NEBRASKA

BluePreferred® Basics Health Plans

OUTLINE OF COVERAGE

HEALTH PLANS for Individuals

For coverage beginning January 1, 2012

NEBRASKA

You should read your contract carefully.

This outline of coverage provides you with an overview of the Blue Cross and Blue Shield of Nebraska Blue*Preferred*® Basics coverage.

This is not your contract. Only the actual benefit provisions in your contract determine your benefits. The contract itself sets forth in detail the rights and obligations of both you and Blue Cross and Blue Shield of Nebraska. In the event that there are discrepancies with the information in this document, the terms and conditions of the contract will govern.

Therefore, it is important that you read your contract carefully.

For more complete information about your plan, including benefits, exclusions and limitations, please refer to the Blue*Preferred* Basics contract. All plans are medically underwritten.

These plans are underwritten and administered by Blue Cross and Blue Shield of Nebraska, an independent licensee of the Blue Cross and Blue Shield Association.

Blue*Preferred* Basics

Blue*Preferred* Basics Health Plans outlined here and detailed in the contract are designed to provide you with coverage for hospital, medical and surgical expenses incurred as the result of a covered illness or injury. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital services and out-of-hospital care. Covered services are subject to deductible and coinsurance provisions, or other limitations set forth in the contract.

Blue*Preferred* Basics are available for single coverage only to adults age 19 and older.

Important Information: Blue*Preferred* Basics does not provide benefits for pregnancy and maternity services or treatment for mental illness or substance abuse. Blue*Preferred* Basics Options 1 and 2 do not provide outpatient benefits.

Calendar Year Deductible

The deductible is the fixed dollar amount you pay for covered services each calendar year before benefits are available.

Coinsurance and Your Calendar Year Coinsurance Maximum

After you have met your calendar year deductible, you are responsible for paying a certain percentage of covered charges (called "coinsurance") until you reach your coinsurance maximum. Once you reach your coinsurance maximum, you pay nothing for most covered services for the rest of the calendar year.*

**The following do not apply toward the coinsurance maximum: Copay amounts for prescription drugs and office visits.*

Refer to the chart on page 3 to determine the deductible and coinsurance responsibilities for your coverage.

Allowable Charge

Payment is based on the allowable charge for a covered service. Generally, the allowable charge for services by PPO and participating providers will be the contracted amount. The allowable charge for services by noncontracting providers will generally be the lesser of the billed charge or the reasonable allowance for the service. You are responsible for the charges in excess of the contracted amount for services provided by a non-contracting provider.

NEtwork BLUE

Blue*Preferred* Basics is a NEtwork BLUE health benefit plan. Whatever option you choose, you have access to a large network of hospitals, doctors and other health care providers. Our NEtwork BLUE network is made up of 93% of the state's doctors and 100% of non-governmental acute care hospitals. You save money when you use in-network providers. In most cases, you pay less in deductible and coinsurance when you use in-network providers – plus, in-network providers have agreed to accept our benefit payment for covered services as payment in full (except for deductibles, copays, coinsurance and/or charges for noncovered services, which are your responsibility). NEtwork BLUE providers, under the terms of their contract with us, *can't* bill you for amounts over our benefit allowance. Out-of-network providers *can* bill you for amounts in excess of the amount payable under the contract.

To locate NEtwork BLUE providers in Nebraska:

- **nebraskablue.com**
- **Or, call the Member Services number on the back of your I.D. card.**

BlueCard® Program: Your National PPO Network

You have access to a national Blue Cross and Blue Shield PPO network called the BlueCard Program.

To access your benefits wherever you are, all you have to do is use hospitals and doctors in the local Blue Cross and Blue Shield Plan's PPO provider network. When you do, you enjoy the discount and claim filing agreements Blue Cross and Blue Shield Plans across the country have negotiated with the BlueCard doctors and hospitals in their area.

To locate BlueCard PPO providers nationwide:

- **nebraskablue.com**
- **1 (800) 810-2583**

Blue*Preferred* Basics

PLAN BENEFITS		OPTION 1		OPTION 2		OPTION 3		OPTION 4	
		In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Deductible (Calendar year)	SINGLE	$5,000	$8,000	$2,000	$5,000	$3,000	$6,000	$0	$0
Coinsurance maximum (Calendar year)	SINGLE	$5,000	$8,000	$5,000	$7,000	$3,000	$6,000	$10,000	$20,000
Total out-of-pocket (Deductible + coinsurance maximum; no copays)	SINGLE	$10,000	$16,000	$7,000	$12,000	$6,000	$12,000	$10,000	$20,000
Coinsurance percentage for most covered services		Inpatient Services		Inpatient Services		Inpatient/Outpatient Services		Inpatient/Outpatient Services	
		20%	50%	30%	50%	20%	40%	50%	50%
Periodic preventive services		N/A*	N/A	N/A*	N/A	$100 first dollar coverage		$200 first dollar coverage	
Office visits		N/A	N/A	N/A	N/A	$25 copay (2 annually)		50%	
Prescription drug coverage		Rx discount card		Rx discount card		20% generic drugs/ 40% formulary brand-name drugs* / 60% non-formulary brand name drugs* *subject to $1,000 deductible		20% generic drugs/ 40% formulary brand-name drugs* / 60% non-formulary brand name drugs* *subject to $1,000 deductible	
Accidents		Inpatient only		$250 first dollar coverage		$250 first dollar coverage		50%	
Maternity care/pregnancy services		NOT COVERED							
Mental illness/substance abuse treatment		NOT COVERED (including Rx drugs)							

Please note: This coverage does not provide benefits for the following types of care: inpatient and outpatient treatment of mental illness and/or substance abuse treatment; maternity care and pregnancy services. Plan Options 1 and 2 do not provide benefits for oupatient care/services.

Note: A $250 copay applies to out-of-network inpatient hospital benefits, in addition to any applicable out-of-network coinsurance and deductible amounts.

* Limited benefits available in-network.

Benefits

Inpatient Hospital Benefits

Benefits are available for (but not limited to) the following covered services:

- Semi-private room; cardiac and intensive care units; treatment rooms and equipment
- Anesthesia
- Physical, occupational and speech therapy
- Radiology, pathology and radiation therapy
- Respiratory care
- Inpatient physical rehabilitation, subject to certain requirements*

Requires benefit certification

Outpatient Hospital Benefits

Blue*Preferred* Basics Options 3 and 4
Benefits for the covered services listed under "Inpatient Hospital Benefits" are also available (subject to certain limitations) when they are received in a hospital outpatient department, emergency room or ambulatory surgical facility. Benefits for outpatient cardiac and pulmonary rehabilitation are available, subject to medical criteria.

Outpatient cardiac and pulmonary rehabilitation programs require benefit certification. (More information on page 7.)

Physician Benefits

Under Blue*Preferred* Basics Options 1 and 2, benefits are payable for (but not limited to) the following physician services for inpatient care only:

- Surgery and surgical assistance
- Anesthesia
- Consultations
- Inpatient screening mammograms

Under Blue*Preferred* Basics Options 3 and 4, benefits are available for (but not limited to) the following services:

- Office visits (including renal dialysis)
- Allergy tests and extracts
- Anesthesia
- Consultations
- Radiation therapy and chemotherapy
- Radiology and pathology
- Surgery and surgical assistance (for specified procedures)

Supplemental Accident Benefit

Available under Blue*Preferred* Basics Options 2 and 3
Up to $250 in benefits is available each calendar year for covered services provided to you for the care and treatment of injuries caused by an accident, whether or not you are admitted to a hospital. Such benefits are not subject to deductible or coinsurance amounts.

Coverage for Complications of Pregnancy and Newborn Care

Benefits for pregnancy and maternity services are not provided. However, benefits are payable for medically necessary hospital and physician-covered services for complications occurring prior to the end of pregnancy. This includes radiological, pathological or other diagnostic procedures. Complications are conditions that are distinct from the pregnancy but are caused or adversely affected by it. The need for a Cesarean section is not considered a complication of pregnancy.

Benefits for covered services will be payable at birth for a newborn infant who is an eligible dependent. This includes coverage for injury or illness (including the necessary care and treatment of medically diagnosed congenital abnormalities). Covered Services for a newborn infant include hospital services for room and board, screening tests and necessary medical or surgical treatment. Newborn coverage will continue for a period of 31 days. To continue your newborn's coverage after this period of time, a separate application for coverage to a product line that allows family or single parent membership must be submitted. The application for coverage is subject to medical underwriting.

Preventive Services/Routine Care

Available with Blue*Preferred* Basics Options 1-4
Benefits will be provided for in-network preventive services as required by the Patient Protection and Affordable Care Act (PPACA) and will not be subject to cost-sharing requirements, such as copayment, coinsurance or deductible. A listing of these services is available upon request.

Preventive (routine) services, other than those required by PPACA, are not covered on Blue*Preferred* Basics Options 1 and 2 except as specifically stated in your contract.

Available with Blue*Preferred* Basics Option 3
Preventive services not required by PPACA are subject to first dollar coverage (deductible and coinsurance will not apply) up to $100 per person each calendar year for routine care. After this benefit is exhausted, covered services are then subject to deductible and coinsurance.

Available with Blue*Preferred* Basics Option 4
Preventive services not required by PPACA are subject to first dollar coverage (deductible and coinsurance will not apply) up to $200 per person each calendar year for routine care. After this benefit is exhausted, covered services are then subject to deductible and coinsurance.

Oral Surgery and Dentistry

Blue*Preferred* Basics Options 1 and 2
Benefits are available for oral surgery and other dental services benefits when related to an accidental injury and provided in a hospital inpatient setting.

Blue*Preferred* Basics Options 3 and 4
Benefits are available for oral surgery and other dental services benefits when related to an accidental injury. Benefits are available for (but not limited to) the following covered services:

- Bone grafts to the jaw
- Evaluation and outpatient removal of impacted teeth
- Removal of tumors and cysts
- Treatment of natural teeth due to an accident which occurs within 12 months of an injury not related to eating, biting or chewing
- Hospital inpatient, outpatient or ambulatory facility charges related to covered services for medically necessary oral surgery and dentistry

Diagnosis, surgery, treatment and services related to TMJ (temporomandibular jaw joint) as a direct result of accidental injury are covered. Please refer to your contract for any additional exceptions.

Organ and Tissue Transplant

Benefits are available for services associated with medically necessary organ and tissue transplant, including (but not limited to) liver, heart, lung, heart-lung, small intestine, kidney, pancreas, pancreas-kidney and cornea. Limited benefits are also available for allogeneic/autologous bone marrow transplants for the specific conditions listed in the contract.

Transplant procedures require benefit certification by Blue Cross and Blue Shield of Nebraska.

Other Covered Services

(Please note: Limitations and exclusions apply.)

Included under all Blue*Preferred* Basics Options:

- Ambulance service
- Routine immunizations
- Services in accordance with the Women's Health and Cancer Rights Act, which requires that insurance companies that provide medical and surgical benefits for mastectomies also provide benefits for breast reconstruction, prostheses and treatment for physical complications

Included under Blue*Preferred* Basics Options 3 and 4:

- Diabetes outpatient self-management training and patient management from an approved provider
- Outpatient occupational therapy, physical therapy, speech therapy, cognitive training, chiropractic/osteopathic physiotherapy and spinal manipulations and adjustments, up to 15 sessions per calendar year
- Rental/initial purchase (whichever costs less) of medically necessary home medical equipment ordered by a doctor; limited benefits are available for the repair, maintenance and adjustment of purchased covered medical equipment

Prescription Drug Coverage

Available under Blue*Preferred* Basics Options 3 and 4: Prescription drug coverage is available to Blue Cross and Blue Shield of Nebraska members under Blue*Preferred* Basics coverage through our Rx Nebraska Prescription Drug Program.

Benefits are based on Blue Cross and Blue Shield of Nebraska's drug formulary, which is divided into three tiers. The coinsurance percent you pay for each 30-day supply of your covered prescription drug depends on the tier in which your medication is listed.

Tier 1	Generic drugs	20%
Tier 2	Formulary brand-name drugs*	40%
Tier 3	Non-formulary brand-name drugs*	60%

Formulary brand-name and non-formulary brand-name drugs are subject to a $1,000 prescription drug deductible.

To review the drug formulary, go to **nebraskablue.com** and click on the "Member Services" tab and select "Prescription Drug List" and then "Drug Formulary."

Prescription drug copay amounts do not apply toward your coinsurance maximum.

Retail Pharmacies

Take your prescription to a participating Rx Nebraska pharmacy and show the pharmacist your Blue Cross and Blue Shield of Nebraska I.D. card. You pay the coinsurance listed above, based on how your medication is classified (generic, formulary or non-formulary), and whether the applicable deductible has been met.

Please note: Whenever appropriate, generic drugs will be used to fill your prescriptions. If you prefer a brand name drug, even when a generic is appropriate, you will be responsible for the difference in cost plus the applicable coinsurance amount.

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

If you have to file an Rx Nebraska claim form (for example, if you have the prescription filled at a non-participating pharmacy, or if you don't present your card at a participating pharmacy), you will be reimbursed the reasonable allowance for the drug less the applicable coinsurance, a 25% penalty and the deductible (if applicable). **The coinsurance penalty amounts do not apply toward the deductible or coinsurance maximum.**

Mail Service

If you use the PrimeMail® Mail Service Program, you may order a 90-day supply of your maintenance medication at one time by paying the applicable coinsurance amount for each 30-day supply.

NEtwork BLUE coverage includes preauthorization programs for COX-2 drugs and Proton Pump Inhibitors. These programs help Blue Cross and Blue Shield of Nebraska members manage the monetary costs involved with the use of these drugs.

Please refer to your contract for more information about these programs.

Limitations and Exclusions

This document contains only a partial list of the limitations and exclusions that apply to Blue*Preferred* Basics health plan coverage. For a complete listing, please refer to your contract.

No benefits are available for the following except for covered services provided as part of the preventive services benefit:

- Services determined to be not medically necessary
- Audiological exams (except newborn); hearing aids and their fittings
- Routine eye exams, refractions, eyeglasses, contact lenses, eye exercises or visual training
- Artificial insemination; in vitro fertilization, fertility treatment and monitoring
- Massage therapy by a massage therapist
- Nutrition care, supplies, supplements or other nutritional substances, including Neocate, Vivonex and other over-the-counter supplements
- Radial keratotomy or any other procedures/alterations of the refractive character of the cornea to correct myopia and/or astigmatism
- Services we consider to be investigative, experimental, cosmetic or obsolete
- Services, drugs, medical supplies, devices or equipment that are not cost effective compared with established alternatives or that are provided for the convenience or personal use of the patient
- Services provided before the coverage effective date or after termination
- Services for illness or injury sustained while performing military service
- Services for injury/illness arising out of or in the course of employment
- Charges for services which are not within the provider's scope of practice
- Charges in excess of the contracted amount
- Charges made separately for services, supplies and materials we consider to be included within the total charge payable
- Treatment for weight reduction/obesity, including surgical procedures

Inpatient Notification Requirements

The following are requirements you or your NEtwork BLUE provider must follow to receive the maximum benefits available under your coverage.

Notification

Blue Cross and Blue Shield of Nebraska must be notified of all medical/surgical inpatient hospital admissions. This enables us to coordinate discharge planning, case management and disease management services with the patient's providers. If the patient is hospitalized in a contracting NEtwork BLUE hospital in Nebraska, notification will be provided by the hospital.

If the patient is hospitalized in a non-NEtwork BLUE hospital in Nebraska or is admitted to an inpatient facility in another state, Blue Cross and Blue Shield of Nebraska must be notified.

Certification

The purpose of precertification is to determine whether a service or admission discussed below meets the medical necessity criteria of your coverage. If you choose to have these services performed even though we are unable to certify the medical necessity of the services, you will be responsible for the charges.

Precertification is required for the following inpatient care, regardless of where the care is received, in or out of network:

- Physical rehabilitation
- Long-term acute care
- All medical/surgical inpatient hospital admissions

When possible, certification/notification should be completed prior to the inpatient admission. Benefits for services that are not medically necessary will be denied.

Certification/notification of benefits for an inpatient admission, call 1 (800) 247-1103 or 1 (402) 390-1870.

General Information

Applications are subject to our approval. Coverage is available only to adult Nebraska residents age 19 and older.

Premium rates will be reviewed and adjusted each year with a renewal date of January 1. Blue Cross and Blue Shield of Nebraska plans are age-rated.

Your rate for the entire year is based on your age as of the annual renewal date. We will notify you at least 30 days in advance of any premium change.

Waiting Periods for Pre-Existing Conditions and Congenital Abnormalities

No benefit payment will be made for covered services provided for a pre-existing condition, congenital defect or birth abnormality until NEtwork BLUE coverage has been in effect for at least 365 continuous days.

Definition of a Pre-Existing Condition

An illness or injury, whether physical or mental, regardless of the cause of the condition, for which diagnosis, care or treatment was recommended or received within the 12-month period prior to the effective date of coverage.

A pre-existing condition is also defined as an illness or injury that exhibited signs or symptoms within 12 months prior to the effective date of coverage that would lead an ordinarily prudent person to seek medical advice, diagnosis or treatment.

Definition of 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.

Discounts

Premium Discount

A reduced premium rate is available if you do not currently use tobacco products and have not used tobacco products for a minimum of 12 months.

Vision Care Discount

When participating providers are used, you will receive a 10% discount off the cost of routine vision exams and a 17.5% discount off the retail price of frames, lenses and contacts. To obtain the discount, show the participating provider your Blue Cross and Blue Shield of Nebraska I.D. card when services are rendered.

Please note: This is a discount program only; no claims are filed. Discount programs may be changed or terminated at any time without prior notification.

Online Tools and Resources

Online Member Services

Our secure online member services Website is available 24 hours a day, seven days a week. When you register with online member services, you can check the status of a claim, view your Explanations of Benefits online, request I.D. cards, find a NEtwork BLUE hospital and use interactive tools to help manage your family's health care needs and costs – whenever and wherever it's convenient for you.

Once your coverage becomes effective, you will be able to register to start using online member services. If you have any questions about registration, just call the online member services Help Line at **1 (877) 704-2583**.

To learn more about online member services and to register visit **nebraskablue.com**.

Registered online member services users have access to three interactive online tools: Healthcare Advisor, Cost Advisor and Cost Estimator.

Healthcare Advisor℠

You can learn what to expect when diagnosed with an illness or before having surgery as well as research different treatment options and which hospitals have met leading standards for patient safety.

Cost Estimator℠

Find cost information for many common medical conditions and health care services, get reliable cost estimates and locate in- and out-of-network cost comparisons with this tool.

Coverage Advisor℠

This online resource helps you make informed benefit plan decisions.

MyPrime®

MyPrime, from Blue Cross and Blue Shield of Nebraska's pharmacy benefits manager, Prime Therapeutics, Inc., is loaded with valuable information and interactive tools that you can use to manage your prescription drug purchases.

At MyPrime, you can find benefit information, prescription drug information and other resources.

To access the personalized information available via MyPrime, you must be a registered Online Member Services user. Simply visit **nebraskablue.com** and enter your Member ID as it appears on your ID card (e.g.YEP123456789). Then sign in to our Online Member Services Website to view your personal pharmacy information.

Questions about MyPrime? Call **1 (877) 794-3574**.

LiveWellNebraska.com Website

The lifestyle decisions people make – regarding diet, weight, exercise, smoking, seatbelt use and more – directly impact their health care costs.

LiveWellNebraska.com, our wellness and lifestyle management website, can help you make positive lifestyle changes. LiveWellNebraska.com offers:

- Educational health and wellness information
- Lifestyle management guides
- Personal health assessment tools

Check out all the valuable health and healthy living resources available to you at **LiveWellNebraska.com**.

CUSTOMER SERVICE:

Please call the Member Services number
on the back of your I.D. card

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

This outline of coverage for Blue*Preferred* Basics provides a brief description of the important features of your coverage.

This is not your contract. Only the actual benefit provisions in your contract determine your benefits. The contract itself sets forth in detail the rights and obligations of both you and Blue Cross and Blue Shield of Nebraska.

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