NEBRASKA

EHA

An Overview of Your

Health and Dental Benefits

Educators Health Alliance **Direct Bill Plan**

Direct Bill Health Plan Option 1

	In-Network	Out-of-Network
Calendar year deductible Individual Family	 $750 $1,500	 $1,500 $3,000
Calendar year out-of-pocket limit Individual Family	 $4,250 $8,500	 $8,500 $17,000
Coinsurance (the amount you pay for most covered services after satisfaction of the calendar year deductible)	20% of allowable charges	40% of allowable charges
Physician office visit exam	Primary care physician: $30 copay Specialist: $50 copay Urgent Care: $50 copay, then deductible & coinsurance	Subject to deductible and 40% coinsurance
Preventive services	Benefits for covered services paid at 100%, subject to age, gender and frequency limits. Refer to page 6 for additional information.	Subject to deductible and 40% coinsurance
Inpatient and outpatient mental illness and/or substance abuse treatment	Subject to deductible and 20% coinsurance	Subject to deductible and 40% coinsurance
Emergency care services	Facility: $75 copay, then deductible and coinsurance Professional: deductible and coinsurance	Same as in-network level of benefits

Prescription Drug Benefits

Tier	Classification	Copay/Coinsurance per 30-day Supply		Out-of-Pocket minimums and maximums per prescription	
		In-Network	Out-of-Network		
1	Generic drugs	25%	25% + 25% penalty	$5 minimum / $25 maximum*	
2	Formulary brand name drugs	25%	25% + 25% penalty	$30 minimum / $60 maximum*	
3	Nonformulary brand name drugs	50%	50% + 25% penalty	$60 minimum / $90 maximum*	
4	Specialty drugs**	25%	50%	In-Network	Out-of-Network
				$50 minimum / $100 maximum	$150 minimum / $300 maximum

Insulin, Diabetic and Ostomy Supply Benefits		
Member Coinsurance per 30-day supply		
	In-Network	Out-of-Network
Insulin and diabetic supplies Generic and formulary Nonformulary	 20% 30%	 20% + 25% penalty 30% + 25% penalty
Ostomy supplies	20%	20% + 25% penalty

Calendar Year Prescription Drug Out-of-Pocket Maximums	
Per individual - Combined with medical coinsurance/copay maximums Family maximum - Combined with medical coinsurance/copay maximums	Once the applicable out-of-pocket maximum is reached, you pay nothing for covered prescription drugs for the remainder of the calendar year.

* Does not include 25% out-of-network penalty, if applicable.
**To be considered in-network, specialty drugs must be purchased through a PrimeRXSpecialty pharmacy.

Direct Bill Health Plan Option 2

	In-Network	Out-of-Network
Calendar year deductible Individual Family	 $1,650 $3,300	 $1,650 $3,300
Calendar year out-of-pocket limit Individual Family	 $6,150 $12,300	 $10,650 $21,300
Coinsurance (the amount you pay for most covered services after satisfaction of the calendar year deductible)	30% of allowable charges	40% of allowable charges
Physician office visit exam	Primary care physician: $45 copay Specialist: $65 copay Urgent Care: $65 copay, then deductible & coinsurance	Subject to deductible and 40% coinsurance
Preventive services	Benefits for covered services paid at 100%, subject to age, gender and frequency limits. Refer to page 6 for additional information.	Subject to deductible and 40% coinsurance
Inpatient and outpatient mental illness and/or substance abuse treatment	Subject to deductible and 30% coinsurance	Subject to deductible and 40% coinsurance
Emergency care services	Facility: $90 copay, then deductible and coinsurance Professional: deductible and coinsurance	Same as in-network level of benefits

Prescription Drug Benefits

Tier	Classification	Copay/Coinsurance per 30-day Supply		Out-of-Pocket minimums and maximums per prescription	
		In-Network	Out-of-Network		
1	Generic drugs	30%	30% + 25% penalty	$7 minimum / $30 maximum*	
2	Formulary brand name drugs	30%	30% + 25% penalty	$35 minimum / $70 maximum*	
3	Nonformulary brand name drugs	50%	50% + 25% penalty	$60 minimum / $90 maximum*	
4	Specialty drugs**	25%	50%	In-Network	Out-of-Network
				$50 minimum / $100 maximum	$150 minimum / $300 maximum

Insulin, Diabetic and Ostomy Supply Benefits		
Member Coinsurance per 30-day supply		
	In-Network	Out-of-Network
Insulin and diabetic supplies Generic and formulary Nonformulary	 20% 30%	 20% + 25% penalty 30% + 25% penalty
Ostomy supplies	20%	20% + 25% penalty

Calendar Year Prescription Drug Out-of-Pocket Maximums	
Per individual - Combined with medical coinsurance/copay maximums Family maximum - Combined with medical coinsurance/copay maximums	Once the applicable out-of-pocket maximum is reached, you pay nothing for covered prescription drugs for the remainder of the calendar year.

* Does not include 25% out-of-network penalty, if applicable.
**To be considered in-network, specialty drugs must be purchased through a PrimeRXSpecialty pharmacy.

Direct Bill Health Plan Option 3 (HSA-eligble Plan)

	In-Network	Out-of-Network
Calendar year deductible Individual Family (aggregate)	 $3,100 $6,200	 $6,200 $12,400
Calendar year out-of-pocket limit Individual Family (aggregate)	 $3,100 $6,200	 $11,200 $22,400
Coinsurance (the amount you pay for most covered services after satisfaction of the calendar year deductible)	0% of allowable charges	20% of allowable charges
Physician office visit exam	Subject to deductible	Subject to deductible and 20% coinsurance
Preventive services	Benefits for covered services paid at 100%, subject to age, gender and frequency limits. Refer to page 6 for additional information.	Subject to deductible and 20% coinsurance
Inpatient and outpatient mental illness and/or substance abuse treatment	Subject to deductible	Subject to deductible and 20% coinsurance
Prescription drugs	Subject to in-network deductible	
Emergency care services	Subject to deductible	Same as in-network level of benefits

Direct Bill Health Plan Option 4 (HSA-eligble Plan)

	In-Network	Out-of-Network
Calendar year deductible Individual Family (embedded)	 $4,000 $8,000	 $8000 $16,000
Calendar year out-of-pocket limit Individual Family (embedded)	 $6,350 $12,700	 $12,700 $25,400
Coinsurance (the amount you pay for most covered services after satisfaction of the calendar year deductible)	30% of allowable charges	50% of allowable charges
Physician office visit exam	Subject to deductible and coinsurance	Subject to deductible and 50% coinsurance
Preventive services	Benefits for covered services paid at 100%, subject to age, gender and frequency limits. Refer to page 6 for additional information.	Subject to deductible and 50% coinsurance
Inpatient and outpatient mental illness and/or substance abuse treatment	Subject to deductible and coinsurance	Subject to deductible and 50% coinsurance
Prescription drugs	Subject to in-network deductible and coinsurance	
Emergency Care services	Subject to deductible and coinsurance	Same as in-network level of benefit

Direct Bill Dental Coverage

	In-Network	Out-of-Network
Coverage A: Preventive & Diagnostic Dentistry		
Calendar year deductible	None	None
Coinsurance you pay	20% of allowable charges	30% of allowable charges
Coverage B: Maintenance & Simple Restorative Dentistry; Oral Surgery; Periodontic & Endodontic Services		
Calendar year deductible	None	$50* per family
Coinsurance you pay	20% of allowable charges	30% of allowable charges
Coverage C: Complex Restorative Dentistry		
Calendar year deductible	$25 per family	$50* per family
Coinsurance you pay	50% of allowable charges	50% of allowable charges

* Dental coverage B and C combined per family is $50 per calendar year.
Note: See pages 13 and 14 for the list of covered and noncovered services.

What is a PPO?

A PPO, or preferred provider organization, is a special arrangement between an insurer and a network of hospitals, doctors and other types of providers to pay for health care services. As a result of these special arrangements, you save money, because in most cases, you pay less in deductible and coinsurance when you use PPO network providers. If you go outside the network for medical care, you'll pay more money out of pocket.

Your PPO Network in Nebraska

In Nebraska, your PPO network is called NEtwork BLUE and it's made up of 90% of the state's doctors and 88% of the state's hospitals and medical facilities. That makes obtaining in-network care easy and convenient.

NEtwork BLUE providers have agreed to accept our benefit payment for covered services as payment in full, except for any deductible, copays and coinsurance amounts and charges for noncovered services, which are your responsibility. That means 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 payable amount under the contract.

NEtwork BLUE providers also file your claims for you, meaning you have less paperwork to worry about. And as an additional time-saving convenience for you, we send our benefit payment directly to in-network providers.

The 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 BlueCard PPO provider network. When you do, you also 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.

It's easy to locate in-network providers wherever you are.

Locate NEtwork BLUE Providers in Nebraska

By phone: **1-877-721-2583**
On the Web: **www.nebraskablue.com**

Locate BlueCard PPO Providers Nationwide

By phone: **1-800-810-BLUE (2583)**
On the Web: **www.bcbs.com**

Calendar Year Deductible

Options 1 and 2
If you're covered under a single membership, you must satisfy one individual deductible each calendar year. The family deductible is equal to two times the individual deductible. Family members may combine their covered expenses to satisfy the required deductible amount. No one family member pays more than the individual deductible amount.

If you don't meet your deductible in a given year, covered charges incurred during October, November and December of that year may be carried over and applied toward the following year's deductible.

Option 3 (HSA-Eligible Plan)
If you're covered under a single membership, you must satisfy one individual deductible each calendar year. This plan requires satisfaction of an aggregate family deductible. Aggregate deductible means that if you have family coverage, the entire family deductible must be met prior to any benefits becoming available. Family members may combine their covered expenses to satisfy the required family deductible.

Option 4 (HSA-Eligible Plan)
If you're covered under a single membership, you must satisfy one individual deductible each calendar year. The family deductible is equal to two times the individual deductible. Family members may combine their covered expenses to satisfy the required deductible amount. No one family member pays more than the individual deductible amount.

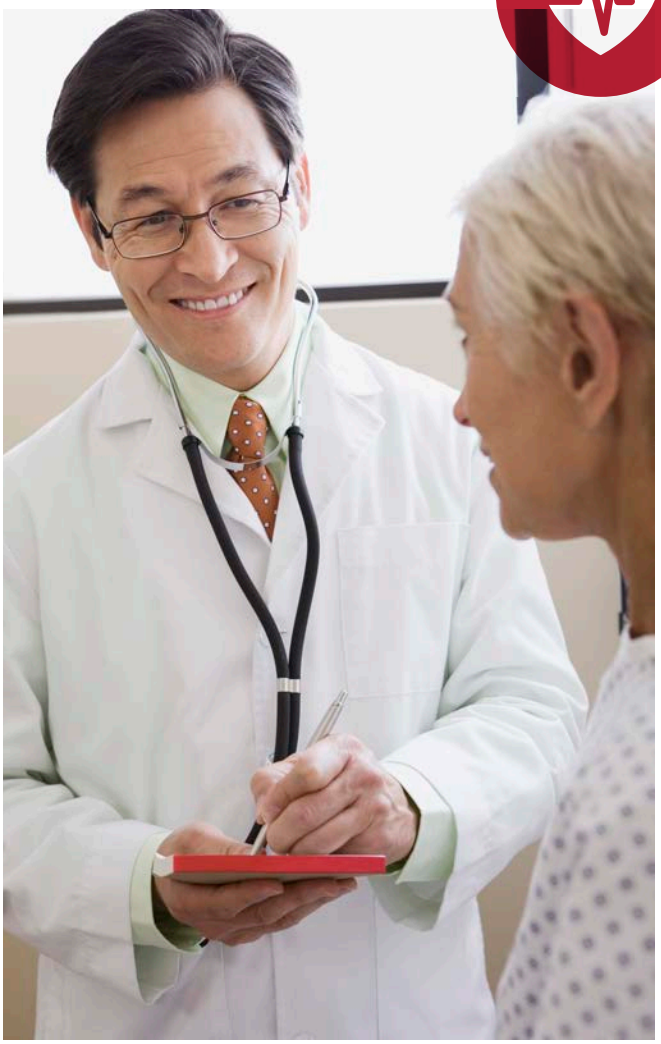
Coinsurance and Your Calendar Year Out-of-Pocket Limit

Options 1, 2 and 4
The out-of-pocket limit is the maximum amount of cost-sharing each covered person 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. Once you reach your out-of-pocket limit, you pay nothing for most covered services for the rest of the calendar year.

Under family membership, family members may combine their covered expenses to satisfy the required family out-of-pocket limit. No one family member contributes more than the individual out-of-pocket limit.

Option 3 (HSA-Eligible Plan)
After you meet your calendar year deductible, you are responsible for paying a certain percentage of covered charges (called "coinsurance") for out-of-network providers, until you reach your out-of-pocket limit. Once you reach your out-of-pocket limit, you pay nothing for most covered services for the rest of the calendar year.

Under this plan's family membership, the entire out-of-network aggregate family out-of-pocket limit must be met before benefits for covered services are paid at 100% of the allowable charge. Family members may combine their covered expenses to satisfy the required out-of-pocket limit.



Under all EHA options, prescription drug benefits are subject to limitations and exclusions. Please refer to your certificate of coverage and schedule of benefits summary for more information.

Benefits for Preventive Services

Preventive services benefits are available under all EHA health plan options. When a network provider is used, benefits are paid at 100% of the allowable charge (deductible and coinsurance are waived).*

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

- Office visits, well woman visits, and periodic exams to determine physical development
- Radiology/X-ray/pathology/lab
- Mammograms and Pap smears
- Immunizations (including pediatric**)
- Colorectal cancer screenings and related services
- Cardiac stress tests
- Hearing exams
- Contraceptive methods, as well as contraceptive prescriptions for women (most paid at 100%)
- Breast pumps and supplies, as well as counseling for breastfeeding
- Developmental/autism screening for infants, children, and adolescents

*Preventive benefits may be subject to age, gender and frequency limits. Preventive services benefits outside these limits, as well as services received out-of-network, are subject to the plan's applicable deductible and coinsurance, unless otherwise stated. For a list of the preventive services mandated under the Patient Protection and Affordable Care Act (PPACA), along with their corresponding age, gender and frequency limits, please visit nebraskablue.com/preventivecare.

**Deductible (if applicable) is waived for out-of-network pediatric immunizations.

Office Visit Exam Copay

Options 1 and 2 Only
When you go to an in-network doctor, you pay a copay for a diagnostic (non-routine) office visit exam (does not apply to mental illness/substance abuse office visits). X-ray and lab charges and any tests or services the doctor may order will be subject to deductible and coinsurance. Refer to the charts at the beginning of this booklet for your plan's copay amount.

Prescription Drug Coverage

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

Options 1 and 2
Your coverage is based on Blue Cross and Blue Shield of Nebraska's (BCBSNE) drug formulary. A formulary is a list of generic and brand name prescription medications. Your prescription drug benefits are divided into four tiers: generic drugs, formulary brand drugs that are in the formulary, non-formulary brand name drugs that are not in the formulary, and specialty drugs. The coinsurance amount you pay for up to a 30-day supply of a covered prescription drug depends on what tier your medication is in.

Refer to the charts on pages 1 and 2 for further details. To review the drug formulary online, go to **www.nebraskablue.com.** Hover over Member Services and select Pharmacy Tools, then Prescription Drug List, or call our Member Services Department at the number on the back of your BCBSNE member ID card.

Option 3 and 4 (HSA-Eligible Plans)
With option 3, your prescription drug benefits are subject to your plan's in-network deductible.

With Option 4, your prescription drug benefits are subject to your plan's in-network deductible and coinsurance.

When you use a participating Rx Nebraska pharmacy, you'll automatically receive a special pre-negotiated discount on most of your prescription drugs. (The actual discount you receive depends on the pharmacy and the type of drug you purchase.)

Using Your Prescription Drug Benefits
To use your prescription drug benefits, take your Blue Cross and Blue Shield of Nebraska member ID card and your prescription to an Rx Nebraska participating pharmacy and pay the applicable coinsurance amount.

Please note: To be considered in-network, specialty drugs must be purchased through a designated specialty pharmacy. One of BCBSNE's designated specialty pharmacies is Prime Therapeutics Specialty Pharmacy. For more information, please refer to the Prime Therapeutics Specialty Pharmacy brochures.

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

If you have to file a claim (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 for the cost of the drug less the applicable coinsurance amount and a 25% penalty. Prescription drug coinsurance amounts do not apply toward the health plan's deductible or coinsurance maximum, but do apply toward the calendar year prescription drug out-of-pocket maximum. Benefit amounts paid by the health plan for all prescription drug claims will be applied to your overall contract benefit maximum.

Using Your Mail Service Pharmacy Benefit
If you use the PrimeMail® Mail Service Pharmacy Program, you may order up to a 180-day supply of a covered medication at one time (if allowed by your prescription). The minimum and maximum coinsurance amounts shown in the charts on pages 1-3 apply per 30-day supply, with a maximum of five times the amount per 180-day supply.

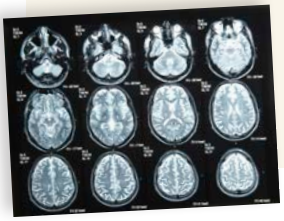
Please note: If you are ordering a 180-day supply, make sure the prescription is written for a 180-day supply, not including refills. For questions regarding available medications, please call PrimeMail at 1-877-357-7463.

Certification

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

Blue Cross and Blue Shield of Nebraska requires that all hospital stays, certain surgical procedures and specialized services and supplies be certified prior to receipt of such services or supplies. Ultimately, it is your responsibility to see that certification occurs; however, a hospital or provider may initiate the certification.

To initiate the certification process, Blue Cross and Blue Shield of Nebraska must be contacted by you, your family member, the physician, the hospital or someone acting on behalf of you or your family member.



The following services, supplies or drugs must be certified:

- Organ and tissue transplants;
- Pulmonary rehabilitation;
- Subsequent purchases of home medical equipment;
- Specified medications and/or quantities of medications;
- Skilled nursing care in the home;
- Skilled nursing facility care;
- Hospice care;
- All inpatient hospital admissions;
- Inpatient mental illness and/or substance abuse;
- Inpatient physical rehabilitation;
- Long term acute care; and
- Services subject to surgical preauthorization programs.

If certification requirements are not met, the following penalties may apply:

- Payable benefits may be reduced, and/or
- Benefits for all services may be denied.

Please note: Certification does not guarantee payment. All other group plan provisions apply, including copayments, deductibles, coinsurance, eligibility and exclusions.

Inpatient Hospital & Long Term Acute Care Benefits

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

- Semiprivate room; cardiac and intensive care units; treatment rooms and equipment.
- Anesthesia.
- Respiratory care.
- FDA-approved drugs, intravenous solutions and vaccines administered in the hospital.
- Chemotherapy.
- Radiology, pathology and radiation therapy.
- Physical, occupational and speech therapy.
- Inpatient physical rehabilitation, subject to benefit precertification and certain requirements.
- Physician-ordered skilled nursing facility services, up to 60 days per calendar year; subject to medical necessity criteria.

Outpatient Hospital Benefits

Benefits for the services listed under "Inpatient Hospital and Long Term Acute Care Benefits" are also available (subject to certain limitations) when they are received in a hospital outpatient department, emergency room or freestanding ambulatory surgical facility. In addition, benefits for outpatient cardiac and pulmonary rehabilitation are available, subject to preauthorization requirements and medical criteria.

Physician Benefits

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

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

Please note: Some physician services such as total knee replacement, total hip replacement, and back surgery require pre-authorization. For questions regarding specific procedures, please contact BCBSNE's Member Services department at the number shown on the back of your BCBSNE member ID card.

Maternity & Newborn Coverage

Maternity coverage is available to subscribers and covered spouses and dependent daughters. If the employee is covered under a single membership, a newborn will be covered for a period of 31 days. Application for change to family coverage must be made within 31 days of birth to continue the baby's coverage.

Benefits for covered newborn care include hospital room and board, screening tests (including newborn hearing), physician services and other medically necessary treatment. Obstetrical benefits include prenatal and postnatal care. All covered charges incurred by a newborn from birth will be subject to a separate, individual calendar year deductible.

To learn more about our free maternity management program, please call 1-877-348-4329 or visit nebraskablue.com/maternity.

Oral Surgery Benefits

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

- Removal of tumors and cysts.
- Bone grafts to the jaw.
- Osteotomies.
- Treatment of natural teeth due to an accident which occurs within 12 months of an injury not related to eating, biting or chewing.
- Medically necessary services for the treatment of TMJ and craniomandibular disorder.

Home Health Aide, Skilled Nursing Care and Hospice Benefits

The following covered services require benefit preauthorization. Limitations and exclusions apply.

Home health aide: When related to active medical treatment, benefits include personal services (e.g. bathing, feeding and performing necessary household duties). Benefits are subject to a 60-day per calendar year limit.

Skilled nursing care: Benefits are available for medically necessary physician-ordered care by a registered or licensed practical nurse, up to eight hours per day.

Hospice care: Benefits include Medicare-certified home health aide services for a terminally ill patient, including nursing services, respite care, medical social worker visits, crisis care and bereavement counseling. Limited benefits for inpatient hospice care are also available.

Organ and Tissue Transplant Benefits

Benefits are available for covered services associated with medically necessary organ and tissue transplants, including (but not limited to) liver, heart, lung, heart-lung, 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.

Other Covered Services

- Ambulance services.
- Outpatient occupational therapy, physical therapy, speech therapy, cognitive training and chiropractic/osteopathic physiotherapy, up to a combined maximum of 60 sessions per calendar year.
- Chiropractic and osteopathic manipulative treatments, up to 30 sessions per calendar year.
- Inpatient and outpatient treatment of mental illness and/or substance abuse.*
- 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.
- Diabetes outpatient self-management training and patient management; podiatric appliances.
- Services in accordance with the Women's Health and Cancer Rights Act, which requires that a group health plan providing medical and surgical benefits for mastectomies also provide benefits for breast reconstruction, prostheses and treatment of physical complications.

* Inpatient is defined as a patient 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.

Outpatient is defined as 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.

A more complete list of limitations and exclusions can be found in the master group contract or by referring to the certificate of coverage and schedule of benefits summary.

Noncovered Services

This brochure contains only a partial listing of the limitations and exclusions that apply to your health care coverage. A more complete list may be found in the master group contract or by referring to the certificate of coverage and schedule of benefits.

No benefits are available for the following:

- Audiological exams (except newborn); hearing aids and their fitting.
- Abortions (except to save the life of the mother).
- Blood, plasma, or services by or for blood donors.
- Eye exams, refractions, eyeglasses, contact lenses, eye exercises or visual training.
- Artificial insemination; invitro fertilization; fertility treatment, and related testing.
- Massage therapy.
- Treatment for weight reduction/obesity, including surgical procedures.
- Nutrition care, supplies, supplements or other nutritional substances, including Neocate, Vivonex and other over-the-counter infant formulas and supplements.
- Radial keratotomy or any other procedures/alterations of the refractive character of the cornea to correct myopia, hyperopia and/or astigmatism.
- Services we consider to be investigative, not medically necessary, experimental, cosmetic or obsolete.
- Services, drugs, medical supplies, devices or equipment that are not cost effective compared to 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 our contracted amount.
- Charges made separately for services, supplies and materials we consider to be included within the total charge payable.

Late and Special Enrollment

A "late enrollee" is defined as an employee or dependent for whom coverage is not requested within 31 days of his or her initial eligibility or during a special enrollment period. No late enrollees are accepted into the Direct Bill Program. Depending on your eligibility, other enrollment restrictions may apply. For further information, please contact our Member Services Department.

Your eligible dependents are not considered late enrollees if:

- your dependent was covered under other qualifying previous coverage at the time of your initial eligibility for this group coverage; and
- your dependent lost coverage under the qualifying previous coverage as a result of: termination of employment; termination of eligibility; involuntary termination of the qualifying previous coverage; death of a spouse; divorce of a spouse; and
- your eligible dependent requests enrollment within 31 days after termination of qualifying previous coverage; or within 60 days of the loss of Medicaid or SCHIP coverage

Types of Enrollment

Single Membership: Covers the employee only.

Employee and Spouse: Covers the employee and his/her spouse.

Employee and Child(ren): Covers the employee and eligible dependent children, but does not provide coverage for a spouse.

Family Membership: Covers the employee, spouse, and eligible dependent children.

The employee's dependent children (excluding foster children) are covered to age 26. Reaching age 26 will not end the covered child's coverage as long as the child is and remains both incapable of self-sustaining employment by reason of mental or physical handicap and dependent upon the subscriber for support and maintenance.

Allowable Charge

Payment is based on the allowable charge for a covered service. Generally, the allowable charge for services by in-network providers will be the contracted amount. The allowable charge for services by out-of-network providers will be based on the contracted amount for Nebraska providers or an amount determined by the onsite Plan for out-of-network providers.

What is an HSA?

Direct Bill Options 3 and 4 are HSA-eligible health plans. HSA stands for "Health Savings Account." An HSA is a special tax-exempt account established through a qualified financial institution to pay for medical expenses.

In general, any individual who is covered under a "high deductible health plan" is eligible to establish an HSA. To qualify as a high deductible health plan, the plan must satisfy certain requirements with respect to deductibles and out-of-pocket expenses.

Funds in an HSA may be used to pay qualified medical expenses not reimbursed by insurance. Examples include deductibles and coinsurance, eye exams, glasses, contacts, dental services, prescription drugs, and qualified long term care insurance premiums. Withdrawals for other purposes are taxable and, for individuals who are not disabled or over age 65, subject to a 20% penalty.

Please note: HSA deductible and coinsurance maximums may be increased annually to conform with cost of living adjustments permitted by Section 223 of the Internal Revenue Code and subsequent amendments.

Direct Bill Dental Coverage

Covered Services

Coverage A

- Two oral exams per calendar year.
- Consultations when medically necessary.
- Two prophylaxis per calendar year, including cleaning, scaling and polishing of teeth.
- Two topical fluoride applications per calendar year for covered family members up to age 16.
- One full-mouth or panorex series of X-rays in any three-consecutive-year period; one set of four supplemental bitewing X-rays in a calendar year.
- Application of sealants to the permanent first or second molar teeth for covered family members under age 16, once every four years.
- Space maintainers for prematurely lost primary teeth for covered family members under age 16.
- Pulp vitality tests.

Coverage B

Oral surgery consisting of:

- Simple and impacted extractions (excluding orthodontic extractions).
- Alveoloplasty.
- Removal of dental cysts and tumors.
- Surgical incision and drainage of dental abscess.
- Reduction of a complete dislocation or fracture of the temporomandibular joint of the jaw (TMJ) required as the direct result of an accident which occurred while the patient was covered under this contract. Benefits must be provided within 12 months of the injury, and will not be available if the injury is the result of eating, biting or chewing.
- Tooth replantation.
- Excision of hyperplastic tissue.

Periodontic services consisting of:

- Up to four periodontic cleanings per calendar year.
- Gingivectomy and gingival curettage.
- Osseous surgery and grafts.
- Scaling and root planing.
- Provisional or permanent periodontal splinting.
- Mucogingivoplastic surgery.
- Treatment of acute infection and oral lesions.

Endodontic services consisting of:

- Pulp cap and vital pulpotomy.
- Root canal therapy (treatment plan, diagnostic X-rays, clinical procedures and follow-up).
- Apical curettage.
- Root resection and hemisection.

Other covered services:

- General anesthesia for oral/dental surgery when medically necessary.
- Restorations of silver amalgam and/or composite materials (if gold is used, reimbursement will be made as for silver).
- Temporary crowning of teeth as a result of an accident if provided within 72 hours of the accident.
- Preformed stainless steel or acrylic crowns on diseased or damaged teeth.
- Re-cement inlays and crowns on diseased or damaged teeth.
- Palliative treatment limited to opening and drainage of a tooth when no endodontics follows, smoothing down chipped teeth, dry socket treatment, pericoronitis treatment and treatment of canker sores.
- Repair of dentures, bridges, crowns and cast restorations.

Coverage C

- Crowns.
- Inlays when used as abutments for fixed bridgework.
- Installation of permanent bridges.
- Full and partial dentures.
- One denture relining each 36-consecutive month period.
- Adjustments of dentures after six months have elapsed from the date of installation.

Noncovered Dental Services

The following is only a partial listing of the exclusions and limitations that apply to EHA Direct Bill dental coverage. A complete list is in the master contract.

- Services not identified as covered under Coverages A, B and C in the contract.
- Dental services related to congenital malformations or primarily for cosmetic purposes.
- Services for orthodontic dentistry and treatment of the temporomandibular jaw joint.
- Supplies, education or training for dietary or nutrition counseling, personal oral hygiene or dental plaque control.
- Services received before the effective date of coverage or after termination of coverage.
- Services determined to be not medically necessary, investigative, or obsolete.
- Charges in excess of our contracted amount.
- Services covered under Workers' Compensation or Employers' Liability Law.
- Services provided by a person who is not a dentist, or by a dental hygienist not under the dentist's direct supervision.
- Charges made separately for services, supplies and materials considered to be included within the total charge payable.

How Using In-network Dentists Benefits You

Our dental network in Nebraska is part of a larger provider network of multiple Blue Cross and Blue Shield Plans that, when combined, offers one of the largest national PPO dental networks. It provides you and your covered family members with lower out-of-pocket costs and broad access to participating dentists.

If you or your covered family members live or travel outside of Nebraska, you will be able to obtain covered services at the in-network level of benefits through the combined PPO dental network.

How to Locate In-network Dentists in Nebraska

By phone:
1-877-721-2583

On the web:
nebraskablue.com/find-a-doctor

Keep Track of Your Health Care

Quick, Easy and When You Need It

myblue

Personalized for You

Make sense of your medical bills and health care spending – all in one place.

- Track your health care spending
- Access your mobile ID card or order printed cards
- Print a summary of your claims activity
- Find a doctor close to work or home
- Get in touch with us

Put myblue at Your Fingertips!

1. Go to **mynebraskablue.com**
2. Select "Sign Up"
3. Complete the four easy steps

You will need your member ID number found on your member ID card.

If you have questions about *my*blue, just call the number on the back of your member ID card.

Tools to help you answer important health care questions:

How good is my care? Can I afford it?

Know Before You Go

Estimate medical costs before you receive care. You can find cost information for many common health care services, and compare costs of physicians and hospitals.

Review Your Doctor

Write a review of your health care experience and read other reviews of doctors and hospitals.

MyPrime®

MyPrime is loaded with interactive tools to help manage your family's prescription drugs.

With MyPrime, you can find:

- your prescription benefits
- your drug claim history
- a prescription drug list (also known as a formulary)
- a pharmacy locator
- a drug cost calculator
- a comparison of brand name and generic drug costs

Health and Wellness Resources

A healthier you. Little things can make a big difference.

The lifestyle decisions we make regarding nutrition, weight, exercise, smoking, seatbelt use, and more directly impact our health care costs. Blue Cross and Blue Shield of Nebraska offers resources to help you make positive lifestyle changes.

livewellnebraska

In conjunction with the *Omaha World-Herald* newspaper, our health care and healthy living information site provides comprehensive, reliable health information specifically for Nebraskans.

To learn more, visit **www.livewellnebraska.com**.

Blue Health Advantage
Little Things. Big Difference.

Our wellness and lifestyle management website offers:

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

To check out all the valuable health and wellness resources available to you, go to **www.bluehealthadvantagene.com**.

Blue Cross and Blue Shield of Nebraska Contacts and Resources

Blue Cross and Blue Shield of Nebraska Member Services Department

Phone
1-877-721-2583

Website
www.nebraskablue.com

To locate NEtwork BLUE providers in Nebraska

Phone
1-877-721-2583

Website
www.nebraskablue.com

To locate BlueCard PPO providers nationwide

Phone
Toll-free 1-800-810-BLUE (2583)

Website
www.bcbs.com

To locate participating Rx Nebraska pharmacies nationwide

Phone
1-877-800-0746

Website
www.nebraskablue.com

Blue Cross and Blue Shield of Nebraska is an independent licensee of the Blue Cross and Blue Shield Association.

This brochure provides you with an overview of the Blue Cross and Blue Shield of Nebraska health and dental coverage offered to Direct Bill members of Educators Health Alliance (EHA). This is not a contract. It is intended as a general overview only. It does not contain all the details of this coverage. For more complete information about your plan, including benefits, exclusions and contract limitations, please refer to the certificate of coverage or the master group contract. In the event there are discrepancies between this document and the contract, the terms and conditions of the contract will govern.

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