TempCare Health Plan

NEBRASKA

BENEFITS BROCHURE

Short-Term Health Plan for Individuals and Families

TempCare is a short-term limited duration health insurance policy and does not constitute minimum essential coverage under the Patient Protection and Affordable Care Act (ACA). Individuals and dependents not enrolled in minimum essential coverage could be responsible to pay federal penalties for the months during which they do not meet individual shared responsibility requirements. Blue Cross and Blue Shield of Nebraska is not responsible for any penalties an individual incurs from noncompliance with the ACA.

You should read your contract carefully.

This benefits brochure provides you with an overview of the Blue Cross and Blue Shield of Nebraska TempCare 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 TempCare contract.

Count On Us to Be There

Blue Cross and Blue Shield of Nebraska

For over 75 years, Blue Cross and Blue Shield of Nebraska has been an important part of Nebraskans' lives. We provide health care coverage or benefits administration to over 700,000 people. We're a Nebraska-based company with our main office in Omaha and a satellite location in Lincoln.

To locate NEtwork BLUE providers in Nebraska:

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

To locate BlueCard PPO providers nationwide:

- Visit nebraskablue.com
- Or call (800) 810-2583

TempCare

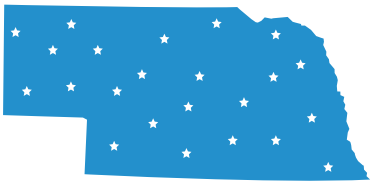
The TempCare Health Plan outlined here and detailed in the contract is designed to provide you with coverage for hospital, medical and surgical expenses incurred as the result of a covered illness or injury.

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, and other limitations set forth in the contract. Coverage under this plan is available for a period of 10 months.

Important Information: TempCare does not provide benefits for pre-existing conditions (including any prescriptions used to treat pre-existing conditions), pregnancy services or maternity care, skilled nursing facility care, mental illness or substance abuse treatment or organ transplants.

This coverage is available to you ("single" coverage); to you and your eligible dependent children ("single parent" coverage — does not include spouse); or to you and your family ("family" coverage includes you, your spouse and any eligible dependent children). The primary applicant must be age 19 or older.

Provider Networks



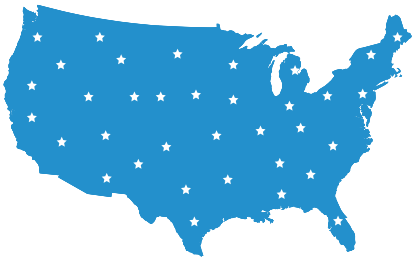
NEtwork BLUE

90% Doctors across the state

88% Hospitals and medical facilities across the state

BlueCard® Program: Your National PPO Network

Access to benefits nationwide – all you have to do is use hospitals and doctors in the local Blue Cross Blue Shield Plan's PPO provider network.



BlueCard® Worldwide Program

Outside of the U.S., you have access to doctors and hospitals in nearly 200 countries and territories around the world.

TempCare

PLAN BENEFITS		OPTION 1		OPTION 2	
		In Network	Out of Network	In Network	Out of Network
Deductible (Calendar year)	SINGLE	$1,500	$3,000	$5,000	$10,000
	FAMILY	$3,000	$6,000	$10,000	$20,000
Coinsurance max (Calendar year)	SINGLE	$1,000	$2,000	$1,000	$2,000
	FAMILY	$2,000	$4,000	$2,000	$4,000
Total out-of-pocket (Deductible + coinsurance maximum)	SINGLE	$2,500	$5,000	$6,000	$12,000
	FAMILY	$5,000	$10,000	$12,000	$24,000
Coinsurance percentage for most covered services*		20%	40%	20%	40%
Maternity care/pregnancy services		NOT COVERED			
Mental illness/substance abuse treatment		NOT COVERED (including prescription drugs)			
Prescription drug coverage		*Coinsurance applies after deductible (Medical Plan deductible applies)			
Total contract benefit maximum		$2 million per covered person			

Please note: This coverage does not provide benefits for pre-existing conditions (including any prescriptions used to treat pre-existing conditions) and the following types of care: pregnancy services or maternity care, services in a skilled nursing facility, mental illness or substance abuse treatment or organ transplants.

Calendar Year Deductible

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

Family Deductible

The family deductible is equal to two times the individual deductible, unless otherwise indicated on your Schedule of Benefits. Family members may combine their covered expenses to satisfy the required deductible amount. No one family member pays more than the individual deductible amount.

Three-Month Carry-Over Provision

Covered charges applied toward your deductible from October through December may be carried over and applied toward the following year's deductible, if the current year deductible has not been met in full.

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.

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 contracting providers will be the contracted amount. The allowable charge for services by non-contracting providers will generally be the lesser of the billed charge or the reasonable allowance for the service. You are responsible for charges in excess of the contracted amount for services provided by a non-contracting provider.

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
- FDA-approved drugs, intravenous solutions and vaccines administered in the hospital
- Physical, occupational and speech therapy
- Radiology, pathology and radiation therapy
- Respiratory care
- Inpatient physical rehabilitation, subject to certain requirements*

Benefits must be preauthorized

Outpatient Hospital Benefits

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 must be preauthorized.

Physician Benefits

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

- Allergy tests and extracts
- Anesthesia
- Consultations
- Physician home, office and outpatient visits for diagnosis/treatment of an illness or injury
- Radiation therapy and chemotherapy
- Radiology and pathology, including tissue exams and interpretation of Pap smears
- Routine screening mammograms
- Surgery and surgical assistance (for specified procedures)

Preventive Services/Routine Care

Preventive (routine) services are not covered except as specifically stated in your contract.

Benefits for the Complications of Pregnancy and Newborn Care

Benefits for pregnancy services and maternity care 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 of pregnancy are illnesses or 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 are not payable for postpartum depression, psychosis or any other mental illness.

Benefits for covered services will be payable at birth for a newborn infant who is an eligible dependent. Coverage will also begin at birth for the child of an eligible dependent daughter of a subscriber with an existing family or single parent membership, as long as the child meets the definition of an eligible dependent. Covered services for a newborn infant include hospital services for room and board, screening tests and medically necessary medical or surgical treatment.

If you are covered under a single membership, benefits are available for your newborn for 31 days from the date of birth. To continue your newborn's coverage after this period of time, you must request a change to a family or single-parent membership within those 31 days and pay the additional premium.

Oral Surgery

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

- Diagnosis, surgery, treatment and services related to TMJ (temporomandibular jaw joint) as a direct result of accidental injury

Please refer to your contract for any additional limitations.

Other Covered Services

(Please note: Limitations and exclusions apply.)

- Ambulance service
- Covered prescription drugs
- Diabetes outpatient self-management training and patient management from an approved provider. Diabetes education benefits are subject to a maximum of $500
- Skilled nursing care in the home by a registered or licensed practical nurse for up to eight hours a day when medically necessary and ordered by a physician
- Outpatient occupational therapy, physical therapy, speech therapy, cognitive training, chiropractic/osteopathic physiotherapy and spinal manipulations and adjustments, up to a combined maximum of 60 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
- Routine immunizations. Benefits for pediatric immunizations (through age 6) are not subject to calendar year deductible, but are subject to applicable coinsurance
- 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
- Colorectal cancer screening services

Benefit Maximum

From the time the contract is in effect, total benefits are limited to a $2 million maximum per covered person. Total benefits include benefits paid under prior contracts with us.

Limitations and Exclusions

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

No benefits are available for the following:

- Services determined to be not medically necessary
- Maternity/pregnancy services (except for related complications)
- Screening audiological exams (except newborn); hearing aids and their fittings
- Blood donor services
- 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
- Mental health services, including alcoholism and drug abuse counseling
- Treatment for weight reduction/obesity, including surgical procedures
- Organ and tissue transplant services
- Preventive health care services

Certification Requirements

The purpose of certification is to determine whether a service or admission meets the medical necessity criteria of your policy.

All inpatient hospital admissions must be certified by Blue Cross and Blue Shield of Nebraska. 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 (in-network) hospital in Nebraska, notification will be provided by the hospital.

If the patient is hospitalized in a non-contract (out-of-network) hospital in Nebraska or is admitted to an inpatient facility in another state, Blue Cross and Blue Shield of Nebraska must be notified by you or your provider.

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

- Inpatient physical rehabilitation
- Long-term acute care
- Skilled nursing in the home
- Certain prescription drugs

This is not a complete list. Please refer to the contract for additional information.

The covered person is responsible for making sure that certification occurs; however a hospital or provider may initiate the certification. When possible, certification should be completed prior to receiving the services. Benefits for services that are not medically necessary will be denied. 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.

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

General Information

Applications are subject to our approval. Coverage is available to Nebraska residents only. The primary applicant must be age 19 or older.

Blue Cross and Blue Shield of Nebraska plans are age and gender rated. Your rate for the entire term of the contract is based on your age as of January 1. We will notify you at least 30 days in advance of any premium change.

Your contract will be renewed each month when you pay your premium, for a period of 10 months. This coverage cannot be renewed at the end of the 10-month period.

Pre-Existing Conditions

No benefit payment will be made for services provided for a pre-existing condition (including any prescriptions used to treat pre-existing conditions) or congenital abnormality existing at the time coverage is effective for the covered person.

Definition of a Pre-Existing Condition

A condition, 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.

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.

Types of Enrollment

Single membership: Provides coverage to you only.

Single parent membership: Provides coverage to you and your eligible children, but not to a spouse.

Family membership: Covers you, your spouse and any eligible dependent children.

Eligible dependent children are defined as: The member's dependent children (excludes foster children) through 25 years of age. Physically and mentally disabled children may be eligible for continuous coverage after age 25 if application is made within 31 days of the child's 26th birthday.

Discounts

Tobacco-Free Discount

Vision Care Discount*

10% Discount on routine eye exams

17.5% Discount on frames, lenses, and contacts

Hearing Care Discount*

10% Discount on routine hearing exams

10% Discount on hearing aids

* Must show Blue Cross and Blue Shield of Nebraska I.D. Discount program only. No claims are filed. Participating providers must be used.

To find participating providers, visit nebraskablue.com or your *my*blue account.

Online Member Services

Blue365®

We understand helping you live a healthy life means more than regular doctor visits—it's helping you find time for the things that matter most. Blue365 is a national program that gives you exclusive access to discounts and savings that make it easier and more affordable to make healthy choices.

Blue365 features savings on select products and services you can use to improve and maintain your health every day.

Explore the special offerings from leading national companies in the following categories:

- Fitness
- Healthy Eating
- Personal Care

Plus, join the Blue365 e-mail list and you'll receive weekly deals on healthy products, along with discounts on health and fitness clubs, weight-loss programs, and much more. Learn more at nebraskablue.com.

TempCare is a short-term limited duration health insurance policy and does not constitute minimum essential coverage under the Patient Protection and Affordable Care Act (ACA). Individuals and dependents not enrolled in minimum essential coverage could be responsible to pay federal penalties for the months during which they do not meet individual shared responsibility requirements. Blue Cross and Blue Shield of Nebraska is not responsible for any penalties an individual incurs from noncompliance with the ACA.

This benefits brochure for TempCare provides a brief description of the important features of your contract.

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.

NEBRASKA

CUSTOMER SERVICE:

Please call the Member Services number
on the back of your ID card

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

92-069 (11-03-14)