

## Schedule of Benefits Summary

Group Name: Educators Health Alliance

Effective Date: September 01, 2025

Payment for Services	In-network Provider	Out-of-network Provider
Covered Services are reimbursed based on the Allowable Charge. Blue Cross and Blue Shield of Nebraska 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. In some situations, Out-of-network Providers can bill for amounts over the Out-of-network Allowance. Cost-sharing and reimbursement amounts for categories showing "Same as any other illness" may vary based on where services are rendered.		
<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="https://NebraskaBlue.com/Find-a-Doctor">NebraskaBlue.com/Find-a-Doctor</a> . For certain Durable Medical Equipment, Independent Laboratory and Specialty Drug Services, the Doctor Finder may display providers that are considered Out-of-network for these types of Services. Please refer to your benefit book for additional information.		
<b>Deductible</b> (the amount the Covered Person pays each Calendar Year for Covered Services before the Coinsurance is payable) <ul style="list-style-type: none"> <li>Individual</li> <li>Family (Embedded*)</li> </ul>	\$4,000 \$8,000	\$8,000 \$16,000
<b>Coinsurance</b> (the percentage amount the Covered Person must pay for most Covered Services after the Deductible has been met) <ul style="list-style-type: none"> <li>Covered Person Pays</li> <li>Plan Pays</li> </ul>	30% 70%	50% 50%
<b>Out-of-pocket Limit</b> (Includes Deductible, Coinsurance and Copays) <ul style="list-style-type: none"> <li>Individual</li> <li>Family (Embedded*)</li> </ul>	\$7,300 \$14,600	\$14,600 \$29,200
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. Day, session or visit limits for certain services shown on this summary are not applicable to Mental Health and/or Substance Use Disorders. Once the annual Out-of-pocket Limit is reached, most Covered Services are payable by the plan at 100% for the rest of the Calendar Year.		
*Embedded – If you have single coverage, you only need to satisfy the individual Deductible and Out-of-pocket Limit 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.		
<b>Copayment(s) (copay(s)) apply to:</b> <ul style="list-style-type: none"> <li>This plan has no medical or prescription drug copays.</li> </ul>		
The Copay amount varies by the type of Covered Services. Refer to the appropriate category for benefit information.		
<b>Services may require Preauthorization. Failure to obtain Preauthorization will result in denial of benefits.</b> <b>For additional information regarding Preauthorization procedures please visit <a href="https://NebraskaBlue.com/PreAuth">NebraskaBlue.com/PreAuth</a>.</b>		

Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
<b>Physician Office Services</b> <ul style="list-style-type: none"> <li>Primary Care Physician Office Visit</li> <li>Specialist Physician Office Visit</li> <li>Physician Office Services provided in the office (with or without an office visit)</li> </ul>	Deductible and Coinsurance Deductible and Coinsurance 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) consultations and medication checks.</p> <p><b>Other Covered Services not part of the Physician Office Services Benefit (Refer to the appropriate category for benefit information) include:</b> Advanced Diagnostic Imaging (CT, MRI, MRA, MRS, PET and SPECT scans and other Nuclear Medicine); Pregnancy Services; Preventive Services; Radiation Therapy and Chemotherapy; Surgery and Anesthesia; Therapy and Manipulations; Durable Medical Equipment; Sleep Studies; Biofeedback; Mental Health and Substance Use Disorders.</p>		
<b>Telehealth/Virtual Care Services</b> <ul style="list-style-type: none"> <li>Medical</li> <li>Mental Health</li> </ul>	Deductible and Coinsurance See Mental Health and/or Substance Use Disorder Services	Not Covered 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>	Deductible and Coinsurance	Deductible and Coinsurance
<b>Emergency Room 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>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 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="https://www.nebraskablue.com/PreferredCenters">NebraskaBlue.com/PreferredCenters</a> for a list of Covered Services and designated hospitals.</p>		

Preventive Services	In-network Provider	Out-of-network Provider
<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> For additional information please visit <a href="https://www.NebraskaBlue.com/PreventiveCare">NebraskaBlue.com/PreventiveCare</a>	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>Colorectal Cancer Screenings</b> (starting at age 45) <ul style="list-style-type: none"> <li>Colonoscopy Screening <ul style="list-style-type: none"> <li>Diagnostic or Preventive Screening (one every five years)</li> <li>Screenings outside the age or frequency limit</li> </ul> </li> <li>Sigmoidoscopy/Proctoscopy Screening and CT of the Colon <ul style="list-style-type: none"> <li>Preventive Screening (one every five years)</li> <li>Screenings outside the age or frequency limit</li> </ul> </li> <li>FIT DNA <ul style="list-style-type: none"> <li>Preventive Screening (one every three years)</li> <li>Screenings outside the age or frequency limit</li> </ul> </li> <li>Fecal occult blood test <ul style="list-style-type: none"> <li>Preventive Screening (one per year)</li> <li>Screenings outside the age or frequency limit</li> </ul> </li> <li>Barium enema, and other tests as determined under ACA Preventive Services <ul style="list-style-type: none"> <li>Preventive Screenings</li> <li>Diagnostic Screenings</li> </ul> </li> </ul>	Plan Pays 100%  Same as any other illness  Plan Pays 100%  Same as any other illness  Plan Pays 100%  Same as any other illness  Plan Pays 100%  Same as any other illness  Plan Pays 100%  Same as any other illness	Deductible and Coinsurance  Deductible and Coinsurance  Deductible and Coinsurance  Deductible and Coinsurance  Deductible and Coinsurance  Deductible and Coinsurance  Deductible and Coinsurance  Deductible and Coinsurance
<b>NOTE:</b> Related Services will pay in the same manner as the Colorectal Cancer Screening when performed on the same date of service. Screening limits accumulate based on a calendar year.		

<b>Mental Health and/or Substance Use Disorder 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>Therapy Performed in School</li> <li>Telehealth/Virtual Care Services</li> <li>All Other Outpatient Items &amp; Services</li> </ul>	Deductible and Coinsurance Deductible Deductible and Coinsurance Deductible and Coinsurance	Deductible and Coinsurance Deductible and Coinsurance Not Covered Deductible and Coinsurance
<b>Office Services</b> include office visits, medication checks, psychological therapy and/or substance use disorder counseling, x-rays, laboratory tests, supplies and/or drugs administered during the office visit. <b>Other Covered Services not part of the Office Benefit Services are covered under All Other Outpatient Items &amp; Services.</b> This includes but is not limited to: psychological evaluations, assessments, testing, physical therapy, occupational therapy, speech therapy or any other covered Mental Health and/or Substance Use Disorder services.		
<b>Emergency Room 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 In-network level of benefits
<b>Autism Spectrum Disorder</b> <ul style="list-style-type: none"> <li>Testing and Diagnosis</li> <li>Treatment</li> </ul>	Same as mental health Same as mental health	Same as mental health Same as mental health
<b>Biofeedback</b> <ul style="list-style-type: none"> <li>Medical</li> <li>Mental Health</li> </ul>	Deductible and Coinsurance Same as mental health	Deductible and Coinsurance Same as mental health
<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.	Same as any other illness	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>Hearing Services</b> <ul style="list-style-type: none"> <li>Bone Anchored Hearing Aids</li> <li>Cochlear Implants</li> <li>Hearing Aids (up to age 19, limited to \$3,000 every 48 months.)</li> </ul>	Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance	Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance

Other Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
<b>Home Health Care Services</b> <ul style="list-style-type: none"> <li>Home Health Aide (limited to 60 days per Calendar Year)</li> <li>Home Infusion Therapy</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
<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	Deductible and Coinsurance 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 Use Disorder Services Not Covered	Same as Substance Use Disorder Services 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).	Same as any other illness	Deductible and Coinsurance
<b>Organ and Tissue Transplantation</b>	Same as any other illness	Deductible and Coinsurance
<b>Ostomy Supplies</b>	Deductible and Coinsurance	Deductible and Coinsurance
<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 (Newborns are covered at birth, subject to the plan's enrollment provisions)</li> </ul>	Deductible and Coinsurance Deductible and Coinsurance	Deductible and Coinsurance Deductible and Coinsurance
<b>NOTE:</b> The Plan pays 100% for the initial postpartum depression screening up to one year following a pregnancy or childbirth.		



<b>Prescription Drugs</b>	<b>In-network Provider</b>	<b>Out-of-network Provider</b>
<b>Retail – per 30-day supply</b> <ul style="list-style-type: none"> <li>Preferred Generic Drugs</li> <li>Non-Preferred Generic Drugs</li> <li>Preferred Brand Name Drugs</li> <li>Non-preferred Brand Name Drugs</li> </ul>	Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance	Deductible and Coinsurance + 25% Penalty Deductible and Coinsurance + 25% Penalty Deductible and Coinsurance + 25% Penalty Deductible and Coinsurance + 25% Penalty
<b>Home Delivery – per 180-day supply</b> <ul style="list-style-type: none"> <li>Preferred Generic Drugs</li> <li>Non-Preferred Generic Drugs</li> <li>Preferred Brand Name Drugs</li> <li>Non-preferred Brand Name Drugs</li> </ul>	Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance	Not Covered Not Covered Not Covered Not Covered
<b>Diabetic Supplies</b>	Deductible and Coinsurance	Deductible and Coinsurance + 25% Penalty
<b>Specialty Drugs</b> <ul style="list-style-type: none"> <li>Preferred Specialty Drugs</li> <li>Non-Preferred Specialty Drugs</li> </ul>	Same as Retail Same as Retail	Not Covered Not Covered
<b>Contraceptive Drugs</b> <ul style="list-style-type: none"> <li>Contraceptive Drugs and Methods in accordance with Federal Guidelines</li> <li>All other Contraceptive Drugs and Methods</li> </ul>	Plan Pays 100% Same as any other Generic or Brand Name Drugs	25% Penalty 25% Penalty
For additional information please see Women’s Services listed on <a href="https://NebraskaBlue.com/PreventiveCare">NebraskaBlue.com/PreventiveCare</a>		
<b>Diabetic Insulin</b> <ul style="list-style-type: none"> <li>Preferred Generic Drugs</li> <li>Non-Preferred Generic Drugs</li> <li>Preferred Brand Name Drugs</li> <li>Non-Preferred Brand Name Drugs</li> </ul>	Plan Pays 100% Same as any other Generic Drugs Plan Pays 100% Same as any other Non-Preferred Brand Name Drugs	25% Penalty 25% Penalty 25% Penalty 25% Penalty
<p><b>This Plan utilizes the Broad Network C and NetResults Performance prescription drug list PDL).</b>  <b>You can find this prescription drug list and network listing on <a href="https://NebraskaBlue.com/Pharmacy">NebraskaBlue.com/Pharmacy</a>. Or you may contact Member Services at the phone number on the back of your I.D. card.</b></p>		

**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.