

## Schedule of Benefits Summary

Group Name: Educators Health Alliance

Effective Date: September 01, 2021

Payment for Services	In-network Provider	Out-of-network Provider
<p>Covered Services are reimbursed based on the Allowable Charge. Blue Cross and Blue Shield of Nebraska In-network Providers have agreed to accept the benefit payment as payment in full, not including Deductible, Coinsurance and/or Copayment amounts and any charges for non-covered services, which are the Covered Person's responsibility. That means In-network providers, under the terms of their contract with Blue Cross and Blue Shield, can't bill for amounts over the Contracted Amount. Out-of-network Providers can bill for amounts over the Out-of-network Allowance.</p>		
<p><b>In-network Provider:</b> The provider network is shown on your I.D. card. For help in locating In-network Providers, visit <a href="http://www.nebraskablue.com">www.nebraskablue.com</a>.</p>		
<p><b>Deductible</b> (the amount the Covered Person pays each Calendar Year for Covered Services before the Coinsurance is payable)</p> <ul style="list-style-type: none"> <li>Individual</li> <li>Family (Embedded*)</li> </ul>	<p>\$1,450 \$2,900</p>	<p>\$2,900 \$5,800</p>
<p><b>Coinsurance</b> (the percentage amount the Covered Person must pay for most Covered Services after the Deductible has been met)</p> <ul style="list-style-type: none"> <li>Covered Person Pays</li> </ul>	<p>20%</p>	<p>40%</p>
<p><b>Out-of-pocket Limit</b> (does not include premium, penalty and amounts not covered by the plan)</p> <ul style="list-style-type: none"> <li>Individual</li> <li>Family (Embedded*)</li> </ul>	<p>\$5,150 \$10,300</p>	<p>\$10,300 \$20,600</p>
<p>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.</p>		
<p>In-network and Out-of-network Deductible and Out-of-pocket Limits cross accumulate. All other limits (days, visits, sessions, dollar amounts, etc.) do cross accumulate between In-network and Out-of-network, unless noted differently.</p>		
<p>Day, session or visit limits for certain services shown on this summary are not applicable to Mental Illness and/or Substance Dependence and Abuse.</p>		
<p>*Embedded – If you have single coverage, you only need to satisfy the individual Deductible and Out-of-pocket Limit amounts. 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 amounts.</p>		

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

- Physician Office
- Telehealth Services
- Urgent Care Facility
- Emergency Care
- Prescription Drugs

The Copay amount varies by the type of Covered Service. Refer to the appropriate category for benefit information.

**Out-of-pocket Limit includes:**

- Deductible
- Coinsurance
- Medical Copays
- Prescription Drug Copays

Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
<b>Physician Office</b> <ul style="list-style-type: none"> <li>Primary Care Physician Office Visit</li> <li>Specialist Physician Office Visit</li> <li>Other Covered Services and supplies provided in the Physician’s Office (with or without an office visit billed)</li> </ul>	\$35 Copay \$55 Copay Deductible and Coinsurance	Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance
<ul style="list-style-type: none"> <li>Allergy Injections and Serum</li> <li>Other Injections</li> </ul>	Deductible and Coinsurance Deductible and Coinsurance	Deductible and Coinsurance Deductible and Coinsurance
<p><b>Primary Care Physician</b> is a physician who has a majority of his or her practice in internal or general medicine, obstetrics/gynecology, general pediatrics or family practice. A <b>physician assistant</b> is covered in the same manner as a Primary Care Physician.</p> <p><b>Specialist Physician</b> is a physician who is not a Primary Care Physician.</p> <p><b>Office Visit Benefits</b> for Primary Care and Specialist Physician Office Visit include office visits (including the initial visit to diagnose pregnancy) and consultations.</p> <p><b>Other Covered Services not part of the Physician Office Benefit (Refer to the appropriate category for benefit information) include:</b> Allergy Injections &amp; Serum; Other Injections; Advanced Diagnostic Imaging (CT, MRI, MRA, MRS, PET &amp; SPECT scans and other Nuclear Medicine); Pregnancy Services; Preventive Services; Radiation Therapy &amp; Chemotherapy; Surgery &amp; Anesthesia; Therapy &amp; Manipulations; Durable Medical Equipment; Sleep Studies; Biofeedback; Psychological Evaluations, Assessments, and Testing.</p>		
<b>Telehealth Services</b>	\$10 Copay	Not Covered
<b>Convenient Care/Retail Clinics (Quick Care)</b>	Same as a Primary Care Physician	Deductible and Coinsurance
<b>Urgent Care Facility Services</b> (a single copay applies to each urgent care visit)	\$55 Copay then Deductible and Coinsurance	Deductible and Coinsurance
<b>Emergency Care Services</b> (services received in a Hospital emergency room setting) <ul style="list-style-type: none"> <li>Facility</li> <li>Professional Services</li> </ul> (Copayment is waived if admitted to the hospital within 24 hours for the same diagnosis)	\$85 Copay then Deductible and Coinsurance Deductible and Coinsurance	In-network level of benefits In-network level of benefits
<b>Outpatient Hospital or Facility Services</b> Services such as surgery, laboratory and radiology, cardiac and pulmonary rehabilitation, observation stays, and other services provided on an outpatient basis	Deductible and Coinsurance	Deductible and Coinsurance
<b>Inpatient Hospital or Facility Services</b> Charges for room and board, diagnostic testing, rehabilitation and other ancillary services provided on an inpatient basis	Deductible and Coinsurance	Deductible and Coinsurance
<b>Orthopedic Specialty Inpatient Hospital or Facility Services</b>	Deductible and Coinsurance	Deductible and Coinsurance
<p><b>NOTE:</b> Coinsurance may be waived if Covered Services are provided at a designated Preferred Center. See <a href="http://www.nebraskablue.com">www.nebraskablue.com</a> for a list of Covered Services and designated hospitals.</p>		

<b>Preventive Services</b>	<b>In-network Provider</b>	<b>Out-of-network Provider</b>
<b>Preventive Services</b> <ul style="list-style-type: none"> <li>Affordable Care Act (ACA) required preventive services (may be subject to limits that include, but are not limited to, age, gender, and frequency)</li> <li>ACA required covered preventive services (outside of limits)</li> <li>Other covered preventive services not required by ACA</li> </ul>	Plan Pays 100%  Deductible and Coinsurance  Plan Pays 100%	Deductible and Coinsurance  Deductible and Coinsurance  Deductible and Coinsurance
<b>Immunizations</b> <ul style="list-style-type: none"> <li>Pediatric (up to age 7)</li> <li>Age 7 and older</li> <li>Related to an illness</li> </ul>	Plan Pays 100% Plan Pays 100% Same as any other illness	Coinsurance Deductible and Coinsurance Same as any other illness

<b>Mental Illness and/or Substance Dependence and Abuse Covered Services</b>	<b>In-network Provider</b>	<b>Out-of-network Provider</b>
<b>Inpatient Services</b>	Deductible and Coinsurance	Deductible and Coinsurance
<b>Outpatient Services</b> <ul style="list-style-type: none"> <li>Office Visit</li> <li>Telehealth Services</li> <li>All Other Outpatient Items &amp; Services</li> </ul>	Plan Pays 100% Deductible and Coinsurance Deductible and Coinsurance	Deductible and Coinsurance Not Covered Deductible and Coinsurance
<b>Emergency Care Services</b> (services received in a Hospital emergency room setting) <ul style="list-style-type: none"> <li>Facility</li> <li>Professional Services</li> </ul>	Deductible and Coinsurance Deductible and Coinsurance	In-network level of benefits In-network level of benefits

<b>Other Covered Services – Illness or Injury</b>	<b>In-network Provider</b>	<b>Out-of-network Provider</b>
<b>Acupuncture</b>	Not Covered	Not Covered
<b>Advanced Diagnostic Imaging</b> (CT, MRI, MRA, MRS, PET & SPECT scans and other Nuclear Medicine)	Deductible and Coinsurance	Deductible and Coinsurance
<b>Ambulance</b> (to the nearest facility for appropriate care) <ul style="list-style-type: none"> <li>• Ground Ambulance</li> <li>• Air Ambulance</li> </ul>	Deductible and Coinsurance  Deductible and Coinsurance	In-network level of benefits  Deductible and Coinsurance (In-network level of benefits if due to an emergency)
<b>Autism Spectrum Disorder</b>	Same as mental illness	Same as mental illness
<b>Biofeedback</b>	Deductible and Coinsurance	Deductible and Coinsurance
<b>Bone Anchored Hearing Aids and Cochlear Implants</b>	Deductible and Coinsurance	Deductible and Coinsurance
<b>Dermatological Services</b>	Same as any other illness	Same as any other illness
<b>Diabetic Services</b> Services include education, self-management training, podiatric appliances and equipment.	Deductible and Coinsurance	Deductible and Coinsurance
<b>Durable Medical Equipment and Supplies (including Prosthetics)</b> (rental or purchase, whichever is least costly; rental shall not exceed the cost of purchasing)	Deductible and Coinsurance	Deductible and Coinsurance
<b>Eye Glasses or Contact Lenses</b> Only covered if required because of a change in prescription as a result of intraocular surgery or ocular injury (must be within 12 months of surgery or injury)	Deductible and Coinsurance	Deductible and Coinsurance

<b>Other Covered Services – Illness or Injury</b>	<b>In-network Provider</b>	<b>Out-of-network Provider</b>
<b>Hearing Aids</b> (up to age 19 limited to \$3,000 every 48 months)	Same as any other illness	Same as any other illness
<b>Home Health Aide, Skilled Nursing and Respiratory Care</b> <ul style="list-style-type: none"> <li>Home Health Aide (limited to 60 days per Calendar Year)</li> <li>Skilled Nursing Care (limited to 8 hours per day)</li> <li>Respiratory Care (limited to 60 days per Calendar Year)</li> </ul>	Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance	Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance
<b>Home Infusion Therapy</b>	Deductible and Coinsurance	Deductible and Coinsurance
<b>Hospice Services</b>	Deductible and Coinsurance	Deductible and Coinsurance
<b>Independent Laboratory</b> <ul style="list-style-type: none"> <li>Diagnostic</li> <li>Preventive</li> </ul>	Deductible and Coinsurance Same as Preventive Services In-network level of benefits	In-network level of benefits Same as Preventive Services In-network level of benefits
<b>Infertility</b> <ul style="list-style-type: none"> <li>Services to diagnose</li> <li>Treatment to promote fertility</li> </ul>	Same as any other illness Not Covered	Same as any other illness Not Covered
<b>Nicotine Addiction</b> <ul style="list-style-type: none"> <li>Medical services and therapy</li> <li>Nicotine addiction classes &amp; alternative therapy, such as acupuncture</li> </ul>	Same as Substance Dependence and Abuse Not Covered	Same as Substance Dependence and Abuse Not Covered
<b>Obesity</b> <ul style="list-style-type: none"> <li>Non-surgical treatment</li> <li>Surgical Treatment</li> </ul>	Not Covered Not Covered	Not Covered Not Covered
<b>Oral Surgery and Dentistry</b> Services such as impacted wisdom teeth, incision and drainage abscesses, excision of tumors and cysts and bone grafts to the jaw. Dental treatment when due to an accidental injury to naturally healthy teeth (treatment related to accidents must be provided within 12 months of the date of injury).	Deductible and Coinsurance	Deductible and Coinsurance
<b>Organ and Tissue Transplantation</b>	Deductible and Coinsurance	Deductible and Coinsurance
<b>Ostomy Supplies</b>	Deductible and Coinsurance	Deductible and Coinsurance

Other Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
<b>Physician Professional Services</b> Inpatient and Outpatient services, such as, surgery, surgical assistant, anesthesia, inpatient hospital visits and other non-surgical services	Deductible and Coinsurance	Deductible and Coinsurance
<b>Pregnancy, Maternity and Newborn Care</b> <ul style="list-style-type: none"> <li>• Pregnancy and maternity (Payment for prenatal and postnatal care is included in the payment for the delivery)</li> <li>• Newborn care</li> </ul> <b>NOTE:</b> Newborns are covered at birth, subject to the plan’s enrollment provisions.	Deductible and Coinsurance  Deductible and Coinsurance	Deductible and Coinsurance  Deductible and Coinsurance
<b>Radiation Therapy and Chemotherapy</b>	Deductible and Coinsurance	Deductible and Coinsurance
<b>Radiology (x-ray) Services and other Diagnostic Test</b>	Deductible and Coinsurance	Deductible and Coinsurance
<b>Rehabilitation Services – Inpatient Facility</b>	Deductible and Coinsurance	Deductible and Coinsurance
<b>Rehabilitation Services</b> <ul style="list-style-type: none"> <li>• Cardiac rehabilitation (limited to 18 sessions per diagnosis)</li> <li>• Pulmonary Rehabilitation (Chronic lung disease is limited to 18 sessions per diagnosis, not to exceed 18 sessions per Calendar Year. Lung, heart-lung transplants and lung volume are limited to 18 sessions following referral and prior to surgery plus 18 sessions within six months of discharge from hospital following surgery.)</li> </ul>	Deductible and Coinsurance  Deductible and Coinsurance	Deductible and Coinsurance  Deductible and Coinsurance
<b>Renal Dialysis</b>	Deductible and Coinsurance	Deductible and Coinsurance

<b>Other Covered Services – Illness or Injury</b>	<b>In-network Provider</b>	<b>Out-of-network Provider</b>
<b>Sexual Dysfunction</b>	Not Covered	Not Covered
<b>Skilled Nursing Facility</b> (limited to 60 days per Calendar Year)	Deductible and Coinsurance	Deductible and Coinsurance
<b>Sleep Studies</b>	Deductible and Coinsurance	Deductible and Coinsurance
<b>Temporomandibular and Craniomandibular Joint Disorder</b>	Deductible and Coinsurance	Deductible and Coinsurance
<b>Therapy &amp; Manipulations</b> <ul style="list-style-type: none"> <li>• Physical, occupational or speech therapy services, chiropractic or osteopathic physiotherapy (combined limit to 60 sessions per Calendar Year)</li> <li>• Chiropractic or osteopathic manipulative treatments or adjustments (combined limit to 30 sessions per Calendar Year)</li> </ul>	Deductible and Coinsurance  Deductible and Coinsurance	Deductible and Coinsurance  Deductible and Coinsurance
<b>Vision Exams</b> <ul style="list-style-type: none"> <li>• Diagnostic (to diagnose an illness)</li> <li>• Preventive (routine exam including refraction)</li> </ul>	See Physician Office Services  Not Covered	See Physician Office Services  Not Covered
<b>Wigs</b>	Not Covered	Not Covered
<b>All Other Covered Services</b>	Deductible and Coinsurance	Deductible and Coinsurance



<b>Prescription Drugs</b>	<b>In-network Provider</b>	<b>Out-of-network Provider</b>
<b>Prescription Drug Deductible</b> (the amount the Covered Person pays each Calendar Year for Covered Prescription Drugs before the Prescription Drug Copayments and/or Coinsurance are applicable) <ul style="list-style-type: none"> <li>Individual</li> <li>Family</li> </ul>		Not Applicable Not Applicable
<b>Retail – per 30-day supply</b> <ul style="list-style-type: none"> <li>Generic drugs/Insulin (including non-preferred contraceptives)</li> <li>Preferred Brand Name Drugs/Insulin</li> <li>Non-preferred Brand Name Drugs/Insulin</li> </ul>	25% Coinsurance, \$10 minimum Copay, \$40 maximum Copay  25% Coinsurance, \$50 minimum Copay, \$100 maximum Copay  50% Coinsurance, \$75 minimum Copay, \$150 maximum Copay	25% Coinsurance, \$10 minimum Copay, \$40 maximum Copay + 25% Penalty  25% Coinsurance, \$50 minimum Copay, \$100 maximum Copay + 25% Penalty  50% Coinsurance, \$75 minimum Copay, \$150 maximum Copay + 25% Penalty
<b>Mail order – per 180-day supply</b> <ul style="list-style-type: none"> <li>Generic drugs (including non-preferred contraceptives)</li> <li>Preferred Brand Name Drugs</li> <li>Non-preferred Brand Name Drugs</li> </ul>	25% Coinsurance, \$50 minimum Copay, \$200 maximum Copay 25% Coinsurance, \$250 minimum Copay, \$500 maximum Copay 50% Coinsurance, \$375 minimum Copay, \$750 maximum Copay	Not Covered  Not Covered  Not Covered
<b>Diabetic Supplies</b> <ul style="list-style-type: none"> <li>Generic</li> <li>Formulary Brand Name</li> <li>Non-formulary Brand Name</li> </ul>	20% Coinsurance 20% Coinsurance 30% Coinsurance	20% Coinsurance + 25% Penalty 20% Coinsurance + 25% Penalty 30% Coinsurance + 25% Penalty
<b>Specialty drugs</b>	25% Coinsurance, \$125 minimum Copay, \$250 maximum Copay	50% Coinsurance, \$250 minimum Copay, \$500 maximum Copay
<b>Contraceptives</b> <ul style="list-style-type: none"> <li>Preferred               <ul style="list-style-type: none"> <li>Generic</li> <li>Brand Name</li> </ul> </li> <li>Non-preferred               <ul style="list-style-type: none"> <li>Generic</li> <li>Brand Name</li> </ul> </li> </ul>	Plan Pays 100% Plan Pays 100%  Same as any other Generic Drugs Same as any other Non-preferred Brand Name	25% Penalty 25% Penalty
<b>Infertility</b> FDA approved prescription drugs to promote fertility	Not Covered	Not Covered
<b>Nicotine Addiction</b> FDA approved prescription drugs and over-the-counter nicotine addiction drugs and deterrents	Plan Pays 100%	25% Penalty
<b>Obesity</b> FDA approved prescription drugs	Not Covered	Not Covered
<b>This plan uses a prescription drug list (PDL). The PDL for this plan is 40, and the Pharmacy Network is C. You can find this prescription drug list and network listing on <a href="http://www.nebraskablue.com">www.nebraskablue.com</a>. Or you may contact Member Services at the phone number on the back of your I.D. card.</b>		

**Please note:** This Schedule of Benefits Summary is intended to provide you with a brief overview of your benefits. It is not a contract and should not be regarded as one. For more complete information about your plan, including benefits, exclusions and contract limitations, please refer to the master group contract. In the event there are discrepancies between this document and the contract, the terms and conditions of the contract will govern.