setting.

B. BENEFITS REQUIRING PREAUTHORIZATION: The following Services, supplies or drugs must be Preauthorized by Us:

1. All inpatient Hospital admissions;
2. Inpatient physical rehabilitation;
3. Long term acute care at an Inpatient facility after receiving treatment in the Hospital;
4. Skilled nursing facility care;
5. Organ and tissue transplants;
6. Hospice Care;
7. Skilled nursing care in the home;
8. Subsequent purchases of Durable Medical Equipment (DME) or DME identified on the Preauthorization list;

9. Certain prescription drugs as defined by Us;
10. Advanced Diagnostic Imaging;
11. Genetic testing;
12. Services subject to surgical, laboratory, radiology or other Preauthorization programs, as defined by Us;
13. Orthodontic treatment, under the pediatric dental benefit; and
14. Other Services as may be specifically stated elsewhere in this document.

A list of Services subject to Preauthorization may be obtained at NebraskaBlue.com/Preauth. Preauthorization requirements and Services requiring Preauthorization are subject to change.

C. EFFECT ON BENEFITS: If Services are not properly Preauthorized by Us, a penalty or denial of benefits may apply and the Covered Person may be responsible for unanticipated costs associated with the expense incurred. Certain surgical, laboratory, radiology or other Preauthorization programs require that benefit approval be obtained prior to the Service being provided, with failure to do so resulting in a denial of benefits for the Service.

Out-of-Network or out-of-state

Covered Persons are responsible to obtain Preauthorization for all Services requiring Preauthorization received from an Out-of-network Provider or provider located outside the State of Nebraska. The responsibility for charges denied for failure to obtain Preauthorization or prior authorization rests with the Covered Person, unless the provider is located in Nebraska and a Contracting Provider with BCBSNE.

Benefits are not payable for Services determined to be not Medically Necessary.

D. EXCEPTIONS TO PREAUTHORIZATION:

1. **Maternity:** Preauthorization is not required for the initial 48 hour Inpatient Hospital stay for a vaginal delivery or the 96 hour Inpatient Hospital stay for a Cesarean section delivery.
2. **Emergencies:** If the admission is for an Emergency Medical Condition, the Covered Person or someone acting on his or her behalf must notify Us within 24 hours of the admission or the next business day. If Preauthorization 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 Covered Person'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.

PART IV. BENEFITS FOR HOSPITAL AND OTHER INSTITUTIONAL FACILITY SERVICES

OVERVIEW: Benefits are payable for Inpatient and Outpatient Covered Services, subject to all exclusions and limitations in the Contract.

A. COVERED INPATIENT HOSPITAL SERVICES, INCLUDING LONG TERM ACUTE CARE:

1. **Hospital Room and Board.** If an intensive care unit, cardiac care or similar type of room is used during a 24hour period, benefits are available, but only one room charge will be payable and benefits will be based on the most intensive care provided during that period. All ancillary charges, including special diet and nursing Services are considered to be included in the Hospital room charge.

Note: Once benefits are denied for Hospital room and board, all other Inpatient Services are denied.

2. **Treatment Rooms.** Includes use of appropriate treatment rooms and equipment. Benefits are not available for separate rooms used for procedures that are customarily provided in the patient's room.
3. **Anesthesia.**
4. **Respiratory care.**
5. **FDA-approved drugs,** intravenous solutions, vaccines, biologicals, and medicines which are prescribed for and administered to the Covered Person while hospitalized. Benefits are also payable for chemotherapy, except as excluded in this Contract.
6. **Administration and processing of intravenous solutions,** blood, blood plasma, blood derivatives, or blood fractionates.
7. **Supplies, materials and equipment,** including but not limited to FDA-approved implantable and prosthetic devices, except "take-home" supplies and convenience items.
8. **Radiology, laboratory, pathology and other diagnostic Services** when billed by the Hospital. Benefits are also payable for radiation therapy.
9. **Physical therapy** when provided by a Licensed physical therapist, or Licensed physical therapist's assistant supervised by and assigned to a physical therapist.
10. **Occupational therapy Services** when provided by a Licensed occupational therapist or Licensed occupational therapist assistant supervised by a Licensed occupational therapist.
11. **Speech therapy** when provided by a Licensed speech-language pathologist or registered speech-language pathology assistant practicing under the direct supervision of a Licensed speech-language pathologist.

B. PHYSICAL REHABILITATION COVERED SERVICES

1. **Covered Hospital Services.** In addition to the Services defined as Covered Services for Inpatient care in this Contract, the following will be Covered Services when provided as part of the Physical Rehabilitation admission:
 - a. recreational therapy;
 - b. social service counseling;
 - c. prosthetic devices and fitting; and
 - d. psychological testing.

2. **Covered Physician Services.** All Covered Physician Services as defined in this Contract that are provided to an Inpatient.
3. **Provider Requirements:** For benefits to be available for Physical Rehabilitation, the provider must be accredited for comprehensive Inpatient Rehabilitation by the Commission on the Accreditation of Rehabilitation Facilities (CARF), or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or appropriately Certified as determined by Us.

C. SKILLED NURSING FACILITY:

Benefits for skilled nursing facility care is available subject to Medical Necessity criteria and to the limit specified in the Schedule of Benefits Summary. After the exhaustion of the specified limit, all Services provided by the skilled nursing facility will be denied. This care must be provided in a Licensed or Medicare-Certified skilled nursing facility or in a part of a Hospital with designated Skilled Nursing or swing beds. Such facility, or part of a facility, must be Licensed to provide Medically Necessary room, board, 24-hour-a-day Skilled Nursing Care as defined in this Contract and other related non-Custodial Services for the care and rehabilitation of injured, disabled or sick persons.

In addition, the confinement must have been ordered by a Physician and the Covered Person must be receiving Skilled Nursing Care.

Exclusions and Limitations:

1. A skilled nursing facility does not include a place that is primarily used for rest, care and treatment of Mental Health and Substance Use Disorders; or for Custodial Care or educational or nonmedical personal Services.
2. Skilled nursing facility care does not include:
 - a. supportive Services for a stabilized condition;
 - b. care which can be learned and given by unlicensed or uncertified medical personnel;
 - c. routine health care Services;
 - d. general maintenance or supervision of routine daily activities; or
 - e. routine administration of oral or nonprescription drugs.

D. COVERED HOSPITAL OR FACILITY OUTPATIENT SERVICES:

1. **Outpatient Services.** Benefits are available for Outpatient Covered Services provided by a Hospital (including an Emergency room), Ambulatory Surgical Facility, Urgent Care Facility or other Outpatient facility, including, but not limited to, those Services identified in this Part.

NOTE: If applicable, any separate Copayment for Outpatient Covered Services provided at an Emergency room will be waived if the Covered Person is admitted to the Hospital within 24 hours for the same diagnosis.

2. **Observation Stay.**

3. Cardiac or Pulmonary Rehabilitation Program.

a. Benefit Provision:

1) Benefits will be provided for Outpatient rehabilitation program Services according to the terms of this paragraph.

2) **Covered Hospital Services:** Services for Outpatient care defined in this Part and the following Covered Services when provided as part of the Rehabilitation Program:

- a) initial rehabilitation evaluation;
- b) exercise sessions;
- c) concurrent monitoring during the exercise session for high risk patients.

3) **Covered Physician Services:** All Covered Physician Services as defined by the Benefits for Physician's Services Part which are provided to an Outpatient.

b. Covered Person Eligibility: Covered Persons will be eligible for the benefits provided by this paragraph subject to the following criteria:

1) **Cardiac Rehabilitation:** Services will be provided at any therapeutic level, limited to 18 sessions per diagnosis or condition.

2) **Pulmonary Rehabilitation:** Services will be provided prior to and following lung transplant, heart-lung transplant and lung volume reduction surgery, and for severe chronic lung disease patients as reviewed and determined by Us. The rehabilitation Services will be covered only when under the continuing supervision of a Physician and in a Hospital environment.

- a) Pulmonary rehabilitation Services for chronic lung disease patients are limited to 18 sessions (including follow-up home sessions) initially and after significant changes in clinical status. However, no more than 18 sessions will be covered in a single calendar year for a Covered Person.
- b) Pulmonary rehabilitation Services related to lung transplant, heart-lung transplant and lung volume reduction surgery are limited to 18 sessions following referral and prior to surgery plus 18 sessions within six months of discharge from the hospital following surgery.

c. Cardiac or Pulmonary Rehabilitation Program Qualifications: The cardiac or pulmonary rehabilitation program must be accredited by the JCAHO, or as otherwise approved by Us.

4. DRUGS ADMINISTERED IN AN OUTPATIENT SETTING: Benefits for some prescription drugs administered in an Outpatient setting, other than an emergency room, are payable only under the Rx Nebraska Prescription Drug Program, as determined by BCBSNE and as indicated in your Schedule of Benefits Summary. A list of the prescription drugs for which benefits are only available under the Rx Nebraska Prescription Drug Program is available on the BCBSNE website NebraskaBlue.com/Pharmacy (see Drugs Administered in an

Outpatient Setting) or by contacting the Member Services Department. This limitation does not apply to prescription medications administered for an Emergency Medical Condition.

E. **ORTHOPEDIC SPECIALTY BENEFIT:** Benefits for certain orthopedic Hospital facility Covered Services may be subject to a waiver of the Deductible and Coinsurance amounts if such Covered Services are provided at a Hospital designated by BCBSNE as a Nebraska Preferred Center. A list of the Covered Services and designated Hospitals for this orthopedic specialty benefit may be found at NebraskaBlue.com/PreferredCenters. Exception: The waiver of Deductible is not applicable to an HSA-eligible Qualified High Deductible Health Plan. BCBSNE reserves the right to change or discontinue this specialty benefit or provider participation at its discretion.

PART V. BENEFITS FOR PHYSICIAN'S SERVICES

OVERVIEW: Benefits will be payable pursuant to this Part for Services provided by a Physician, including an oral surgeon, a certified nurse midwife, a certified nurse practitioner, a certified Physician's Assistant, or a chiropractic practitioner, within the provider's scope of practice. Services provided by a chiropractor, including laboratory services, are subject to Nebraska Department of Health and Human Services regulations. Covered Services include:

A. COVERED PHYSICIAN'S SERVICES

1. **Surgery.** Operative invasive procedures and the treatment of fractures and dislocations provided by the Physician in charge of the case. The amount payable for an Inpatient or Outpatient major surgical procedure will include preoperative and postoperative care, and shall not exceed the applicable Allowable Charge. The Allowable Charge may include reductions for procedures involving multiple Physicians or for multiple or bilateral surgical procedures.
2. **Surgical Assistance.** Benefits are payable in connection with certain surgeries for surgical assistance by a Physician or other person who actively assists the operating Physician as listed in the Overview of this Part. The amount payable shall not exceed the applicable Allowable Charge and may include a reduction for surgical assistance. Benefits for a surgical assistant are provided for those surgical procedures specifically identified by Us and such information may be obtained prior to surgery.
3. **Anesthesia Services.** Benefits are payable for the administration of anesthesia by a Physician or Certified registered nurse anesthetist. The amount payable for anesthesia Services will include the usual preoperative and postoperative visits and the necessary management of the patient, during and after the administration of the anesthesia. Payment will not be made for supervision of the administration of anesthesia. Benefits will not be provided for local infiltration or the administration of anesthesia by the attending or assisting surgeon (except spinal, saddle or caudal blocks related to Pregnancy or general anesthesia for oral surgery and dental procedures covered under this health contract). Benefits for Covered Services are payable for an oral surgeon or dentist with a permit issued by the state to administer general anesthesia.
4. **Nonsurgical Inpatient Hospital Visits.** Benefits are payable for nonsurgical Inpatient care or treatment of a condition for which surgical care is not required.
5. **Concurrent Inpatient Hospital Visits.** Inpatient Hospital visits provided by two or more Physicians on the same day are payable, if the Services are:
 - a. for unrelated nonsurgical medical diagnoses which require the Services and skills of two or more Physicians with unrelated specialties, or

- b. necessary because of medical complications requiring supplemental skills not possessed by the attending surgeon or his or her assistants and requiring nonsurgical care not related to surgery and not a part of the usual, necessary and related preoperative and postoperative care.
- 6. **Consultation Services.** Benefits are payable for consultations by providers with different specialties or subspecialties.
- 7. **Intensive Medical Service.** Unusual, repeated and prolonged attendance at the Covered Person's bedside is payable when required by the Illness, Injury or Pregnancy.
- 8. **Radiation Therapy and Chemotherapy.**
- 9. **Tissue Examinations.** Tissue examinations in connection with Covered Services for surgical procedures are payable, whether performed in a Hospital Inpatient or Outpatient facility, Ambulatory Surgical Facility, or in the Physician's office.
- 10. **Radiology, Laboratory, Pathology and Other Diagnostic Services.**
- 11. **FDA-approved drugs,** listed under the Drugs Administered in an Outpatient Setting, intravenous solutions, vaccines, biologicals, and medicines which are prescribed and administered to the Covered Person in the Physician's office. Benefits for some prescription drugs administered in an Outpatient setting, other than an emergency room, are payable only under the Rx Nebraska Prescription Drug Program, as determined by BCBSNE. A list of these prescription drugs payable only under the Rx Nebraska Prescription Drug Program is available on the BCBSNE website NebraskaBlue.com/Pharmacy or by contacting the Member Services Department.
- 12. **Physician Home and Outpatient Visits.** Renal dialysis, not billed under another section of this Contract, is included within this Service.
- 13. **Allergy serums and injections of allergy serums,** except as specifically excluded in this Contract

B. COVERED OFFICE SERVICES

- 1. Benefits for the following Covered Services incurred in the "Primary care" or "Specialist" Physicians' office shall be paid subject to a Copayment, Deductible and/or Coinsurance Amount as indicated in the Schedule of Benefits Summary.

If a Copayment is applicable, the Schedule of Benefits Summary will indicate that the Copayment applies as a "Physician Office Visit" benefit or a "Physician Office Services" benefit, as described below. If a Covered Person receives services from more than one Physician on the same day, a separate Copayment will be assessed for each Physician; however, only one Physician Office Copayment will be applied per Physician per day regardless of the diagnosis. If additional Services billed by the Physician on the same day are subject to a separate Copayment, more than one Copayment could be applied per day.

Services performed in a Convenient Care/Retail Clinic or performed by a Physician assistant are covered in the same manner as a Primary Care Physician.

- 2. **Physician Office Visit** includes, but is not limited to:

- a. Physician office visits and consultations, including the initial visit to diagnose Pregnancy.
- b. Medication checks.
- c. Psychological therapy and/or Substance Use Disorder counseling/rehabilitation provided in the office, as described in the Benefits for Mental Illness and Substance Use Disorder Treatment Part of this Contract.

3. **Physician Office Services**, include but are not limited to:

- a. Physician Office Visits, as stated above.
- b. X-ray, laboratory and pathology services performed in the Physicians' office, including pap smears and mammograms due to Illness.
- c. Supplies used to treat the Covered Person during the office visit (not including Durable Medical Equipment).
- d. Drugs administered by the Physician during the office visit, except those drugs payable only under the Rx Nebraska Prescription Drug Program.
- e. Hearing exams and testing due to Illness or Injury (non-Preventive).
- f. Eye exams due to Illness or Injury (non-Preventive), excluding refractions. Refractions are covered when related to ocular injury or intraocular surgery when provided within 12 months of the date of surgery or injury.
- g. Allergy testing, injections and serums.
- h. Although these Services may be covered under other parts of this Contract, the Covered Office Visit or Office Services benefit does not include:
 - a. Preventive services, as required by State or Federal Law.
 - b. Services for Pregnancy, other than the initial visit to diagnose Pregnancy.
 - c. Surgical procedures and/or anesthesia.
 - d. Injections (except allergy injections).
 - e. Immunizations.
 - f. Sleep studies.
 - g. Radiation therapy.
 - h. Advanced Diagnostic Imaging.
 - i. Chemotherapy infusion and chemotherapy drugs.
 - j. Infusion therapy.
 - k. Durable Medical Equipment.
 - l. Chiropractic and osteopathic manipulations and adjustments.
 - m. Physical, occupational or speech therapy, including cognitive training or chiropractic or osteopathic physiotherapy.

- n. Biofeedback.
- o. Psychological evaluations, assessments and testing; or other Outpatient Covered Services for treatment of Mental Health and Substance Use Disorders.
- p. Sublingual allergy therapy.
- q. Outpatient services received at a place other than a Physician's office.

C. TELEHEALTH AND TELEMEDICINE SERVICES

Covered Physician's Services include Telehealth services for the diagnosis and treatment of a Covered Person's medical condition. Telehealth services shall mean web-based, video or telephonic visits, calls or consultations between a Covered Person and a Licensed Physician or other professional provider qualified to provide such services. Telehealth services are considered a "delivery of care method" and do not constitute medical benefits under the Contract. The provision and scope of telehealth services are subject to applicable state and federal laws and regulations. Telehealth services are subject to the cost-sharing amounts shown in the Schedule of Benefits Summary. Benefits may be limited to In-network Providers only.

Telehealth services described in this section are not applicable to, or available for:

- a. reporting lab or other test results;
 - b. office appointment requests;
 - c. communications primarily educational in nature;
 - d. billing, insurance or payment questions;
 - e. Preauthorization procedures;
 - f. Physician to Physician consultations;
 - g. calls or consults by telemedicine, telephone or other electronic means to another health care provider during a Covered Person's visit in a provider's office, unless otherwise covered by this Contract;
 - h. Services, treatment or conditions outside the scope of the Covered Services payable via a telehealth delivery of care method.
1. Telemedicine shall mean web-based, video or telephonic visits, calls or consultations between or related to a Covered Person (with or without the Covered Person present) and a Licensed Physician and other professional provider qualified to provide such services.
 2. **Primary/Secondary Coverage - Coordination of Benefits:** If a Covered Person receives telehealth services which may be covered under more than one health plan or contract, and identifies to the telehealth services provider at the time of service that this Contract is to be used for coverage, this Contract will provide benefits as the primary coverage. When another health plan or contract is used or identified at the time of service, this Contract will become the secondary coverage pursuant to Coordination of Benefits, as allowed by law. The Covered Person must submit a claim form and itemized statement and other plan's Explanation of Benefits to BCBSNE reflecting the charges and cost-sharing amount paid

pursuant to the other plan for benefit consideration under this Contract as the secondary coverage.

PART VI. BENEFITS FOR PREVENTIVE SERVICES

OVERVIEW: Benefits will be payable pursuant to this Part for Preventive Services provided by an Approved Provider.

A. Benefits will be provided for Preventive Services required by the ACA, which are defined as:

1. Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task force.
2. With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.
3. With respect to women, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.
4. Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

The ACA-required Preventive Services may include age, gender and frequency limits. A list of these Preventive Services may be obtained by contacting the BCBSNE Member Services Department or by visiting NebraskaBlue.com/PreventiveCare.

Benefits for the Preventive Services outlined above will be paid as indicated on Schedule of Benefits Summary. Preventive services may include state mandated services but do not generally include Services intended to treat an existing illness or condition.

PART VII. BENEFITS FOR PREGNANCY, MATERNITY AND NEWBORN CARE

A. PAYMENT: Benefits are available for Pregnancy, maternity and newborn care pursuant to the Hospital and Physician Covered Services outlined in this Contract. Charges for pre-natal (excluding the initial visit to diagnose Pregnancy), post-natal, and delivery Services for Pregnancy and maternity care are payable as a total (global) charge, pursuant to American Medical Association Current Procedural Terminology (CPT) descriptive terms and identifying codes and related guidance. Charges for additional Covered Services outside the total (global) maternity charge, such as radiology, pathology and other diagnostic Services are payable as stated on the Schedule of Benefits Summary.

Under federal law, benefits may not be restricted for any hospital stay in connection with childbirth for the mother or newborn child for less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, unless otherwise agreed by the Covered Person and her Physician.

Also under federal law, a health insurance issuer 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 to the mother or newborn than any earlier portion of the stay. In addition, an issuer may not require the provider to obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours), unless otherwise agreed to by the Covered Person and her Physician.

B. MATERNITY MANAGEMENT: BCBSNE may from time to time offer a voluntary maternity management program.

Any information provided through such a program is for educational purposes only; BCBSNE does not provide medical services or advice, or engage in the practice of medicine. The purpose of the program is to provide education and support to expectant mothers to promote healthy pregnancy and childbirth. We reserve the right to discontinue or change a program at any time.

C. NEWBORN CARE: Benefits will be payable at birth for Covered Services for a newborn infant who is an Eligible Dependent. Covered Services include:

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

Benefits for Covered Services will be payable for the newborn infant for a period of 31 days from the date of birth. To continue coverage for the child, a request must be made to enroll the child within the 60-day Special Enrollment Period, and any additional premium must be paid. The newborn infant will be subject to a separate, individual Deductible for Covered Services.

D. NOTE: Benefits for postpartum depression, psychosis or any other Mental Health diagnoses resulting from Pregnancy or childbirth will be provided in the same manner as all other Mental Health Services.

PART VIII. BENEFITS FOR MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES

OVERVIEW: Benefits will be provided for the following Medically Necessary Covered Services for the treatment of Mental Health and Substance Use Disorders, or any combination of these Services. Specified Copayments, Coinsurance and Deductibles for Inpatient Services, Outpatient Services and Emergency Services are indicated in the Schedule of Benefits Summary.

The following Covered Services are subject to all exclusions and limitations in the Contract:

A. INPATIENT SERVICES, including but not limited to, psychological therapy and/or Substance Use Disorder counseling/rehabilitation Services provided by and within the scope of practice of a:

1. Qualified Physician, Licensed Psychiatrist or Licensed Psychologist.
2. Licensed Special Psychologist, Licensed Mental Health Practitioner, Licensed Clinical Social Worker, Licensed Professional Counselor or Licensed Marriage and Family Therapist.

3. Auxiliary Providers supervised, and billed for by a qualified Physician, Licensed Psychiatrist or Licensed Psychologist, or as otherwise permitted by state law.

Inpatient 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). **A person shall be considered an Inpatient if he or she is confined to a Hospital, or to a Substance Use Disorder Treatment Center that provides medical management including 24-hour nursing care.** Services provided by a facility that does not meet these criteria are considered part of a Residential Treatment Program.

All Licensing or Certification shall be by the appropriate state authority. Supervision and consultation requirements shall be governed by state law.

B. RESIDENTIAL TREATMENT SERVICES and room and board provided as part of a Residential Treatment Program of Mental Health and Substance Use Disorder.

The Residential Treatment Program and/or facility must be licensed, accredited or certified to provide such Services by the appropriate state agency, or accredited by CARF International or JCAHO.

Benefits for Residential Treatment Center Services are available subject to Preauthorization and Medical Necessity criteria and Utilization Management. If Preauthorization is not obtained and the Services requested do not meet BCBSNE's Medical Necessity criteria, coverage for those Services may be denied.

C. OUTPATIENT SERVICES, including but not limited to:

1. Psychological therapy and/or Substance Use Disorder counseling/rehabilitation provided by and within the scope of practice of a:
 - a. Qualified Physician, Licensed Psychiatrist or Licensed Psychologist.
 - b. Licensed Special Psychologist, Licensed Mental Health Practitioner, Licensed Clinical Social Worker, Licensed Professional Counselor, or Licensed Marriage and Family Therapist.
 - c. Auxiliary Providers supervised, and billed for by a qualified Physician, Licensed Psychiatrist or Licensed Psychologist, or as otherwise permitted by state law.

All Licensing or Certification shall be by the appropriate state authority. Supervision and consultation requirements shall be governed by state law.

2. Office or clinic visit, Consultation, or emergency room visit.
3. Evaluation and assessment.
4. Medication checks.
5. Biofeedback.

6. An Outpatient day or a partial hospitalization program for Mental Health and Substance Use Disorder Treatment Program which bills one charge for all-inclusive Services for each Outpatient day.

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 equivalent state agency) or accredited by the Joint Commission on Accreditation of Rehabilitation Facilities (CARF).

7. Psychological and neuro-psychological testing.
8. Individual, family, and group therapy.
9. Methadone maintenance programs for the treatment of opioid use disorder.

D. EMERGENCY SERVICES, which include Covered Services for the treatment of Mental Health and Substance Use Disorder which are provided in an Emergency room setting.

Note: Any separate Copayment for Emergency Services provided at an Emergency room will be waived if the Covered Person is admitted to the Hospital within 24 hours for the same diagnosis.

E. AUTISM SPECTRUM DISORDER: Benefits are available for the screening and diagnosis, of autism spectrum disorders. Autism spectrum disorder means any of the pervasive developmental disorders or autism spectrum disorder as defined by the most recent Diagnostic and Statistical Manual of Mental Disorders.

PART IX. BENEFITS FOR ORAL SURGERY AND DENTISTRY

A. OVERVIEW: Benefits are payable for Covered Services, subject to the exclusions, limitations and other conditions stated in the Contract for the following:

1. Incision and drainage of abscesses, and other nonsurgical treatment of infections. This does not include periodontic or endodontic treatment of infections.
2. Excision of exostoses, tumors and cysts, whether or not related to the temporomandibular joint of the jaw.
3. Reduction of a complete dislocation or fracture of the temporomandibular joint of the jaw required as a direct result of an accidental Injury. Benefits for such Services are limited, however, to Covered Services provided within 12 months of the date of Injury. Benefits shall not be provided for such Services when the dislocation or fracture occurs as the result of eating, biting or chewing.
4. Diagnostic or surgical procedures involving a bone or joint of the face, neck or head, including osteotomies, for treatment of temporomandibular joint disorder or craniomandibular disorder.
5. Services, supplies or appliances for dental treatment of natural healthy teeth required as the direct result of an accidental Injury. Benefits for such Services are limited, however, to Covered Services provided within 12 months of the date of Injury. Benefits are not available for orthodontics or dental implants. Benefits shall not be provided for Services when the Injury occurs as the result of eating, biting or chewing.

6. Medically Necessary hospitalization and general anesthesia, as required by law, for Covered Persons who are under eight years of age or developmentally disabled in order for the Covered Person to safely receive dental care.

B. SPECIAL HOSPITAL ADMISSIONS: Benefits will be provided for Hospital Inpatient, Outpatient or Ambulatory Facility charges related to Covered Services for oral surgery and dentistry.

C. EXCLUSIONS: No payments shall be made under this Part nor under any other Part of this Contract, except for Services expressly described in paragraph A. for:

1. Care in connection with the treatment, filling, removal, repositioning or replacement of teeth, including orthodontics or dental implants.
2. Root canal therapy or care.
3. Bone grafts to the jaw, in relation to dental implants or preparation of the mouth for dentures.
4. Preparation of the mouth for dentures.
5. Treatment of the dental occlusion or temporomandibular joint of the jaw by any means or for any reason, except as stated in paragraph A.
6. All other procedures involving the teeth or structures directly related to or supporting the teeth, including the gums and the alveolar processes.
7. Evaluation and treatment of impacted teeth.
8. Osteotomies of the face, neck or head, except as specifically provided in paragraph A.4.
9. Evaluation and treatment of myofascial pain.
10. Treatment of sleep disorders by a dentist, including sleep apnea, except for the fabrication of an orthotic for treatment of a sleep disorder.

PART X. BENEFITS FOR ORGAN AND TISSUE TRANSPLANTATION

OVERVIEW: Benefits will be provided as set forth in this Contract for Covered Services directly related to or resulting from a transplant of body organs or tissues. These benefits are subject to all exclusions and limitations in the Contract.

A. BENEFITS FOR THE COVERED PERSON WHO IS A RECIPIENT:

1. **Benefits for organ or tissue transplant:** Benefits including, but not limited to, the following organ and tissue transplants may be available for Covered Persons, if they meet Our approved established criteria or medical policies. All transplants require Preauthorization.
 - a. liver;
 - b. heart;
 - c. single and double lung;
 - d. lobar lung;
 - e. heart-lung;
 - f. heart valve (heterograft);

- g. kidney;
- h. kidney-pancreas;
- i. pancreas;
- j. cornea;
- k. parathyroid;
- l. small intestine;
- m. small intestine and liver;
- n. small intestine and multiple viscera;
- o. bone marrow transplants, including, but not limited to, autologous and allogeneic stem cell transplants.

2. **Benefits for the donation of organs or tissues to a Covered Person:** The cost of care for Services arising from an organ donation from either live or nonliving donors, including all acquisition costs, when the recipient is a Covered Person, will be covered for the duration of the Contract of the Covered Person. Benefits for donation include Covered Services for treatment of complications resulting from the organ/tissue donation.

B. EXCLUSIONS AND LIMITATIONS:

1. **Purchased Organs or Tissue:** Benefits will not be provided for the purchase of human organs or tissue which are sold rather than donated to the recipient.
2. **Nonhuman or artificial/mechanical organs or tissue:** Benefits will not be provided for transplantation of any nonhuman organ or tissue to a human recipient, or the implantation of an artificial/mechanical organ into a human recipient. This provision does not apply to the implantation of pacemakers or LVAD's, or other devices approved by Our medical policy.

XI. BENEFITS FOR PEDIATRIC DENTAL SERVICES:

OVERVIEW: The Deductibles, Copayments, and Coinsurance amounts are stated on the Covered Person's Schedule of Benefits Summary. Benefits payable under this Contract are only available for Covered Persons up to age 19.

A. TYPES OF COVERAGE

1. Coverage A (preventive and diagnostic dentistry) shall provide benefits for:
 - a. Two comprehensive and/or periodic oral examinations (evaluations) every calendar year.
 - b. Consultation with a dental consultant.
 - c. Two prophylaxes, including cleaning, scaling and polishing of teeth every calendar year.
 - d. Two topical fluoride applications every calendar year.
 - e. Two fluoride varnishes every calendar year.
 - f. Dental x-rays, (intraoral, bitewing, occlusal periapical, extraoral) but not more than one full-mouth of x-rays in 5 calendar years, and two sets of four supplemental bitewing x-rays every calendar year.

g. Application of sealants to unrestored permanent molar teeth, but not more often than once per tooth every 3 calendar years.

h. Space Maintainers, including recementation. This does not include removal of fixed space maintainers if billed separately.

i. Pulp vitality tests.

2. Coverage B (maintenance and simple restorative dentistry) shall provide benefits for:

a. Restorations of silver amalgam and/or composite materials (if gold is used as a filling material, reimbursement will be made as for amalgam).

3. Coverage C (complex restorative dentistry) shall provide benefits for:

a. Oral surgery consisting of:

- 1) Simple and impacted extractions (not available for orthodontic extractions).
- 2) Alveoloplasty.
- 3) Surgical incision and drainage of dental abscess.
- 4) Tooth replantation.

b. Periodontic Services (treatment of diseases of gums and supporting tooth structure) consisting of:

- 1) Two periodontal evaluations every calendar year.
- 2) Up to four Periodontic cleanings every calendar year.
- 3) One gingivectomy every 3 calendar years.
- 4) One gingival curettage every 3 calendar years.
- 5) One osseous surgery, including flap entry and closure, every 3 calendar years.
- 6) One scaling and root planing per quadrant every 2 calendar years.
- 7) Mucogingivoplastic surgery.
- 8) One full mouth debridement while covered.

c. Endodontic Services (treatment of diseases or injuries of pulp chambers, Root Canals and periapical tissue) consisting of:

- 1) Pulp cap.
- 2) Pulpotomy.

- 3) Root Canal therapy including treatment plan, diagnostic x-rays, clinical procedures and follow-up care or retreatment. This shall include pulpal therapy (resorbable filling).
- 4) Apicoectomy.
- 5) Root resection.
- 6) Hemisection.
- 7) Pulpal regeneration.
- d. General Anesthesia and intravenous conscious sedation.
- e. One pre-fabricated crown per tooth on diseased or damaged teeth in 5 calendar years for Covered Persons up to age 15.
- f. Recement inlays and crowns on diseased or damaged teeth.
- g. Palliative treatment limited to opening and drainage of a tooth when no endodontics follows pericoronitis treatment or treatment for aphthous ulcers (canker sores).
- h. Treatment of complications (post-surgical), including dry socket treatment.
- i. Repair of dentures, bridges, crowns, and cast restorations after six months from the date of initial installation.
- j. Problem focused and/or emergency oral examinations.
- k. One crown per tooth every 5 calendar years.
- l. Inlays when used as abutments for fixed bridgework every 5 calendar years.
- m. Inlay restorations, subject to reimbursement as for amalgam.
- n. Onlays, limited to one per tooth every 5 calendar years.
- o. One installation of permanent bridges every 5 calendar years.
- p. One set of dentures – full or partial – every 5 calendar years.
- q. One denture relining every 3 calendar years, after six months from the date of installation.
- r. One denture rebasing every 3 calendar years, after six months from the date of installation.
- s. Adjustments of dentures after six months from the date of installation.
- t. Core buildup, limited to one per tooth every 5 calendar years.

- u. Cast post and core in addition to crown, limited to one per tooth every 5 calendar years.
- v. Dental implants are considered a Covered Service only if determined to be Medically Necessary. A review of clinical documentation will occur. In cases where services are determined to be Medically Necessary, payment would include the implant body, attachment and abutments. If the implant procedure is determined not Medically Necessary, no benefits are payable for the implant or implant related services. The alternate benefit of a standard procedure for a crown, bridge, full or partial dentures will be provided.
- w. Veneers if Medically Necessary.
- x. One occlusal guard every calendar year for Covered Persons age 13 and older.
- y. Therapeutic drug injection.

NOTE: When Coverage C services that are subject to a frequency limitation were performed prior to the effective date of coverage, the date of the prior service will be counted toward the time, frequency limitations and/or replacement limitations under this Contract.

4. Coverage D (orthodontic dentistry) shall provide benefits for:
All Services related to orthodontic treatment must be Certified to determine Medical Necessity.
- a. Cephalometric X-rays.
 - b. Panorex series x-rays, limited to not more than one in 5 calendar years.
 - c. Surgical exposure to aid eruption.
 - d. Extractions related to orthodontia.
 - e. Casts and models.
 - f. The initial and subsequent installations of orthodontic appliances, and orthodontic treatments. Benefits for braces are limited to metal appliances only.
 - g. Oral/Facial photographic images.

5. Special Provisions for Orthodontia Covered Services and Treatment:

For all forms of orthodontic treatment, if a Provider bills a single charge for the entire treatment at the start of Coverage D Covered Services, payment will be made as set forth below, unless otherwise agreed between BCBSNE and the Provider.

- a. Benefits for the initial banding will be paid upon receipt of the claim.
- b. Covered Charges will be divided by the number of months in the period of treatment, and the appropriate amount will be paid each month.

EXCLUSIONS AND LIMITATIONS

In addition to the exclusions and limitations stated in the Contract, the following may apply:

A. **EXCLUSIONS:** Benefits are not provided for the following:

- 1. Services that are not Covered Services under this Contract, or Services to the extent they exceed the limitations stated in this Contract. If a Noncovered Service is provided to a Covered Person, the responsibility for payment rests with the Covered Person unless otherwise stated. Noncovered Services include, but are not limited to, any Services, procedures or supplies for, or related to:
 - a. Dental Services received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trustee or similar person or group.
 - b. Dental Services with respect to congenital malformations (including, but not limited to missing teeth) or primarily for Cosmetic or aesthetic purposes, except as provided under Coverage D. Gnathologic tests, Orthognathic Surgery, osteoplasties, Osteotomies, LeFort procedures, vestibuloplasties and stomatoplasties are not Covered Services.

- c. Appliances, devices, procedures, dentures or restorations necessary to modify vertical dimensions of, or restore, the Occlusion, or to replace tooth structure lost through attrition, erosion, abrasion or any expense for Occlusal adjustment or equilibration, except as provided elsewhere in this Contract.
- d. Gold restorations, except as provided under coverage B or as limited under this Contract.
- e. Full or partial replacement for:
 - 1) A denture replacement made necessary by reason of the loss or theft of a denture.
 - 2) A dental appliance or prosthesis that is replaced by reason of a loss or theft.
 - 3) Crown, bridge, inlay and denture replacement made less than 5 calendar years after placement or replacement, and which were covered initially under this Contract.
- f. Temporary crowns.
- g. Caries susceptibility tests, bacteriologic studies and histopathologic exams.
- h. Magnetic resonance imaging and computed tomography (CT) scans.
- i. Replacement of third molars with prostheses.
- j. Services for orthodontic dentistry except as identified under coverage D.
- k. Services for treatment of Temporomandibular (jaw) Joint.
- l. Education or training in, and supplies used for dietary or nutrition counseling, personal oral hygiene or dental plaque control.
- m. Implants or any procedure associated with the preparation for, maintenance of or placement or removal of implants, except as otherwise indicated in this Contract.
- n. For any procedure begun after coverage under this Contract terminates or for any prosthetic dental appliance installed or delivered after coverage terminates.
- o. Retreatment or adjustment, recementation, relining, rebase, replacement or repair of cast restorations, crowns and prostheses when made by the same Dentist or dental office which provided the initial service, either within six months of the completion of the service or within any time frame, if the initial service is determined by us not to be adequate to meet nationally accepted dental standards.
- p. Duplication of x-rays.
- q. Oral pathology and laboratory services, including but not limited to biopsies.
- r. Topical medicament carrier.

- s. Desensitizing medicament and resin.
- t. Bleaching.
- u. Sealants for teeth other than permanent molars.
- v. Precision attachments, personalization, precious metal bases and other specialized techniques.
- w. Removal of dental cysts and tumors (including biopsies and excisions of mouth lesions).
- x. Excision of hyperplastic tissue.
- y. Treatment of acute infection and oral lesions.

2. Services determined by Us not to be payable after a request for Preauthorization.

3. Benefits will not be provided for services, procedures or any supplies which are considered to be for Cosmetic purposes, for personalization, or for any related services.

4. Benefits will not be provided for services, procedures or any supplies which are considered by Us to be obsolete, or for any related services. Procedures will be considered to be obsolete when such procedures have been superseded by more efficacious treatment procedures, and are generally no longer considered effective in clinical medicine or dentistry.

5. Services provided to any person 19 years of age or older.

6. Charges which exceed any calendar year or total benefit limits; charges which exceed the reimbursement amount or the Allowable Charge; or charges which exceed the actual charge for the service.

7. Charges for services provided by a Hospital, ambulatory surgical facility or any other facility charge.

8. Any expense for a procedure provided by a person who is not a Dentist or dental hygienist or who is not under the direct supervision of a Dentist.

9. Drugs dispensed in a provider's office.

10. Duplicate, provisional and temporary devices, appliances and services, unless otherwise stated.

11. Oral surgery, including but not limited to bone and osseous grafts, except as provided by this Contract.

12. Charges for services which are paid or payable under the medical provisions of the Contract or under another medical Contract issued or administered by Us.

B. LIMITATIONS:

1. If, in the construction of a denture, fixed bridgework, crown or implants to replace missing teeth, the Covered Person and the Dentist decide on personalized restoration or to employ special techniques as opposed to standard procedures, the benefits provided shall be limited to the standard procedures for prosthetic services as determined by BCBSNE.
2. If a Covered Person transfers from the care of one Dentist to another during a course of treatment, or if more than one Dentist provides services for the same treatment, our liability shall not exceed what it would have been had only one Dentist provided the service.
3. If there are optional techniques of treatment with different charges, our liability shall not exceed the lower charge.
4. Benefits for exams are limited to one exam per day when an initial or a periodic oral exam is performed during the same visit.

DEFINITIONS

Accident: An unexpected occurrence that results in injury, loss or damage such as a fall or auto accident. Fractures of teeth due to eating, biting or chewing are not considered Accidents.

Consultation: Dental services for a patient in need of specialized care requested by the attending Dentist who does not have that knowledge.

Covered Services: Dental procedures, supplies, drugs, or other dental care services, for which benefits are payable, while this Contract is in effect.

Dentist: Any person who is appropriately Licensed and qualified to practice dentistry under the law of the jurisdiction in which the dental procedure is performed and is operating within the scope of his/her license.

General Anesthesia: A controlled state of unconsciousness, accompanied by a partial or complete loss of protective reflexes, including loss of ability to independently maintain airway and respond purposefully to physical stimulation or verbal command, produced by a pharmacologic or non-pharmacologic method or combination thereof.

Gingivectomy: The excision or removal of gingival tissue.

Implant: An artificial material grafted or implanted into or onto bone.

Occlusion: Any contact between biting or chewing surfaces of maxillary (upper) and mandibular (lower) teeth.

Orthognathic Surgery: Surgery performed to correct facial imbalances caused by abnormalities of the jaw bones.

Osteotomy: Surgical cutting of bone.

Palliative: Action that relieves pain but is not curative.

Periodontal: Pertaining to the supporting and surrounding tissues of the teeth.

Pulpotomy: Surgical removal of a portion of the pulp with the aim of maintaining the vitality of the remaining portion by means of an adequate dressing; pulp amputation.

Root Canal: The portion of the pulp cavity inside the root of a tooth; the chamber within the root of the tooth that contains the pulp.

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

BCBSNE will determine whether a technology is Scientifically Validated.

Space Maintainer: A passive appliance, usually cemented in place, that holds teeth in position until the permanent teeth erupt.

Temporomandibular Joint (TMJ): The connecting joint between the base of the skull (temporal bone) and the lower jaw (mandible).

PART XII. BENEFITS FOR PEDIATRIC VISION SERVICES:

A. OVERVIEW: Benefits are available for the following Vision Services for Covered Persons up to age 19, subject to all the exclusions and limitations in the Contract.

1. One eye examination (contacts or eyeglasses) every calendar year, including refraction and dilation.
2. One eyeglass frame every calendar year.
3. One pair of prescription eyeglass lenses every calendar year.
4. One purchase for prescription contact lenses in lieu of eyeglasses every calendar year, including evaluation and fitting.
5. Medically Necessary prescription contact lenses, in lieu of eyeglasses for certain conditions, subject to Preauthorization as indicated on the Schedule of Benefits Summary. In general, contact lenses may be Medically Necessary and appropriate when the use of contact lenses will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression. Contact lenses may be determined to be Medically Necessary in the treatment of the following conditions: Keratoconus, Pathological Myopia, Aphakia, Anisometropia, Aniseikonia, Aniridia, Corneal Disorders, Post-traumatic Disorders, Irregular Astigmatism.
6. Low vision services and aids as follows:
 - a. One comprehensive low vision evaluation every five calendar years, subject to Preauthorization.
 - b. Four follow-up low vision care visits in any five calendar year period, subject to Preauthorization.
 - c. Low vision aids such as, but not limited to, high-power spectacles, magnifiers and telescopes, subject to Preauthorization. Benefits for a second or subsequent purchase of a low vision aid may be covered when:
 - there is a significant change in the Covered Person's condition;
 - growth of a Covered Person;
 - the item is irreparable or the cost of repairs exceeds the expense of purchasing a second item;
 - the item is five or more years old (unless replacement is Medically Necessary prior to that time); or
 - as otherwise determined to be reasonable and necessary.

B. EXCLUSIONS AND LIMITATIONS: In addition to the exclusions and limitations stated in the Contract, benefits are not available for:

1. Services and materials not meeting accepted standards of optometric practice;
2. Services and materials resulting from failure to comply with professionally prescribed treatment;
3. Office infection control charges;
4. Medical treatment of eye disease or injury;
5. Visual therapy;
6. Replacement of lost or stolen eyewear;

7. Non-prescription lenses, including, but not limited to, safety, athletic, or sunglass lenses;
8. Two pairs of eyeglasses in lieu of bifocals;
9. Vision prosthetic devices and related services;
10. Insurance;
11. Deluxe, athletic, safety, and sunglass frames;
12. Prescription lenses designed for safety, athletic, or sunglass;
13. Color contact lenses;
14. Laser vision correction; and
15. Services provided to any person 19 years of age or older.

PART XIII. BENEFITS FOR HOME HEALTH CARE SERVICES AND HOSPICE SERVICES

OVERVIEW: Benefits will be payable for the Medically Necessary Covered Services listed below, subject to all exclusions and limitations in the Contract. Services include those provided by a Licensed and/or a Medicare-Certified home health agency, Skilled Nursing Services for Covered Persons and Services provided by a MedicareCertified Hospice. -

A. HOME SKILLED NURSING CARE: Benefits will be paid for Skilled Nursing Care in accordance with the treatment limits stated on the Schedule of Benefits Summary. The Covered Person must need care which requires the skill, proficiency and training of a registered nurse (R.N.) or a Licensed practical nurse (L.P.N.), subject to the following:

1. The care under this paragraph must not be provided in a Hospital, a skilled nursing facility, an intermediate care facility, or a sub-acute or rehabilitation facility.
2. The care must be ordered by a Physician.
3. The care must not be primarily for the convenience of the Covered Person or his or her family.
4. Time spent bathing, feeding, transporting, exercising or moving the Covered Person, giving oral medication or acting as a companion, sitter or homemaker, will not be considered for benefit payment under this provision.
5. The care must not be provided by a nurse who is an immediate relative by blood, marriage, or adoption, or a member of the Covered Person's household.

B. HOME HEALTH AIDE: Benefits will be paid for home health aide Services provided by a Licensed or Medicare-Certified home health agency. Benefits will be payable for personal care Services provided to a Covered Person.

Home health aide Services must be ordered by a Physician, be performed in the home, and must be related to active and specific medical, surgical or psychiatric treatment of the Covered Person,

which requires the skills of a registered nurse. These Services include, but are not limited to bathing, feeding and performing household cleaning duties directly related to the Covered Person.

Benefits available for home health aide Services shall be subject to the limit indicated in the Schedule of Benefits Summary.

C. **HOSPICE SERVICES:** Benefits will be paid for Hospice Services provided primarily in the Covered Person's home by a Medicare-Certified hospice. Benefits available for covered Hospice Services shall be subject to any applicable limit indicated on the Schedule of Benefits Summary.

1. Hospice Services include the following:

- a. Hospice nursing Services provided in the home.
- b. Inpatient Hospice care.
- c. **Respite Care:** Short-term Inpatient care which is necessary for the Covered Person in order to give temporary relief to the person who regularly assists with the care at home. Respite Care may be provided in the Hospice program's designated Inpatient unit that is affiliated with the Hospice that is providing Services to the Covered Person, which may be a skilled nursing facility or a Hospital. Respite Care in such a unit need not meet Our Medical Necessity criteria ordinarily applied to Inpatient admissions.
- d. **Medical Social Services:** Services provided by a medical social worker employed by the Hospice, directly related to the Covered Person's medical condition.
- e. **Crisis Care:** Extended Skilled Nursing Care provided for up to 24 hours per day in lieu of a Medically Necessary Inpatient hospitalization.
- f. **Bereavement Counseling:** Counseling sessions provided to a Covered family member of the deceased Covered Person who was the recipient of Hospice Services. Such Services must be provided within six months of the death.

2. Benefits are subject to the following requirements:

- a. The Covered Person must have a life expectancy of six months or less as documented in writing by the attending Physician.
- b. The Hospice Services must be ordered by a Physician.
- c. Services provided must be appropriate for palliative support or management of a Covered Person with terminal medical illness.

D. **RESPIRATORY CARE:** Benefits will be paid for respiratory care services provided by a Licensed or Medicare Certified home health agency employing licensed health care practitioners operating within their scope of practice. Respiratory care services must be ordered by a Physician, be performed in the home, and must relate to active and specific medical or surgical treatment of the Covered Person which requires the skill of a registered nurse or respiratory therapist. These Services include, but are not limited to, airway maintenance, chest physiotherapy, delivery of medications, oxygen therapy, obtaining laboratory samples and pulmonary function testing.

Benefits available for respiratory care Services shall be subject to the limit indicated in the Schedule of Benefits Summary.

E. Benefits for some prescription drugs administered in an Outpatient setting, other than an emergency room, are payable only under the Rx Nebraska Prescription Drug Program, as determined by BCBSNE. A list of the prescription for which benefits are only available under the Rx Nebraska Prescription Drug Program is available at NebraskaBlue.com/Pharmacy (see Benefit Directed Medication List) or by contacting the Member Services Department.

PART XIV. BENEFITS FOR OTHER COVERED SERVICES

OVERVIEW: Benefits are available for the other Covered Services listed below, subject to all the exclusions and limitations in the Contract.

A. Ambulance Services: Benefits for Ambulance Services are not available if solely for the convenience of the Covered Person, family or provider or if a less intensive level of transportation is medically appropriate. Benefits are available for:

1. Transporting the Covered Person to the nearest facility for appropriate care for an Emergency Medical Condition.
2. Transferring a Covered Person who has received emergent care or who is an Inpatient at an 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, subject to Preauthorization and Medical Necessity.
3. Transporting a respirator-dependent Covered Person.
4. Transporting the Covered Person to and from the nearest appropriate facility for testing and/or procedures that are not available at the present facility.

B. Therapy Services: Benefits are available for Outpatient physical, occupational or speech therapy Services, chiropractic or osteopathic physiotherapy, or any combination of these Services subject to the treatment limits stated on the Schedule of Benefits Summary, and the exclusions and limitations stated in this Contract. Treatment limits stated for physical therapy, occupational therapy and speech therapy Services are not applicable to treatment provided for Mental Health and Substance Use Disorders. Ongoing preventive/maintenance therapy (excluding Habilitative Services) is not a covered benefit once the maximum therapeutic benefit has been achieved for a given condition and continued supportive therapy no longer results in some functional or restorative improvement. A session is defined as one visit. Services must be ordered or prescribed by a Physician and provided by a Licensed Provider acting within his/her scope of practice.

1. Outpatient and/or home physical therapy sessions provided by a Licensed physical therapist or Licensed physical therapist assistant. To be an Approved Provider, the Licensed physical therapist assistant must be assigned to, supervised, and billed for, by a Licensed physical therapist.
2. Outpatient and/or home occupational therapy sessions provided by a Licensed occupational therapist or Licensed occupational therapist assistant under the supervision and billing of a Licensed occupational therapist.
3. Outpatient and/or home sessions of speech therapy or Cognitive Training provided by a Licensed speech-language pathologist or registered speech-language pathology assistant practicing under the supervision of a Licensed speech-language pathologist.

4. Chiropractic or osteopathic physiotherapy by an Approved Provider.

Therapy Services described above include Habilitative Services.

C. Manipulation and Adjustments: Benefits are available for chiropractic or osteopathic manipulative treatments or adjustments by an Approved Provider, subject to the treatment limits stated on the Schedule of Benefits Summary. A session is defined as one visit.

D. Durable Medical Equipment and Related Supplies: Rental or initial purchase, whichever is least costly, of certain items of Durable Medical Equipment when prescribed by a Physician. Benefits for rental of Durable Medical Equipment shall not exceed the cost of purchasing such equipment unless otherwise approved by Us.

Benefits for a second or subsequent purchase of an item of Durable Medical Equipment may be covered as follows:

1. there is a significant change in the Covered Person's condition;
 2. growth of a Covered Person;
 3. the item is irreparable or the cost of repairs exceeds the expense of purchasing a second item;
 4. the item is five or more years old (unless replacement is Medically Necessary prior to that time); or
2. as otherwise determined to be reasonable and necessary.

Note: Benefits for oxygen and its administration, respiratory therapy, ventilation equipment, apnea monitor and continuous positive airway pressure device (CPAP) may be subject to review of the purchase versus rental provision of this paragraph as determined by Us.

In addition, reimbursement will only be made to a Durable Medical Equipment or a medical supply company for Medically Necessary repair, adjustment, and maintenance of purchased items of Durable Medical Equipment. Benefits will not be provided for Durable Medical Equipment rented, purchased from or used while confined to a Hospital, a 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.

E. Eyeglasses or contact lenses: Benefits are payable for eyeglasses or contact lenses (or their replacement), if required because of a change in prescription as a direct result of covered intraocular surgery or ocular Injury. Lens options such as tinting and coating are non-covered. Covered Services must be provided within 12 months of the date of the surgery or Injury and must be ordered by a Physician.

F. Renal dialysis: Services for renal dialysis include all charges for covered home dialysis equipment and covered disposable supplies. Benefits will also be provided dialysis training or counseling.

G. Home Infusion Therapy.

H. **In-facility/attended or home/unattended sleep studies**, when Medically Necessary as determined by BCBSNE.

I. **Diabetes**: Benefits are available for diabetes education when provided by a Certified Diabetes Educator or Licensed Medical Nutrition Therapist, including self-management training and patient management; podiatric appliances for preventing complications associated with diabetes; home visits when Medically Necessary and prescribed by a health care professional legally authorized by law to prescribe such items; and equipment and supplies used for the treatment of diabetes, including but not limited to, insulin pumps; insulin pump supplies; insulin pump batteries; glucose monitoring devices; needles; and alcohol wipes/swabs, unless otherwise covered under the Rx Nebraska Prescription Drug Program.

J. **Colorectal Cancer Screening**: Benefits are available for screening fecal occult blood test, flexible sigmoidoscopy, colonoscopy, or barium enema, or any combination, or the most reliable, medically necessary recognized screening test available and related services.

K. **Breast reconstruction**: The Covered Person who has had a mastectomy may elect coverage for breast reconstruction, surgery and reconstruction of the other breast, and prostheses and treatment for physical complications for all stages of mastectomy, including lymphedema, pursuant to the Women's Health and Cancer Rights Act of 1998.

Benefits for mastectomy bras are limited to four bras annually. Custom breast prostheses are limited to one per side every two years; fiber or foam-filled prostheses are limited to one per side every six months (two standard or prefabricated per year).

L. **Independent Laboratory Services**, regardless of where the initial service was provided.

M. **Ostomy Supplies**. Benefits are available for covered ostomy supplies which include, but are not limited to belts, dressings, pouches and skin barriers.

N. **Cochlear Implants or bone anchored hearing aid**: Benefits are available for the cost of pre-implant evaluation, the implant system, surgery, and post-surgical fitting for cochlear implants or bone anchored hearing aid devices.

O. **Hearing aids and related services**: Benefits are available for Covered Persons up to age 19 for each ear affected by a hearing impairment. Coverage includes the following Services as indicated in the Schedule of Benefits Summary:

1. A hearing aid purchased from a licensed audiologist with the medical clearance from an otolaryngologist and costs related to dispensing such hearing aid;
2. Evaluation for a hearing aid;
3. Fitting of a hearing aid;
4. Programming of a hearing aid;
5. Probe microphone measurements for verification that hearing aid gain and output meet the prescribed targets;
6. Hearing aid repairs;
7. Follow-up adjustments, servicing, and maintenance of a hearing aid;
8. Ear mold impressions;
9. Ear molds; and
10. Auditory rehabilitation and training.

P. **Contraceptive and elective sterilization Services and Supplies** not required to be covered under the federally mandated Preventive Services, including vasectomies for men and prescription drugs not on the contraceptive drug and methods pharmacy list.

Q. **Approved Clinical Trials** for qualified individuals, as described in the ACA. Covered Services include routine patient costs for items and services furnished in connection with the clinical trial, consistent with the coverage available under the Contract for a qualified individual not enrolled in an Approved Clinical Trial. Routine patient costs include:

1. Covered Services for which benefits are typically available absent a clinical trial.
2. Covered Services required solely for the provision of the experimental or Investigative Service or item, the clinically appropriate monitoring of the effects for the Service or item, or the prevention of complications.
3. Covered Services needed for reasonable and necessary care arising from the provision of an experimental or Investigative Service or item.

R. **Biofeedback.**

S. **Short term storage and retrieval** of cord blood for transplants and maternity and delivery care.

PART XV. EXCLUSIONS AND LIMITATIONS

A. This Contract does not provide benefits for the following Noncovered Services, unless otherwise provided in the Contract or required by law, or for amounts above the Allowable Charge for Covered Services, even if such Services are recommended or prescribed by a Physician or are the only available treatments for the Covered Person. Unless otherwise indicated, charges for Noncovered Services are the liability of the Covered Person. Noncovered Services include but are not limited to any Service for, or related to:

1. Services not covered by this Contract.
2. Services which are determined by Us to be not Medically Necessary.
3. Services which are considered by Us to be Investigative, or for any directly related Services.
4. Audiological screening tests (except as otherwise specifically covered under this Contract); external and surgically implantable devices (except for hearing aids, cochlear implants and bone anchored hearing aids as otherwise covered in this Contract) and combination external/implantable devices to improve hearing, including audiant bone conductors or hearing aids and their fitting.
5. Eyeglasses or contact lenses, eye exercises, visual therapy or visual training (orthoptics) except as otherwise allowed in this Contract.
6. Preventive vision examinations or care, extended vision care or exam packages, and screening eye examinations, including eye refractions, except as specifically covered elsewhere in this Contract.
7. Services for or related to any surgical, laser or nonsurgical procedures or alterations of the refractive character of the eye including but not limited to correction of myopia, hyperopia or astigmatism. Benefits for eye glasses and contact lenses are not available after this surgery.

8. Hospital or Physician charges for standby availability.
9. Personal expenses while hospitalized, such as guest meals, television rental and barber Services.
10. Dietary counseling, except as part of nutritional management for diabetes when part of diabetes education, certain conditions covered under ACA Preventive Services, and eating disorders.
11. Treatment and monitoring for obesity or weight reduction, regardless of diagnosis, including but not limited to surgical operations, weight loss programs, health and athletic club memberships, physical conditioning programs such as athletic training, body-building exercise, fitness, flexibility and diversion or general motivation.
12. Services, except as otherwise covered in this Contract, including related diagnostic testing, which are primarily:
 - a. recreational, such as music or art therapy;
 - b. educational, including school-based individualized education programs;
 - c. work-hardening therapy; vocational rehabilitation and training;
 - d. medical and nonmedical self-care; or
 - e. self-help training.
13. Treatment or removal of corns, callosities, or the cutting or trimming of nails, except as Medically Necessary.
14. Pregnancy assistance treatments, which include but are not limited to, infertility treatment and related Services, in addition to:
 - a. 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;
 - b. drug and/or hormonal therapy for fertility enhancement;
 - c. ultrasounds, lab work and other testing in conjunction with infertility treatment;
 - d. reversal of voluntary sterilization;
 - e. surrogate parenting, donor eggs, donor sperm and host uterus; and
 - f. storage and retrieval of all reproductive materials.

Diagnostic testing done to determine the diagnosis of infertility, treatment of polycystic ovary disease, and treatment of endometriosis are not considered to be infertility treatment.

15. Interest and sales or other taxes or surcharges on Covered Services, drugs, supplies or Durable Medical Equipment, other than those surcharges or assessments made directly upon employers or third party payers.

16. Repairs, maintenance or adjustment of Durable Medical Equipment except as specifically covered elsewhere in this Contract; or provided other than by a Durable Medical Equipment or a medical supply company. Repair or replacement of an item of Durable Medical Equipment will not be covered if damage occurred due to misuse, malicious damage or gross neglect, or to replace lost or stolen items.

17. The following items of Durable Medical Equipment, even if prescribed by a Physician:

- a. enuresis alarms and incontinence devices and supplies;
- b. external defibrillators;
- c. mouth guards;
- d. power seat elevation systems and chairs; and
- e. items purchased for the convenience of the Covered Person.

18. Charges made while the Covered Person is temporarily out of the Hospital.

19. Any amount paid for eligible Claims expenses which arise out of or are caused or contributed to by war or an active war. "War" means declared or undeclared war, whether civil or international, and any substantial armed conflict between organized forces of a military nature.

20. Genetic testing, unless Scientifically Validated per Our medical policy, or as required by law. Coverage for genetic counseling is limited to one (1) visit prior to genetic testing and one (1) visit following a covered genetic test.

21. Lodging, meals, and/or travel expenses by a Covered Person or provider, even though directed by a Physician for the purpose of obtaining medical treatment, except as specifically covered elsewhere in this Contract.

22. Charges made for filling out Claim forms or furnishing any records or information or special charges such as dispensing fees, admission charges, Physician's charge for Hospital discharge Services, after-hours 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.

23. Charges for any office or facility overhead expenses including, but not limited to, staff charges, copying fees, facsimile fees and office supplies.

24. Charges for failure to cancel a scheduled appointment.

25. Custodial Care, domiciliary care, rest cures, or Services provided by personal care attendants.

26. Nutrition care, nutritional supplements, FDA-exempt infant formulas, supplies, electrolytes, or other nutritional substances, including but not limited to Neocate, Vivonex, Elecare, Cyclinex-1, Pro-Phree, vitamins, minerals, elements, foods of any kind (including high protein foods and low carbohydrate foods) and other over-the-counter nutritional substances.

27. Enteral feedings, even if the sole source of nutrition.

28. Equipment for purifying, heating, cooling or otherwise treating air or water.
29. The building, remodeling or alteration of a residence; investigation and remediation of harmful contaminants such as lead and mold.
30. The purchasing or customizing of vans or other vehicles.
31. Exercise equipment.
32. Orthopedic shoes (except for initial purchase when permanently attached to a brace) and orthotics for the feet, 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 Us.
33. Food antigens, skin titration, cytotoxicity testing, treatment of non-specific candida sensitivity and/or urine auto injections.
34. 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.
35. The reduction or elimination of snoring, when that is the primary purpose of treatment.
36. Charges received when there is inadequate documentation that a service was provided.
37. Calls or consults by telephone or other electronic means, including email, and video or internet transmissions, except in conformance with Our policies and procedures, or unless provided and administered by a third party designated by Us with whom we have an agreement.
38. Mental Health Services, psychological or Substance Use Disorder counseling Services which are not within the scope of practice of the provider and Services other than by a:
 - a. Qualified Physician, Licensed Psychiatrist or Licensed Psychologist.
 - b. Licensed Special Psychologist, Licensed Mental Health Practitioner, Licensed Clinical Social Worker, Licensed Professional Counselor or Licensed Marriage and Family Therapist.
 - c. Auxiliary Providers who are supervised and billed for, by a professional provider listed at a. above, or as otherwise permitted by state law.

All Licensing or Certification shall be by the appropriate state authority. Supervision and consultation requirements shall be governed by state law.

39. Mental Health Services, psychological or Substance Use Disorder counseling Services which consist of:
 - a. programs for co-dependency; employee assistance; probation; prevention; educational or self-help;
 - b. self-help programs which treat obesity, gambling, or nicotine addiction;

- c. education, socialization, delinquency or Custodial Care for Mental Health and Substance Use Disorder;
- d. halfway houses, foster homes, or group homes and treatment groups or Substance Use Disorder maintenance programs unless otherwise covered;
- e. Inpatient or Outpatient Services ordered by the Court determined by Us to be not Medically Necessary;
- f. stress reduction classes and pastoral counseling; and
- g. Inpatient confinement for environmental change or similar treatment.

40. 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.

41. Cosmetic Services, except for Covered Services:

- a. Required as a result of a traumatic Injury.
- b. To correct a Congenital Abnormality of a Covered Person, only when the defect severely impairs or impedes normal essential functions.
- c. To correct a scar or deformity resulting from cancer or from non-cosmetic surgery. Reconstructive surgery is available only when required to restore, reconstruct or correct any bodily function that was lost, impaired or damaged as a result of Injury or Illness.

Except as stated above, this exclusion applies regardless of the underlying cause of the condition or any expectation that the Cosmetic procedure may be psychologically or developmentally beneficial to the Covered Person. Procedures for tattoo removal or revision, liposuction, telangiectasias, dermabrasion, protruding ears, breast augmentation, breast replacement, breast reduction (except when Medically Necessary) and spider veins are examples of excluded Services. Benefits for treatment of complications are not payable, unless such treatment is normally covered under this Contract.

42. Removal of skin tag.

43. Wigs, hair prostheses and hair transplants, regardless of the reason for the hair loss.

44. Hair analysis, including evaluation of alopecia or age-related hair loss.

45. Services provided to or for:

- a. Any dependent of a Subscriber who has a Single Membership, except as specified in this Contract for newborn or adopted children.
- b. Any person who does not qualify as an Eligible Dependent.
- c. Any Covered Person before his or her effective date of coverage, or after the effective date of cancellation or termination of coverage.
- d. Any Covered Person for which coverage is not available because of any Contract Waiting Periods.

46. Services for Illness or Injury related to military service.

47. Non-approved Facility: A health care facility that does not meet the Licensing or Accreditation Standards required by Us.

48. 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.

49. 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 a Covered Person is eligible for under such program (except Medicaid).

With respect to persons 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.

50. Services for which there is no legal obligation to pay, including:

- a. Services for which no charge would be made if this coverage did not exist;
- b. any charge above the charge that would have been made if no coverage existed; or
- c. any service that is normally furnished without charge.

51. Services arising out of or in the course of employment, whether or not the Covered Person fails to assert or waives his or her rights 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 an employer or individual that is not legally required to carry Workers' Compensation coverage and that does not elect Workers' Compensation coverage will be covered.

52. Charges for Services provided by a relative or person who is a member of the Covered Person's immediate family by blood, marriage or adoption.

53. Charges for Services by a health care provider which are not within the scope of practice of such provider; or charges for Services by a non-Approved Provider, or provided by or under the supervision of a health care provider determined to be non-payable by BCBSNE.

54. Charges in excess of the Contracted Amount.

55. Charges made separately for Services when they are considered to be included within the charge for a total Service payable under this Contract, 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 Blue Cross and Blue Shield of Nebraska In-network Provider, then this amount is not the Covered Person's liability.

56. Services and supplies required by an Employer as a condition of employment including, but not limited to immunizations, blood testing, work physicals and drug tests.

57. Charges made pursuant to a Covered Person's engagement in an illegal occupation or his or her commission of or attempt to commit a felony.

58. 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 Us.

59. Computed tomography (CT) of the heart with quantitative evaluation of coronary calcium, or electron beam computed tomography, for screening of cardiovascular, cerebrovascular and peripheral vascular disease.

60. Private Duty Nursing.

61. Respite care when not provided as part of a covered hospice benefit.

62. The following Services related to home health aide, Skilled Nursing Care or Hospice Services:

- a. services performed by volunteers.
- b. pastoral Services, or legal or financial counseling Services.
- c. Services primarily for the convenience of the Covered Person, or someone other than the Covered Person.
- d. home delivered meals.

63. Shipping and handling charges.

64. Services provided at the following places of Services unless otherwise approved by BCBSNE:

- a. day care;
- b. Program of All-Inclusive Care for the Elderly (PACE);
- c. school, except Covered Mental Health Services by an Approved Provider;
- d. library;
- e. church; or
- f. employee worksite, except for immunizations.

65. Services provided in association with a health fair or other employer-sponsored wellness event, unless otherwise approved by BCBSNE.

66. Supplies, equipment and similar incidental Services for personal comfort, including, but not limited to:

- a. batteries and battery chargers, unless the device is covered by Us;
- b. hot tubs;
- c. humidifiers;
- d. Jacuzzis;

- e. medical alert systems;
- f. music devices;
- g. personal computers;
- h. pillows;
- i. radios;
- j. saunas;
- k. strollers;
- l. equipment, primarily for education or a person's safety;
- m. video players;
- n. whirlpools.

67. Services otherwise covered under this Contract when:

- a. required solely for purposes of camp, travel, career, employment, insurance, marriage, adoption, or other administrative reason;
- b. related to judicial or administrative proceedings or orders;
- c. conducted for the purpose of medical research;
- d. required to obtain or maintain a license of any type.

68. Foreign language and sign language services.

69. Driving tests or exams.

70. Autopsies.

71. Services for voluntary abortions unless the attending Physician certifies that the abortion was necessary to safeguard the life of the woman, or due to a sexual assault (rape) or incest. Services for any medical complication arising from a voluntary abortion are not excluded from coverage.

72. Services, procedures, supplies or drugs provided for treatment of sexual arousal disorders or erectile dysfunction, regardless of cause.

73. Alternative therapies and programs, including, but not limited to:

- a. massage therapy, including Rolfing;
- b. acupuncture;
- c. dry needling;
- d. prolotherapy;
- e. aromatherapy;

- f. light therapy, infrared or ultraviolet therapy, and related devices;
- g. naturopathy;
- h. Vax-D therapy (vertebral axial decompression);
- i. support therapies, including personal counseling and assertiveness training;
- j. dream therapy;
- k. activity therapy, including but not limited to music, dance, art, and play;
- l. recreational therapy or care, unless covered elsewhere in this Contract;
- m. cruises;
- n. wilderness programs;
- o. adventure therapy;
- p. camps, including all activities and therapies;
- q. day care services;
- r. animal-based therapy programs; and
- s. vitamin therapy and herbal remedies.

74. Whirlpools, contrast baths, paraffin baths and iontophoresis.

75. Services provided by a massage therapist.

76. Surrogate mother Services, including but not limited to all Services and supplies relating to the conception and Pregnancy for a Covered Person or non-covered person acting as a surrogate mother.

77. Services provided under a direct primary care agreement.

78. Services by a Provider which were pre-paid by the Covered Person by virtue of a discount program, coupon, retail or online offer.

79. Replacement of lost, broken, destroyed, or stolen Covered Prescription Drug Products within the Covered Person's control. BCBSNE may allow one month supply fill per year, per medication.

80. Over-the-counter supplies, devices, tests, and medications and non-prescription medications (unless otherwise required by law or specifically designated for coverage by BCBSNE).

81. Social services.

82. Transportation, except as otherwise covered under this Contract.

83. Short term storage and retrieval for cord blood, breast milk, and other materials, except as specifically covered elsewhere in this Contract.

84. Services provided by a doula.

85. Pediatric dental or vision care services required by the ACA, for Covered Persons age 19 and over.

86. Charges for Covered Services paid by another health coverage or policy: the obligation to provide benefits under this Contract will be reduced by the amount of payment or benefits the Covered Person receives from the other coverage (unless otherwise prohibited by law, or inconsistent with other provisions of this Contract).

87. Services for the treatment of autism spectrum disorders or pervasive developmental conditions, developmental delays or sensory integration disorders (i.e., the brain's ability to integrate, process, and respond to certain information received from the body's sensory systems with respect to detecting sights, sounds, smell, taste, temperatures, pain and the position and movement of the body) unless otherwise required by law.

88. Services provided by an Out-of-network or Out-of-area Provider, except in the case of an emergency or as otherwise required by law.

PART XVI. RX NEBRASKA PRESCRIPTION DRUG PROGRAM

A. OVERVIEW:

This Part provides a description of the definitions, benefit administration, Claim filing, limitations and exclusions applicable to the Rx Nebraska Prescription Drug Program. All Covered Prescription Drug Products must be Medically Necessary and Scientifically Validated in order for benefits to be payable for a Covered Person. A Covered Person may obtain Covered Prescription Drug Products from an In-network Pharmacy. Benefits are available for up to a 90-day supply per medication, or per refill, unless otherwise specified. Some Prescription Drug Products are prepackaged or only available according to specific manufacturer guidelines. In those cases the pharmacy will be limited in the quantity dispensed, which may be less than the maximum quantity available under this Part. Benefits will be provided pursuant to this Part and in compliance with the manufacturer's packaging practices and specific guidelines.

The Covered Person will be responsible for either a Copayment or Coinsurance and a Deductible if applicable, for each 30-day supply of the medication, refill or purchase of supplies as indicated on the Schedule of Benefits Summary. Prorated cost-sharing may apply if a partial supply is requested by the prescribing physician and/or the pharmacist for the purpose of synchronizing medications. An additional Copayment is assessed for any supply in excess of 30 days, and to each 30-day supply thereafter. Benefits are available for a maximum of up to a 90-day supply per purchase. This amount may be subject to change based on the prescription drug costs of the Blue Cross and Blue Shield of Nebraska health plans. Benefits are also available for purchases from an In-network home delivery pharmacy, for up to a 90-day supply, subject to a Copayment or Coinsurance and Deductible, if any, for each 30-day supply. Additionally, the Covered Person is responsible for either a Copayment or Coinsurance and a Deductible, if applicable, for each prescription unit, dispensed container or prepackaged item. The Deductible, Coinsurance and Copayment, if applicable, are included in the Out-of-pocket Limit. Any cost-sharing, however, for prescription drugs paid with a pharmaceutical discount, drug coupon or Copay card as part of a BCBSNE sponsored program will be excluded from the Out-of-pocket Limit.

The Rx Nebraska Prescription Drug Program does not apply to prescription medication and services prescribed, dispensed and intended for use during or for Inpatient care, unless otherwise stated.

Benefits for some Prescription Drugs Products administered in an Outpatient setting, other than an emergency room, are payable only under the Rx Nebraska Prescription Drug Program, as determined by BCBSNE. A list of the prescription drugs for which benefits are only available under the Rx Nebraska Prescription Drug Program is available on the BCBSNE website NebraskaBlue.com/Pharmacy (see Drugs Administered in an Outpatient Setting) or by contacting the Member Services Department. Such prescription drug products may be subject to Specialty Pharmacy requirements.

Benefits provided pursuant to this Part are subject to all other terms, conditions, definitions, limitations and exclusions of the Contract that are not in conflict with this Part. The provisions in this Part shall supersede conflicting provisions in the other Parts of the Contract.

B. DEFINITIONS:

The following definitions are applicable to the Rx Nebraska Prescription Drug Program:

Brand Name Drug: Single source and multisource brand drugs as set forth in the Medi-Span Master Drug Database File or such other recognized source relied upon by the Pharmacy Benefit Manager or by Us. All products identified as “brand name” by the manufacturer, pharmacy, or the Provider may not be classified as Brand Name Drugs by the Pharmacy Benefit Manager or Us.

Coinsurance: The percentage amount payable by the Covered Person for the Covered Prescription Drug Products. The Coinsurance amount is indicated in the Schedule of Benefits Summary.

Compound Medication: A prescribed medication in which the ingredients are combined, mixed or altered specifically to meet the needs of a patient. A covered Compound Medication must contain at least one FDA-approved prescription ingredient.

Contracted Amount: The amount the In-network Pharmacy has agreed to accept as payment in full for Covered Prescription Drug Products pursuant to an agreement with the designated Pharmacy Benefit Manager.

Copayment or Copay: The fixed dollar amount payable by the Covered Person for the Covered Prescription Drug Products. Unless otherwise stated, Copayments do not apply to the Deductible. The Copayment amount is indicated in the Schedule of Benefits Summary.

Covered Prescription Drug Products: A prescription medication, service or supply that:

- Has been approved by the U.S. Food and Drug Administration (FDA)*;
- Has been evaluated for coverage by the Pharmacy and Therapeutics Committee of BCBSNE or the Pharmacy Benefit Manager;
- Requires a prescription from a Physician, Dentist, or other health care Provider with prescribing authority; and
- Is dispensed in compliance with a permit to conduct a Pharmacy or as otherwise permitted by state law.

**Specific non FDA-approved drugs may be covered, based on clinical guidelines or evidence as determined by the Pharmacy and Therapeutics Committee, or as required by law.*

Covered Prescription Drug Products include but are not limited to the following diabetic and insulin supplies, as shown on your Prescription Drug List:

- Insulin syringes;
- Test strips;
- Lancets/lancet devices; and
- Continuous glucose monitoring devices and supplies.

Other diabetic and insulin supplies not listed above, including, but not limited to, needles, alcohol wipes/swabs, glucose/sugar test tablets, and insulin pump supplies, are not covered under the Rx Nebraska Prescription Drug Program but are available under Other Covered Services.

Covered Prescription Drug Products also includes vaccines administered at a pharmacy.

Deductible: An amount which the Covered Person must pay each calendar year before benefits are payable under this Part. The Deductible (if applicable) is indicated in the Schedule of Benefits Summary.

Extended Supply Network: A limited network of retail In-network Pharmacies, for which Covered Prescription retail purchases in excess of 30 days may be purchased subject to the cost-share amount indicated on the Schedule of Benefits Summary.

Generic Drug: A Generic Drug as set forth in the Medi-Span Master Drug Database File or such other recognized source relied upon by the Pharmacy Benefit Manager or by Us. All products identified as “generic” by the manufacturer, pharmacy, or the Provider may not be classified as Generic Drugs by the Pharmacy Benefit Manager or by Us.

In-network Pharmacy: Licensed pharmacies that have entered into written agreements with the Pharmacy Benefit Manager designated by BCBSNE. This prescription drug coverage may include more than one level of In-network (Preferred) Pharmacies.

Narrow Therapeutic Index Medications: Medications that generally require careful dosage adjustment and patient monitoring due to small variances in a patient’s blood levels which can change the effectiveness and toxicity of the drug.

Noncovered Services: Prescription medications, services and supplies for which benefits are not payable.

Out-of-area Pharmacy: a pharmacy that contracts with another Blue Cross Blue Shield licensee outside the State of Nebraska.

Out-of-network Pharmacy: Licensed pharmacies that have not entered into written agreements with the Pharmacy Benefit Manager designated by BCBSNE.

Pharmacy Benefit Manager (PBM): Prime Therapeutics, LLC has been retained by BCBSNE to administer the Rx Nebraska Prescription Drug Program, and provide home delivery and Specialty Pharmacy services.

Pharmacy and Therapeutics Committee: The PBM/BCBSNE panel of Physicians, pharmacists and other health care professionals who are responsible for pharmacy management activities such as managing and updating the Prescription Drug List.

Preauthorization: The process of obtaining authorization from BCBSNE or the Pharmacy Benefit Manager for specified medications or specified quantities of medications.

Prescription Drug List: A continually updated list of covered pharmaceutical products, which represents the current clinical judgment of Physicians and other experts in the diagnosis and treatment of disease and preservation of health. This list is provided to In-network Pharmacies, Covered Persons, Physicians or other health care providers, and is also available on-line at NebraskaBlue.com/Pharmacy or by contacting BCBSNE member services. We reserve the right to change the Prescription Drug List at any time without prior notice in compliance with federal law.

Specialty Drugs: Designated complex injectable and oral drugs generally covered up to a 30-day supply that have very specific manufacturing, storage, and dilution requirements. Specialty Drugs are drugs including, but not limited to drugs used for: multiple sclerosis; rheumatoid arthritis; hepatitis C; Crohn's disease; anemia; and hemophilia. Specialty Drugs may only be available through designated Specialty Pharmacies. A current list of designated Specialty Drugs and suppliers is available at NebraskaBlue.com/Pharmacy or by contacting BCBSNE Member Services. We reserve the right to change designated Specialty Drugs and suppliers at any time without prior notice.

Specialty Pharmacy: A licensed pharmacy designated by BCBSNE or the Pharmacy Benefit Manager to provide Specialty Drugs.

C. BENEFIT ADMINISTRATION:

1. **In-network Pharmacies:** The Covered Person must present his or her identification card to an In-network Pharmacy, at the time a prescription is purchased. The Deductible, Copayment and/or Coinsurance must be paid directly to the dispensing In-network Pharmacy. These In-network Pharmacies have agreed not to bill or collect any amount in excess of the Copayment or Coinsurance for Covered Services, except as provided in paragraphs 3. and 4. below.

When a Covered Person presents his or her identification card at the time of purchase, the In-network Pharmacy has agreed to be reimbursed based on the Contracted Amount for the Covered Prescription Drug Product. The Covered Person is responsible for payment of the lesser of the Deductible, Copayment and/or Coinsurance; the Contracted Amount; and the usual retail price for the item.

If the Covered Person does not present his or her identification card to the In-network Pharmacy at the time of purchase, the In-network Pharmacy may collect its usual retail price for the item from the Covered Person. The Covered Person is responsible to pay this amount and to submit the Claim directly to Us for benefit payment. Benefits will be provided to the Covered Person based on lesser of the Contracted Amount or the usual retail price less:

- a. the Copayment or Coinsurance (if applicable), and
- b. the Deductible (if applicable).

2. **Out-of-network Pharmacies:** If a Covered Person obtains Covered Prescription Drug Products from an Out-of-network or Out-of-area Pharmacy, the Covered Person will be responsible to pay the pharmacy the full retail price for the Covered Prescription Drug Product. Benefits will not be provided to the Covered Person.

3. **Generic Drugs:** If a bioequivalent Generic Drug is available and has multiple manufacturers or other criteria as determined by the Pharmacy Benefit Manager or Us, reimbursement for the drug dispensed will be based on the price of the Generic Drug, unless

such reimbursement is specifically prohibited by law. If the Covered Person or the ordering provider requests a Brand Name Drug when a Generic Drug is available, and the Brand Name Drug is not otherwise excluded under the Contract, the Covered Person will be responsible for a penalty equal to the difference in cost between the Generic Drug and the Brand Name Drug equivalent (this is referred to as mandatory generic pricing). This penalty will be in addition to the Deductible, Copayment and/or Coinsurance. If the ordering provider requires a Brand Name Drug equivalent, the penalty may be waived when meeting certain requirements. The Schedule of Benefits Summary may include other specifications regarding the applicable Deductible, Copayment and/or Coinsurance for the purchase of Generic or Brand Name Drugs, including tiered benefit designs.

4. Deductible: Benefits for Covered Prescription Drug Products may be subject to a calendar year Deductible, if indicated in the Schedule of Benefits Summary. Until the Deductible is met, the Covered Person is responsible to pay the Contracted Amount for a Covered Prescription Drug Product to an In-network Pharmacy, or the usual retail price to the Out-of-network or Out-of-area Pharmacy. A Covered Person's Deductible will be met when charges paid by the Covered Person for Covered Services provided in a calendar year equal the Deductible specified in the Schedule of Benefits Summary for the Rx Nebraska Prescription Drug Program. Once the calendar year Deductible is met, the Covered Person must pay the Copayment or Coinsurance and/or any penalty amount, if applicable, as described in paragraphs 1. and 2.

5. Tiered Benefit Design: A tiered benefit design features multiple levels of Deductible, Copayments or Coinsurance for different prescription classifications. The tiers may include but are not limited to classifications or sub-classifications for: Generic Drugs, Brand Name Drugs and Specialty Drugs, and preferred and non-preferred Prescription Drugs. Sub-classifications may also be based on cost or other factors. The Deductible, Copayment or Coinsurance applicable to each tier is indicated on the Schedule of Benefits Summary.

6. Limitation on Pharmacy: We reserve the right to limit a Covered Person to an In-network Pharmacy and/or prescribing physician of his or her choice, as approved by Us or deny prescription service if We determine that his or her utilization of a prescription medication exceeds certain threshold amounts. It must be shown that such utilization reasonably demonstrates a pattern of usage that is not Medically Necessary. If a Covered Person is limited to one In-network Pharmacy, and/or one prescribing physician, no benefits will be provided for prescription medications obtained from any other pharmacy or prescribing physician. We also reserve the right to limit a Covered Person from receiving Prescription Drug Products prescribed by a certain prescriber and/or pharmacy and deny prescription claims if We determine that utilization exceeds certain threshold amounts.

7. Preauthorization Requirements: Preauthorization is required for specific medications or specified quantities of medication, as determined by Us. This authorization may require obtaining certain medications from specified pharmacies. A list of the Covered Prescription Drug Products requiring Preauthorization is available at NebraskaBlue.com/Preauth or by contacting BCBSNE Member Services. We reserve the right to change the Covered Prescription Drug Products requiring Preauthorization at any time without prior notice.

8. Prescription Drug List Exception Process: The Covered Person or Physician may request an exception for prescription drugs identified as an Essential Health Benefit not otherwise excluded under this Contract. A request for a Prescription Drug List exception must be in writing on the appropriate Prescription Drug List Exception Form, identified as a request for a Prescription Drug List exception, and include the name of the Covered Person and additional information to be considered for review. Submit the request to the address on the back of the ID card. If approved, a Prescription Drug List exception drug will be covered at the

applicable tier for the excepted drug. If the request for an exception is denied, the member or his or her prescribing physician may request a review of the denial by an Independent Review Organization.

9. Drug Copayment Program: the plan includes a drug Copayment program that utilizes manufacturer coupon assistance for the payment of select drugs purchased at designated pharmacies. For Covered Persons enrolled in this program, a variable Copayment may apply, which takes into account the manufacturer subsidy available toward the Covered Person's cost for the drug. Under this program, cost-share may be zero. Subsidy amounts paid by the manufacturer, or the plan, do not apply to the Deductible or Out-of-pocket Limit. If a Covered Person is not enrolled in the program, their standard cost-share will apply. This program may not be available to Covered Persons enrolled in an HSA-eligible plan.

D. CLAIM FILING:

1. Submission of Claims by an In-network Pharmacy: In-network Pharmacies will submit Claims to Us or to our designated Pharmacy Benefit Manager for a Covered Person's purchase of Covered Prescription Drug Products, if the Covered Person presents his or her identification card at the time of purchase. The presentation of a prescription to the pharmacist is not considered a Claim until it is submitted to the payor. If the prescription is noncovered, the pharmacist will advise the Covered Person that the usual retail price of the drug must be paid.

2. Submission of Claims by the Covered Person: The Covered Person must submit a Claim to Us for Covered Prescription Drug Products purchased from an In-Network Pharmacy if the identification card is not presented at the time of purchase. A Covered Person may also be required to submit a Claim to Us for processing of secondary plan benefits under the Coordination of Benefits provision of the Contract.

A complete itemized statement identifying the Covered Prescription Drug Product must be attached to an appropriate Claim form. To process a Claim, We must always have the Covered Person's identification number, an itemized statement identifying each item purchased, prescription number, quantity and date purchased, National Drug Code, amount charged, and other coverage information if applicable. We are entitled to any additional information needed to process the Claim. Claim forms are available at NebraskaBlue.com/Forms or by contacting BCBSNE Member Services.

If the prescription must be Preauthorized, the Covered Person's Physician must submit a Preauthorization form to Us or the Pharmacy Benefit Manager. Appeals of a denial must be sent to BCBSNE for review.

3. Time Limit for Filing a Claim: A Claim should be filed within 90 days of the time the services are provided, or as soon thereafter as is reasonably possible. If the Covered Person does not file a Claim, and any revisions or adjustments to the Claim, within 15 months of the date of service (except in the absence of legal capacity), and it was reasonably possible to do so, benefits will not be paid.

It is suggested that all Claims be filed with BCBSNE as soon as possible after expenses are incurred.

Claims should be sent to: Blue Cross and Blue Shield of Nebraska, P. O. Box 3248, Omaha, Nebraska 68180-0001.

E. ADDITIONAL PROVISIONS AND LIMITATIONS:

1. The Covered Person, by accepting benefits under this Program, authorizes and directs the In-network Pharmacies and the Pharmacy Benefit Manager to furnish copies of all information and records concerning the Covered Person to BCBSNE.
2. BCBSNE and its Pharmacy Benefit Manager will not be liable for any claim, injury, demand or judgment based on tort or other grounds (including warranty of prescriptions) arising out of or in connection with the sale, compounding, dispensing, manufacturing, or use of any prescription or supply.
3. The Rx Nebraska Prescription Drug Program may include home delivery benefits, Specialty Pharmacy requirements, Extended Supply Networks, selective Prescription Drug Lists, tiered benefit designs, reference-based pricing, maximum benefits or Preauthorization requirements. Such requirements may be stated in the Schedule of Benefits Summary.
4. Primary/Secondary Coverage: If a Covered Person has prescription drug coverage under more than one health plan, Coordination of Benefits provisions will apply. Coordination of Benefits will only apply when the Services are covered under both the primary and secondary plan's pharmacy benefits. No penalty will be imposed for submission of paper claims when BCBSNE is paying as the secondary payer.
5. Services that are not Medically Necessary are the Covered Person's liability as the agreement the In-network Pharmacies have with the Pharmacy Benefit Manager does not contain a hold harmless provision for these services, notwithstanding any other provision of the Contract.
6. Some drugs are subject to rebate arrangements between the manufacturer of the drug and the Pharmacy Benefit Manager. Rebates are not reflected in the cost paid by the Covered Person for the drug. All or part of the rebates may be passed through to Us.
7. When identical chemical entities including over-the-counter (OTC) drugs and a similar prescription alternative are available, BCBSNE may determine that only one (1) of those drug products is covered and the other equivalent products are not covered.
8. Emergency contraceptives are covered when, based on product labeling and/or FDA documentation, a prescription is required to purchase emergency contraceptives. Benefits are limited to one regimen per prescription.
9. Benefits for certain prescription drugs, based on the route or method of administration, may be payable only under the medical provisions of the Contract, and not under the prescription drug coverage. This includes but is not limited to intravenous, intrathecal, intravesical and epidural routes of administration. The Prescription Drug List reflects this limitation.
10. Coverage for a prescribed, orally administered anticancer medication that is used to kill or slow the growth of cancerous cells will be provided on a basis no less favorable than intravenously administered or injected anticancer medications covered as medical benefits.
11. An FDA approved medication is not excluded from coverage if used for appropriate off-label cancer or HIV/AIDS diagnosis treatment. BCBSNE will determine whether the off-label use is appropriate based on recognition in United States Pharmacopeia-Drug Information or recognized in multiple major peer-reviewed medical literature that are not sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier. All other exclusions listed herein will apply to situations of experimental or investigational medications not approved by the FDA.

F. EXCLUSIONS AND LIMITATIONS

The Rx Nebraska Prescription Drug Program does not provide benefits for Noncovered Services, unless otherwise provided in the Contract or endorsement, or for amounts above the Allowable Charge for Covered Prescription Drug Products, even if such services are recommended or prescribed by a Physician or are the only available treatment for the Covered Person. Unless otherwise indicated, charges for Noncovered Services are the liability of the Covered Person. All other Exclusions and Limitations stated in the Contract apply to the Rx Nebraska Prescription Drug Program unless otherwise expressly stated.

Noncovered Services include, but are not limited to the following:

1. Covered Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Weight loss, diet or appetite suppressant drugs.
3. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Illness or Injury.
4. Drugs or medicinals for treatment of fertility/infertility.
5. Cosmetic alteration drugs and health and beauty aids, including, but not limited to, drugs to promote hair growth/restoration, control perspiration, enhance athletic performance, or improve natural appearance.
6. Home infusion therapy. (See Other Covered Services.)
7. Durable Medical Equipment or devices of any type, including, but not limited to: contraceptive devices; therapeutic devices and supplies; or artificial appliances.
8. Ostomy supplies. (See Other Covered Services.)
9. Investigative drugs or drugs classified by the FDA as experimental.
10. Non-prescription vitamins.
11. Over-the-counter medications and non-prescription medications (unless otherwise required by law or specifically designated for coverage by BCBSNE).
12. Sexual dysfunction aids and treatment.
13. Prescription medications determined to be "less than effective" by the Drug Efficacy Study Implementation Program (DESI); or determined by the Pharmacy and Therapeutics Committee to have insufficient or unfavorable safety and/or efficacy data.
14. Diagnostic agents (except diabetic test strips), general anesthetics and bulk powders/chemicals.
15. Insulin pumps, insulin pump supplies, insulin pump batteries, needles, and alcohol wipes/swabs (See Other Covered Services).
16. Prescription medications purchased in a foreign country.

Exception: If the Covered Person is living in another country, or has an Emergency Medical Condition while traveling in that country, evidence of residency or an Emergency Medical Condition must be provided with the Claim, or the Claim will be denied. This evidence may be reviewed by BCBSNE. This policy is subject to change with changes in federal legislation regarding importation of drugs.

17. Abortifacients, including but not limited to Mifeprex (Mifepristone).

18. Services, drugs, and medical supplies which are not cost effective compared to established alternatives or which are provided for the convenience or person use of the Covered Person.

19. Prescription medications that have (or are comprised of) therapeutically equivalent products available without a prescription over-the-counter (OTC), except as specifically covered in this Contract. or required by law. This limitation may apply to specific prescription medications or categories of prescription medications.

20. Unit dose packaging, or sample, clinic or institutional packs not intended for retail, of Covered Prescription Drug Products.

21. Compound medications that do not contain at least one FDA-approved drug, or include a non-FDA approved ingredient(s) or ingredients that do not require a prescription; compound ingredients that are not FDA-approved.

22. Replacement of lost, broken, destroyed, or stolen Covered Prescription Drug Products within the Covered Person's control. BCBSNE may allow one month supply fill per year, per medication.

23. Prescription drugs which are prescribed, dispensed and intended for use during or for Inpatient care.

24. Prescription drugs or other Covered Services for which benefits are provided elsewhere in the Contract.

25. Any oral non-sedating antihistamine or antihistamine decongestant combination.

26. Prescription drugs or medications which are determined by Us to be not Medically Necessary.

27. Repackaged medications.

28. Brand Name Drugs for which a generic equivalent is available, unless otherwise required by law, or those which are Narrow Therapeutic Index Medications.

29. Prescription drugs, medications, supplies, devices, and tests which are determined by Us to be non-Covered as permitted by state and federal laws, including the ACA.

30. Services, drugs, and medical supplies received at an Out-of-network or Out-of-area Pharmacy.

PART XVII. CLAIM AND APPEAL PROCEDURES

A. **TIME LIMIT FOR FILING A POSTSERVICE CLAIM:** In order to receive benefits under the Contract, We must be notified when the Covered Person has received Services. A Claim should be filed by a Provider or Covered Person as soon as possible after the Services have been provided. Contracting Providers will file Claims on the Covered Person's behalf; the Covered Person is responsible to provide their identification number in order for the claim to be filed. Claims that are not filed by a BCBSNE Contracting Provider in accordance with BCBSNE's timely filing requirements, will become the Nebraska Contracting Provider's liability. A Covered Person is responsible to file a claim for Services provided by a non-Contracting Provider if the provider does not submit on his or her behalf.

If the Claim is not submitted by Covered Person within 15 months of the date of Service, except in the absence of legal capacity, benefits will not be paid.

B. **CLAIM FORMS:** Upon notice of a Claim, We will provide a Claim form within 15 days, if requested. If the form is not supplied within 15 days, the Provider or Covered Person will be deemed to have complied with the requirements of this Contract as to proof of loss upon submitting, within the time frame indicated above, written proof indicating the Service provided, the nature of that Service and the expense incurred. **CLAIMS SHOULD BE SENT TO:**

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

C. **MEDICAL RECORDS:** In consideration for the processing of Claims, We will be entitled to receive without charge, from the Subscriber and all providers of Services, such facts, records, and reports about the examination or treatment of Covered Persons as may be needed to process claims or to determine the appropriateness of benefit payment.

D. CLAIM DETERMINATIONS:

1. Preservice Claims that are not urgent (for an Emergency Medical Condition) will be processed within 15 calendar days of receipt, unless an extension is needed to obtain necessary information. If an extension is needed, We will provide the claimant/provider with notice prior to the expiration of the initial 15-day period. If information is requested, the claimant/provider may be given not less than 45 calendar days from receipt of notice to submit the specified information. A Claim determination will be made within 15 calendar days of receipt of the information or the end of the extension period.

2. If Services are urgent, the claimant/provider will be notified of the decision (whether adverse or not), not later than 72 hours after receipt of the Claim, unless further information is needed. If additional information is necessary, the claimant/provider may be afforded not less than 48 hours from the date of the request, to provide the specified information. Notification of the decision will be provided not later than 48 hours after the earlier of receipt of the specified information or the end of the period allowed to provide the information. Urgent concurrent care requests must be made at least 24 hours prior to the end of the approved Services. The expedited decision will be made 24 hours after receipt of the request. Written confirmation will be sent not later than three days after the expedited notification of the decision.

3. Postservice Claims will be processed within 30 calendar days of receipt. If additional information is needed prior to processing the Claim, payment will not be made until the requested information is received. The Claim then will be reopened or processed based on the additional information.

An extension also may be given to allow the claimant to submit specified information. The claimant may be given not less than 45 calendar days from the receipt of notice to submit the specified information. A Claim determination will be made within 15 calendar days of receipt of information or the end of the extension period.

The provider must submit specified information within the timeframe indicated in the provider contract.

A claim requiring additional information cannot be completed until the requested information is received. If this information is not received, Claims will be denied for "lack of information."

E. PROCEDURE FOR FILING AN APPEAL:

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

1. Internal Appeal:

- a. Requesting an Appeal: A request for an internal appeal must be submitted by the claimant within six (6) months of the date the Claim was processed, or Adverse Benefit Determination was made. The request should include the following information:
 - 1) state that it is a request for an appeal;
 - 2) the name of the person submitting the appeal and their relationship to the patient;
 - 3) the reason for the appeal;
 - 4) any information that might help resolve the issue;
 - 5) the date of service/claim; and
 - 6) if possible, a copy of the Explanation of Benefits (EOB).

This information should be submitted to BCBSNE on the designated appeal request form at the address and telephone number listed on the Covered Person's ID card. The BCBSNE appeal request form is included in adverse benefit determination letters and can also be found at NebraskaBlue.com/Forms.

Within three days after receipt of a request for an appeal, BCBSNE will provide the claimant an acknowledgment of the receipt of the appeal. This notice will include the name, address and telephone number of a person to contact regarding coordination of the review. A claimant does not have the right to attend, nor to have a representative in attendance at the appeal review, but may submit additional information for consideration.

- b. **Decision:** If the Adverse Benefit Determination was based on a medical judgment, including a Medical Necessity or Investigative determination, BCBSNE will consult with health care professionals with appropriate training and experience in the field of medicine involved in the medical judgment, to make the appeal determination. Identification of the medical personnel consulted, if any, will be provided to the claimant upon written request. The appeal determination will be made by individuals who were not involved in the original determination. Written notification of the decision will be provided to the claimant:
- 1) for Preservice Claims (other than Urgent Care), within 15 calendar days after receipt;
 - 2) for Postservice Claims involving an Adverse Benefit Determination based on Medical Necessity, Investigative determination or utilization review, within 15 calendar days after receipt; or
 - 3) for all other Post Service Claims, within 15 calendar days after receipt, unless additional time is needed and written notice is provided to the claimant on or before the 15th day, in which case the decision will be provided within 30 calendar days after receipt.
- c. **Expedited Appeal:** In the case of an Urgent Care Claim, an expedited appeal may be requested orally or in writing. All information, including the decision, will be submitted by telephone, facsimile or the most expeditious method available.

BCBSNE will make a decision and notify the claimant within 72 hours after the appeal is received. Written notification will be sent within the 72-hour period.

Concurrent Care: A request for an expedited appeal of a concurrent care denial must be made within 24 hours of the denial. If requested within this time period, coverage will continue for the health care services pending notification of the review decision, as may be required by law. The decision timeframe will be the same as for other expedited appeals.

- d. The decision made pursuant to this appeal is considered a Final Internal Adverse Determination.

2. Rights to Documentation: A claimant shall have the right to have access to, and request copies of the documentation relevant to the claim and Adverse Benefit Determination(s), including any new evidence or rationale considered or relied upon in connection with the claim on review.

The claimant may submit additional comments, documents or records relating to the claim for consideration during the appeal process.

3. Request for External Review: You can apply for an external review online through the Nebraska Department of Insurance (NDOI) website by going to www.doi.nebraska.gov and selecting "Appeal a Denied Health Insurance Claim." This online application replaces the need to complete forms and submit them to the NDOI by mail or fax. Printable versions of external review forms are also available on the NDOI website or they can be mailed to you upon request by calling the NDOI at 877-564-7323 (toll-free in Nebraska) or 402-471-0888.

a. Standard Review: The claimant may request a review by an Independent Review Organization (IRO) of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination which was based on a judgment as to the Medical Necessity, experimental or investigational nature, appropriateness, health care setting, level of care, or effectiveness of the health care service or treatment. The claimant must exhaust the internal appeal process prior to a request for External Review. The request must be submitted in writing within four (4) months after the date of receipt of a notice of a Final Internal Adverse Benefit Determination. The Covered Person will be required to authorize the release of any of his or her protected health information, including medical records, which may be needed for the purpose of the 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). The request should be submitted to:

Nebraska Department of Insurance
P.O. Box 95087
Lincoln, NE 68509-5087
www.doi.nebraska.gov

Upon receipt of a request for an External Review, the Nebraska Department of Insurance (NDOI) will forward the request to BCBSNE to conduct a preliminary review to determine if it is complete and whether it is eligible for External Review, consistent with applicable law. BCBSNE will conduct this preliminary review within 5 business days of receipt, and notify the NDOI and the claimant of the outcome within one business day. If it is determined that the request is not complete, or is not eligible for External Review, the claimant will be notified of the reason for the ineligibility, or advised of the information needed to make the request complete. The NDOI may determine that the request is eligible notwithstanding BCBSNE's determination, consistent with state law.

If the request is eligible for External Review, the NDOI will assign an IRO to conduct the review, and notify BCBSNE and the claimant of the assignment within one business day. BCBSNE will forward all documentation and information considered in making the initial Adverse or Final Internal Adverse Benefit Determination, including a summary of the Claim and explanation for the determination, to the IRO within 5 business days. The claimant will also be allowed an opportunity to submit additional information for consideration by the IRO. The IRO shall provide BCBSNE with any information submitted by the claimant, to allow BCBSNE an opportunity to reconsider its original determination.

The IRO shall complete its review and provide the claimant written notification and rationale for its decision within 45 days of receipt of the request for review. No deference shall be given to the prior determinations made by BCBSNE pursuant to the internal appeal process.

b. Expedited External Review: An expedited External Review may be requested at the same time a claimant requests an expedited internal appeal (1.c., above) of an Adverse Benefit Determination concerning:

- 1) an Urgent Care Claim; or
- 2) a denial on the basis that the requested service or treatment is Investigative, if the Covered Person's Treating Physician certifies in writing that the service or treatment would be significantly less effective if not promptly initiated.

However, the claimant must first exhaust the internal appeal process, unless otherwise waived by BCBSNE or directed by the IRO, consistent with state law.

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

- 1) the Covered Person has a medical condition where the timeframe for completion of a standard External Review, as described in paragraph 3.a., above, would seriously jeopardize the life or health of the Covered Person or would jeopardize his or her ability to regain maximum function; or
- 2) the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care service for which the Covered Person has received Emergency Services, but has not been discharged from a facility; or
- 3) the Final Internal Adverse Benefit Determination is based on a determination that the requested service or treatment is Investigative, if the Covered Person's Treating Physician certifies in writing that the service or treatment would be significantly less effective if not promptly initiated.

The process for coordination of the expedited request between the NDOI, BCBSNE and the IRO, as described above for a standard review, will be done promptly upon receipt, by telephone, facsimile, or the most expeditious manner available.

An expedited External Review decision shall be made by the IRO within 72 hours after receipt of the request, or as otherwise required by law. If notification of the decision to the claimant and BCBSNE was not in writing, the IRO will provide the decision in writing within 48 hours after the oral notification.

An Expedited External Review is not available for retrospective Adverse or Final Internal Adverse Benefit Determinations.

- c. The decision of the IRO is the final review decision, and is binding upon BCBSNE and the claimant, except to the extent the claimant has other remedies available under applicable federal or state law.

A Covered Person or his or her representative may not file a subsequent request for External Review involving the same Adverse Benefit Determination (initial or Final) for which the Covered Person has already received an External Review decision pursuant to this provision.

ADDITIONAL INFORMATION

The Department of Insurance may be contacted for assistance with the Appeal and External Review process at any time at:

Nebraska Department of Insurance
P.O. Box 95087
Lincoln, NE 68509-5087
(877) 564-7323

PART XVIII. COORDINATION OF BENEFITS

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one Plan. 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 Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan.

When This Plan is secondary, 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. The Secondary Plan will not pay more than the Primary Plan's contracted reimbursement rate. 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 care coverage. Also, where the Primary Plan is medical payments coverage under a motor vehicle policy, the Secondary Plan shall credit payments from the motor vehicle insurance policy to deductibles, copayments and coinsurance after discounts under the health plan.

A. WITHIN THIS PART, THE FOLLOWING DEFINITIONS APPLY:

1. **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, Preauthorization of admissions, and Preferred Provider arrangements.

2. **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.

3. **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.

4. **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 and non-group insurance contracts and subscriber contracts, health maintenance organization (HMO) contracts, or Closed Panel Plans; other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits coverage in motor vehicle “no fault” and traditional “fault” type contracts; group and nongroup insurance contracts and subscriber contracts that pay or reimburse for the cost of dental 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 motor vehicle “no fault” and traditional “fault” contracts; ; uninsured or underinsured coverage under a motor vehicle policy; specified disease or specified accident coverage; limited benefit health coverage, as defined in state law; school accident coverage; disability income insurance; 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.

5. **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.

6. **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.

7. **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.

8. Any other definitions stated in the Nebraska COB regulations are incorporated herein by this reference.

B. ORDER OF BENEFITS:

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

1. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.
2. 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 state that the complying plan is primary.
3. 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.

4. Each Plan determines its order of benefits using the first of the following rules that apply:

a. Subscriber and Dependent. The Plan that covers the person as other than a dependent, such as a subscriber/policyholder/employee, 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.

b. 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:

1) 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; or

If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.

2) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

a. If a court decree states that one of the parents is responsible for the dependent 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 commencing after the Plan is given notice of the court decree;

b. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph 1) above shall determine the order of benefits;

c. 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 provision of subparagraph 1) above shall determine the order of benefits; or

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:

- i) the Plan covering the Custodial Parent;
- ii) the Plan covering the spouse of the Custodial Parent;
- iii) the Plan covering the non-custodial parent; and then

iv) the Plan covering the spouse of the non-custodial parent.

3) For a dependent child covered under more than one Plan of individuals who are not parents of the child, the provisions of subparagraph 1) or 2) above shall determine the order of benefits as if those individuals were the parents of the child.

4) For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in paragraph e., below applies. In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parent's plans, the order of benefits shall be determined by applying the birthday rule in paragraph b.1), above, to the dependent child's parent(s) and the dependent's spouse.

c. 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 rule labeled 4.a. can determine the order of benefits.

d. 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/member/employee/retiree or covering the person as a dependent of a subscriber/member/employee/retiree 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 rule labeled 4.a. can determine the order of benefits.

e. Longer or Shorter Length of Coverage. The Plan that covered the person 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:

- 1) a change in the amount or scope of a plan's benefits;
- 2) a change in the entity that pays, provides or administers the Plan's benefits; or
- 3) a change from one type of Plan to another, such as from a single employer plan to a multiple employer plan.

f. If the preceding 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.

C. MISCELLANEOUS PROVISIONS

1. 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.
2. To properly administer these COB rules, certain facts are needed. The Plan may obtain or release information to any insurance company, organization or person. BCBSNE need not notify, or obtain the consent of, any person to do so. Any person who claims benefits under this Contract agrees to furnish the Plan information that may be necessary to apply these rules and determine benefits available.
3. If another Plan pays benefits that should have been paid under this Contract, this Plan may reimburse such other Plan any amounts determined to be necessary. Amounts paid to other Plans in this manner will be considered benefits paid under this Contract and This Plan is discharged from liability.
4. If the amount of the benefits paid by This Plan exceeds the amount it should have paid under this Part, then 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 the Subscriber.
5. For COB provisions related specifically to telehealth services, please see the Telehealth and Telemedicine Services section.

PART XIX. SUBROGATION AND CONTRACTUAL RIGHT TO REIMBURSEMENT

A. 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 this Contract, We shall be subrogated to all of the Covered Person's rights of recovery against any person or organization to the extent of the benefits paid. The Subscriber, the Covered Person or the person who has a right to recover for a Covered Person (usually a parent or spouse), agrees to make reimbursement under this Part if payment is received from the person who caused the Illness or Injury or from that person's liability carrier. Subrogation does not apply to medical payments made under the medical payments coverage of the Covered Person's own individual automobile policy (Coordination of Benefits is applicable to those payments). In addition, subrogation does not apply to payments made under the underinsured or uninsured provisions of the Covered Person's own individual automobile policy.

Our subrogation claim 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. BCBSNE may seek subrogation in the event that a Covered Person has been compensated for their loss as required by applicable law. Our rights under this provision cannot be defeated by allocating the proceeds, in whole or in part, to nonmedical damages. BCBSNE has the sole authority and discretion to resolve all disputes regarding the interpretation of the language stated under this Part.

B. CONTRACTUAL RIGHT TO REIMBURSEMENT: In the event a Covered Person receives full or partial proceeds from any other source for Covered Services for an Illness or Injury, We have a contractual right of reimbursement to the extent benefits were paid under this 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.

Such proceeds may include any settlement; judgment; payments made under auto insurance (except the Covered Person's own individual auto medical payments or uninsured/underinsured

coverage); individual or group no-fault auto insurance; another person's uninsured, underinsured or 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.

C. When We recover proceeds under this Part for all or a part of the claim, amounts previously credited to a Covered Person's Deductible or Coinsurance liability will be removed. Future Claims will be subject to the reinstated Deductible or Coinsurance.

D. 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 Us. The right to recover, whether by subrogation or other reimbursement, shall apply to settlements or recoveries of deceased persons, or minor dependents of a Subscriber, incompetent or disabled Subscribers or their incompetent or disabled Eligible Dependents.

E. The Subscriber agrees to fully cooperate and assist in any way necessary to recover such payments, including but not limited to notifying Us of a claim or lawsuit filed on his or her behalf or on behalf of any Eligible Dependents for an Injury or Illness. The Subscriber, Eligible Dependent or an authorized representative shall contact Blue Cross and Blue Shield of Nebraska prior to settling any claim or lawsuit to obtain an updated itemization of its subrogation claim or reimbursement amount due. Upon receiving any proceeds subject to this Part, 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. Such party holding the funds that rightfully belong to the Plan shall not interrupt or prejudice the Plan's recovery under this Part.

F. Costs incurred in enforcing these provisions shall also be recovered, including, but not limited to, attorneys' fees, litigation and court costs and other expenses.

PART XX. 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 rights 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 Exclusions and Limitations)

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 this Contract for Services related to that Injury or Illness.

Benefits are not payable for Services determined to be not compensable due to noncompliance with the terms, rules and conditions under Workers' Compensation laws, or 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 this Contract. If payment is received by the Covered Person for such Services, reimbursement must be made. This reimbursement may be funded 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.

PART XXI. GENERAL PROVISIONS

A. **CERTAIN DEFENSES:** All statements, in the absence of fraud, made by You or the Covered Person will be deemed representations and not warranties. No such statements will void coverage or reduce the Contract benefits unless contained in Application. Neither acceptance of premium nor payment of Claims will constitute a waiver of available defenses.

B. **LEGAL ACTIONS:** You cannot bring a legal action to recover under the Contract for at least 60 days after written proof of loss is given to Us. You cannot start a legal action after three years from the date written proof of loss is required.

C. **ADDRESSES FOR NOTICE:** Our address is P.O. Box 3248, Omaha, Nebraska 68180-0001. Your address is the most recent address appearing on Our records.

D. **CONFORMITY WITH STATUTES:** Any Contract provision which on its effective date is in conflict with the law of the federal government or the State of Nebraska is hereby amended to conform to the minimum requirements of such law.

E. **TIME LIMIT ON CERTAIN DEFENSES:** After two years from the effective date of this Contract, no misstatements, except fraudulent misstatements made in the Contract will be used to void the Contract or to deny a Claim for loss incurred after the expiration of such two-year period. No Claim for loss that starts more than 365 days after the Contract effective date will be reduced or denied on the grounds that a condition not excluded from coverage existed prior to such effective date.

F. **INDEPENDENT CORPORATION:** You, on behalf of Yourself and Your dependents, hereby expressly acknowledge Your understanding that this Contract constitutes a contract solely between You and BCBSNE, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting BCBSNE to use the Blue Cross and/or Blue Shield Service Marks in the State of Nebraska and that BCBSNE is not contracting as the agent of the Association. You further acknowledge and agree that You have not entered into this Contract based upon representations by any person other than BCBSNE and that no person, entity, or organization other than BCBSNE shall be held accountable or liable to You for any of the obligations created under this Contract. This paragraph shall not create any additional obligations whatsoever on the part of BCBSNE other than those obligations created under other provisions of this Contract.

G. **INDEPENDENT CONTRACTORS:** BCBSNE does not engage in the practice of medicine and all In-network Providers provide Covered Services under the terms of this Contract as independent practitioners of the healing arts. Such providers are not employees or agents of BCBSNE or the On-site plan, and BCBSNE will not be liable for any act, error or neglect of any Hospital, Physician or other provider or their agent, employee, successor or assignee.

H. ANNUAL MEETING:

When this Contract becomes effective, You become a member of GoodLife Partners, Inc., a mutual insurance holding company and the overall parent company of Blue Cross and Blue Shield of Nebraska, Inc., which is to be distinguished from member of an association as is referred to in this Contract. You have the right to vote at the Annual Meeting of members held at Our home office in Omaha. The Meeting is held at 4:00 p.m. on the last Monday of March each year. If You do not attend the meeting, You may appoint another Member as Your proxy to vote for You. To have another person vote for You, You must appoint that person in writing, and file that appointment with Us at least five days before the meeting. If You do not attend the meeting, and do not appoint another person as Your proxy, the Chairperson of the Board of Directors or in the absence of the Chairperson, a person the Chairperson appoints, will be Your proxy to vote for You on all matters

coming before the meeting. This proxy will be valid as long as this Contract remains in force, unless You revoke it.

I. **LIMITATIONS OF DAMAGES:** Our entire liability shall not exceed the amount of benefits provided by this Contract, regardless of the form of the action. In no event shall We be liable for consequential, incidental, special or indirect damages regardless of whether it has been advised of the possibility of such damages.

J. **HEALTH INSURANCE MARKETPLACE LIABILITY:** BCBSNE is not liable for any action, inaction, error and/or omission (collectively “action”) undertaken by the Health Insurance Marketplace (a/k/a the Exchange), the State of Nebraska, and/or any agency or department of the federal government for anything related to subsidies, including subsidy-eligibility determinations and payment; enrollment, cancellation and/or termination of coverage under the Contract; eligibility for health benefits or cost-share reductions; or for any other action related to health care benefits offered by BCBSNE, including the benefits offered under this Contract.

PART XXII. DEFINITIONS

The definitions contained in this glossary are of terms used in this Contract.

ACA: The Patient Protection and Affordable Care Act and implementing regulations and sub-regulatory guidance.

Advance Premium Tax Credit: The advance premium assistance credit available under Internal Revenue Code section 36B for individuals who meet certain income requirements, as determined by the Health Insurance Marketplace.

Advanced Diagnostic 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 (fMRI), positron emission tomography (PET) scans, single photon emission computed tomography (SPECT) scans and other nuclear medicines.

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:

1. the application of Utilization Review;
2. a determination that the Service is Investigative;
3. a determination that the Service is not Medically Necessary or appropriate;
4. an individual's eligibility for coverage or to participate in a plan;
5. an unexpected (“surprise”) balance bill from an Out-of-network Provider for emergency and certain non-emergency Services.

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.

Aggregate Deductible and/or Out-of-pocket Limit (for Family Membership Units): Aggregate Deductible means the entire family amount must be met before benefits are available. Aggregate Out-of-pocket Limit means the entire family amount must be met before cost-sharing is no longer applicable. Family members may combine their Covered expenses to satisfy the family amounts.

Allowable Charge: An amount We use to calculate Our payment of Covered Services. This amount will be based on the Contracted Amount for In-network Providers.

Ambulance Services: Any privately or publicly owned motor vehicle or aircraft that is especially designed, constructed or modified, and equipped and is intended to be used and is maintained or operated for the overland or air transportation of patients upon the streets, roads, highways, airspace, or public ways or any other motor vehicles or aircraft used for such purposes.

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 Clinical Trial: A phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is one of the following:

1. A federally funded or approved trial.
2. A clinical trial conducted under an FDA investigational new drug application.
3. A drug that is exempt from the requirement of an FDA investigational new drug application.

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 this Contract, Nebraska law or pursuant to the direction of Blue Cross and Blue Shield of Nebraska.

Auxiliary Provider: A Certified social worker, psychiatric registered nurse, Certified alcohol and drug abuse 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, Licensed Psychiatrist or Licensed 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.

BCBSNE: Blue Cross and Blue Shield of Nebraska, Inc.

BlueCard Program: A Blue Cross Blue Shield Association (BCBSA) program which is a collection of policies, provisions and guidelines that enables Blue Cross and Blue Shield of Nebraska to process Claims incurred by Covered Persons residing or traveling outside its Service Area by utilizing the discounts negotiated by the Host Blue Plan and its contracting providers

Certification: 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 JCAHO, CARF, the American Association for Ambulatory Health Care (AAAHC), the 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 Contract.

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.

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.

Contract: The agreement between You and Blue Cross and Blue Shield of Nebraska, including the Application, Your Schedule of Benefits, Your Schedule of Benefits Summary, this document and any attachments or endorsements.

Contracted Amount: The Allowable Charge agreed to by Us or a Host Blue Plan and Contracting Providers, for Covered Services received by a Covered Person.

Contracting Provider: An In-network Provider or a Blue Cross and Blue Shield of Nebraska 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 or Copay: A fixed dollar amount of the Allowable Charge, payable by the Covered Person for a Covered Service. Copayments are separate from and do not accumulate to the Deductible.

Cosmetic: Any Services provided to improve or change the Covered Person's physical appearance or characteristics, 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 this Contract underwritten and administered by Blue Cross and Blue Shield of Nebraska.

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

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 Covered Person who:
 - a. is intellectually 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 Covered Person 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.

A Custodial Care determination may still be made if the care is ordered by a Physician or Services are administered by a registered or Licensed practical nurse.

Deductible: An amount of Allowable Charges that must be paid by the Covered Person each calendar year for Covered Services before benefits are payable by this 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 Covered Person'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. This term also includes items commonly referred to as home medical equipment.

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 guardian, but does not include a foster child.

3. Reaching age 26 will not end the covered child's coverage under this Contract as long as the child is, and remains:

- a. incapable of self-sustaining employment by reason of intellectual or physical disability,
- b. unmarried, and
- c. dependent upon the Subscriber for support and maintenance.

An extension of coverage request must be received within 31 days of the end of the month in which the child reaches age 26 and after that, as required (but not more often than yearly after

two years of such disability). Determination of eligibility under this provision will be made by Us subject to meeting the requirements of a.,b. and c. above, and meeting the disability standards and criteria stated in this paragraph 3. Any extended coverage under this paragraph will be subject to all other provisions of this Contract.

Physical or intellectual disability means a severe disability of a person which: a) is attributed to a physical or mental impairment or combination of physical or mental impairments; b) is manifested before the person attains age 26; c) is likely to continue indefinitely; and d) results in incapability of performing self-sustaining employment.

Severe disability means substantial functional limitations in three (3) or more of the following areas of major life activities: a) self-care; b) receptive and expressive language; c) learning; d) mobility; e) self-direction; or f) capacity for independent living; and reflects the person's need for treatment or other services which are of an indefinite duration and are individually planned and coordinated.

A Physician's statement may be required.

A determination of eligibility to continue a dependent child's coverage under this provision will be made within 45 days. A Subscriber has a right to appeal an adverse benefit determination (denial) regarding an extension of coverage due to disability. An appeal request must be submitted to Us in writing within 180 days of the determination. The Subscriber has a right to have access to, and request copies of the documentation relevant to the adverse benefit determination. Written notification of the appeal decision will be provided within 45 days after receipt of the request.

4. For purposes of a "Child-Only" plan covering more than one child in a family (siblings), Eligible Dependent shall include the covered children other than the primary insured identified by BCBSNE or the Marketplace.

5. Coverage for Eligible dependents turning 26 years of age during the benefit year will continue through December 31 of the same year, or until coverage is terminated by You.

Embedded Deductible and/or Out-of-pocket Limit: An embedded amount means that no one family member contributes more than the individual amount to satisfy the family amount under a Family Membership Unit.

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 layperson, 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.

Emergency Services: Health care Services Medically Necessary to screen and stabilize a Covered Person in connection with an Emergency Medical Condition and the provider or facility determines such individual is able to travel using nonmedical transportation.

Essential Health Benefits: The ACA identifies ten categories of Covered Services as Essential Health Benefits: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; Mental Health and Substance Use Disorder Services, including behavioral health treatment; prescription drugs; rehabilitative and Habilitative services; laboratory services; preventive

and wellness services and chronic disease management; and pediatric services, including oral and vision care. Pediatric oral and vision care Services may be provided under a separate plan or contract.

Exclusive Provider Organization: A panel of Hospitals, Physicians and other health care providers who belong to a network of Preferred Providers, where Services are only covered when visiting the select list of providers, unless otherwise specified.

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 set forth herein.

Habilitative Services: Services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These Services may include physical and occupational therapy, speech-language pathology and other Services for people with disabilities in a variety of Inpatient and/or Outpatient settings.

Health Insurance Marketplace (Marketplace): A governmental agency or non-profit entity that meets the applicable federal standards and makes Qualified Health Plans available to qualified individuals and qualified employers. Unless otherwise identified, this term refers to State, Federally-facilitated, regional or subsidiary Health Insurance Marketplaces. This term may also be referred to as an "Exchange."

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

Hospital: 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 that 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 by 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 an Exclusive Provider Organization in Nebraska.

Inpatient: A Covered Person 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 is investigative if it has not been Scientifically Validated. BCBSNE will determine whether a technology is Investigative.

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.

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

Medically Necessary (or used as "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 Covered Person. 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 Covered Person's Illness, Injury or Pregnancy, without adversely affecting the Covered Person's medical condition; and
4. not provided primarily for the convenience of any 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.

Blue Cross and Blue Shield of Nebraska 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.

1. **Single Membership:** Membership option providing benefits for Covered Services provided to the Subscriber only.
2. **Family Membership:** Membership option providing benefits for Covered Services provided to the Subscriber and his or her Eligible Dependents.

Other Membership Units may be available, as determined by BCBSNE.

Mental Health: 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).

Mental Health Services Provider: A qualified Physician, Licensed Psychologist, Licensed Psychiatrist, Licensed Special Psychologist, or Licensed Mental Health Practitioner. A Licensed Mental Health Practitioner may also be a Licensed Professional Counselor, Licensed Marriage and Family Therapist or a Licensed Clinical Social Worker who is duly Certified/Licensed for such practice by state law. Mental Health Services Provider also includes, for purposes of this 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.

Licensed Psychologist: 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 Psychiatrist: A person Licensed to engage in the practice of psychiatry to diagnose and treat complex and serious Mental Health conditions. In addition to psychotherapy, treatment provided by a Licensed Psychiatrist may involve prescribing medications.

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.

Noncovered Services: Services that are not payable under this Contract.

Open Enrollment Period: The designated period each year during which eligible persons may enroll or change options.

Out-of-network Allowance: An amount We use to calculate Our payment for Covered Services to an Out-of-network Provider. This amount will be determined by BCBSNE, or a Host Blue Plan for out-of-area providers.

Out-of-area Provider: a provider who contracts with another Blue Cross Blue Shield licensee outside the State of Nebraska.

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

Out-of-pocket Limit: The maximum amount of cost-sharing each Covered Person and/or Membership Unit must pay in a calendar year before benefits are payable without application of a cost-share amount. The Out-of-pocket Limit includes Deductible, Coinsurance and Copayment amounts for medical and pharmacy Services. The Out-of-pocket Limit does not include premium amounts, amounts over the allowable charge, or penalties for failure to comply with Preauthorization requirements or as imposed under the Rx Nebraska Prescription Drug Program. The In-network Out-of-pocket Limit is based on the dollar limit set under Section 1302(c)(1) of the ACA, as adjusted on an annual basis under Section 1302(c)(4) of the ACA.

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 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 Health and Substance Use Disorders 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 JCAHO or CARF.

Physical Rehabilitation: The restoration of a person who is disabled as the result of an Injury or an acute physical impairment to a level of function that allows the 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 an unrestricted License and duly authorized to practice medicine and surgery and prescribe drugs.

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

Preauthorization/Preauthorized: A determination by Us or Our designee, that an admission, extension of stay or other health or dental 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.

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 part of the network in Nebraska.

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 Contract, Pregnancy also includes a condition or complication caused by Pregnancy, but separate from, and not part of the Pregnancy if 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(s): Any Claim for a benefit under this 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.

Preventive and/or Preventive Services: Services which focus on the prevention of disease and health maintenance, including the early diagnosis of disease, discovery and identification of high risk for a specific problem, and interventions to avert a health problem in nonsymptomatic individuals.

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 Our 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 Covered Persons over the long term.

Qualified Health Plan (QHP): A health plan that has in effect a certification that it meets the standards issued or recognized by each Health Insurance Marketplace through which the plan is offered.

Residential Treatment Program: Services or a program organized and staffed to provide both general and specialized nonhospital-based interdisciplinary Services 24 hours a day, seven days a week for persons with behavioral health disorders. 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 Summary: A summarized personal document which provides information about Copayments, Deductibles, percentages payable, special benefits, maximums and limitations of coverage

Scientifically Validated: A technology, drug, biological product, device, diagnostic, treatment or procedure is Scientifically Validated that 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 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 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 net health outcome.
4. The technology must improve the net health outcome as much as or more than established alternatives.
5. The improvement must be attainable outside the investigational settings.

Blue Cross and Blue Shield of Nebraska 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 a licensed nurse (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 this Contract.

Special Enrollment Period: A period of time (outside of an Open Enrollment Period) during which an individual 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 this 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 this Contract. For purposes of a "Child-Only" plan covering more than one child in a family (siblings), Subscriber shall mean the primary insured identified by BCBSNE or the Marketplace.

Substance Use Disorder: Alcoholism, drug abuse and nicotine dependence or addiction.

Substance Use Disorder 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 facilities are 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 Use Disorder.

Total Care: Also known as value-based programs. Total Care is an outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local providers that is evaluated against cost and quality metrics/factors and is reflected in provider payment. Total Care (value-based programs) may include, but are not limited to, Accountable Care Organizations, Global Payment/Total Cost of Care arrangements, Patient Centered Medical Homes and Shared Savings arrangements.

Treating Physician: A Physician who has personally evaluated the Covered Person. This may include a Physician or oral surgeon, Certified nurse midwife, 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 the time periods for making non-urgent care determinations:

1. could seriously jeopardize the life or 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.

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

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

You or Your: The Subscriber.