A Guide to Your Health Care Benefits For University of Nebraska 2013

Claims administered by

BlueCross BlueShield of Nebraska

An Independent Licensee of the Blue Cross and Blue Shield Association.

98-167 (01-2013)

This Group Health Plan believes this plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

About Your Certificate Of Coverage

This document is your Certificate of Coverage. It has been written to help you understand your group health plan administered in accordance with the provisions set forth in the Master Group Contract and Administrative Service Agreement between University of Nebraska and your Contract Administrator, Blue Cross and Blue Shield of Nebraska,* an independent licensee of the Blue Cross and Blue Shield Association.

This Certificate of Coverage is only a partial description of the benefits, exclusions, limitations, and other terms of the Master Group Contract to which it refers. It describes the more important parts of that document in a general way. It is not, and should not be considered a contract or any part of one. The Master Group Contract controls the coverage for your group.

The Master Group Contract is made in and governed by the laws of the State of Nebraska. Please note that this Certificate of Coverage may not list all the benefits provided by the laws of your state if you do not reside in Nebraska. Please read this Certificate of Coverage carefully.

Please share the information found in this Certificate of Coverage with your eligible dependents. Additional copies of this document or your Schedule of Benefits, are available from Blue Cross and Blue Shield of Nebraska's Customer Service Center. If you have a question about your coverage or claim, please contact Blue Cross and Blue Shield of Nebraska's Customer Service Center.

**Blue Cross and Blue Shield of Nebraska provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims. Blue Cross and Blue Shield of Nebraska liability may occur only under a stop loss provision set forth in the Administrative Services Agreement.*

Important Telephone Numbers

Customer Service:

Omaha 402-592-8963
Toll-free 1-888-592-8963
TTY/TTD (for the hearing impaired) 800-821-4791

Coordination of Benefits:

Omaha 402-390-1840
Toll-free 1-800-462-2924

Subrogation:

Omaha 402-390-1847
Toll-free 1-800-662-3554

Workers' Compensation:

Omaha 402-398-3615
Toll-free 1-800-821-4786

Preadmission/Admission Certification:

Omaha 402-390-1870
Toll-free 1-800-247-1103

BlueCard Provider Information:

Toll-free 1-800-810-BLUE (2583)
Web site . . . . . .www.bcbs.com

University of Nebraska
Summary of Health Benefits

	In-Network Providers	Out-of-Network Providers
Calendar Year Deductible		
Low Option		
Individual	$1,550	$1,950
Family	$3,100	$3,900
Basic Option		
Individual	$450	$650
Family	$900	$1,300
High Option		
Individual	$300	$450
Family	$600	$900

Coinsurance Percentage Amount of Allowable Charges **Coinsurance Percentage Amount: Your coinsurance amount is computed as a percentage of the allowable charge, less any unpaid deductible.**		
Low Option	30%	45%
Basic Option	30%	45%
High Option	20%	35%
Coinsurance Limit		
Low Option		
Individual	$2,500	$2,900
Family	$5,000	$5,800
Basic Option		
Individual	$1,600	$2,000
Family	$3,200	$4,000
High Option		
Individual	$1,400	$1,700
Family	$2,800	$3,400

Table of Contents

Table Of Contents

Some Important Facts About Your Coverage

This Group Health Plan is a preferred provider organization (PPO) health benefit plan.

Blue Cross and Blue Shield of Nebraska is the contract administrator for the Group Health Plan.

NEtwork BLUE is a Preferred Provider Organization (PPO) established by Blue Cross and Blue Shield of Nebraska through contracts with a panel of hospitals, physicians and other health care providers who have agreed to furnish medical services to you and your family in a manner that will help manage health care costs. These providers are referred to as “In-network” or "Preferred Providers."

Blue Cross and Blue Shield Plans in other states (on-site plans) have also contracted with health care providers in their geographic areas, as “Preferred Providers.”

For help in locating In-network Providers, managing your personal health care benefits, as well as accessing various resources and tools, visit BCBSNE online at www.nebraskablue.com. You may also call Member Services using the toll-free number on your I.D. care or refer to the Important Telephone Numbers in the front of this book. If you would like a printed provider list, BCBSNE will furnish one without charge.

By using In-network Providers, you benefit from these important advantages:

- Lower deductible requirements in most cases.
- Lower coinsurance requirements in most cases.
- Providers accept your deductible and/or coinsurance plus this group plan's benefit payment as payment in full for a covered service. When an In-network or Preferred Provider is used, you are not responsible for charges in excess of the contracted amount for a service.

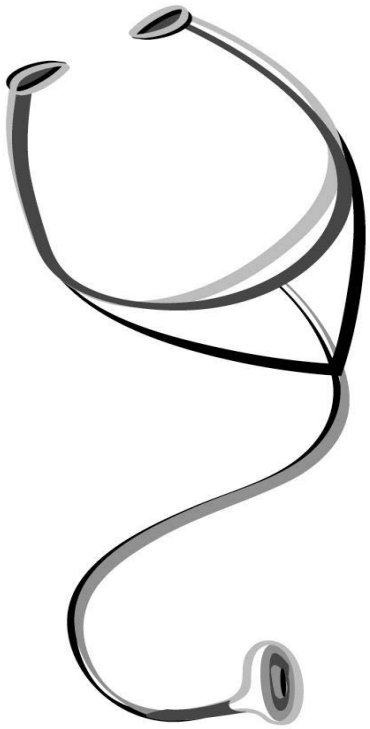
Blue Cross and Blue Shield Plans across the country participate in a national program called the BlueCard Program. Each plan has a network of providers who specifically have agreed to participate as BlueCard Program network (PPO) providers. These providers will also be referred to as “Preferred Providers.” The BlueCard Program enables the Blue Cross and Blue Shield Plan servicing the geographic area where treatment is provided to process the claim, and allows you to take advantage of the local plan’s contracting provider agreements.

USING YOUR BENEFITS WISELY

Blue Cross and Blue Shield of Nebraska and the University of Nebraska want you to get the most from your group health coverage. You can save yourself a considerable amount of time and money by making efficient use of the health care system.

As you read this document, some “Good Care Tips” for efficient health care will be highlighted in boxes just like this one.

Selecting A Provider



No matter where you are when you require health care services, whether you are in Nebraska or in another state, selection of a provider of care always remains your choice. However, the provider you choose may make a difference in the amount of benefits your coverage provides and, therefore, whether your liability will be more or less.

In the NEtwork BLUE Service Area (Nebraska)

Selection of a provider of care always remains your choice. If you choose a NEtwork BLUE Provider, you are eligible to receive the highest benefit level (preferred) possible under your group health plan. However, if you choose a non-Preferred Provider, the benefit level (non-preferred) will generally be less. For help in locating a NEtwork BLUE Provider, contact Blue Cross and Blue Shield of Nebraska's Customer Service Center at their toll-free number (1-888-368-2227). A directory of *NEtwork BLUE* Providers is available upon request or at the Blue Cross and Blue Shield of Nebraska website: **www.nebraskablue.com**.

Outside the NEtwork BLUE Service Area

Selection of a provider of care still remains your choice. If you receive care from a provider who is a Preferred Provider with the On-site Blue Cross and/or Blue Shield Plan, you are eligible to receive the highest benefit level (preferred) possible under your Group health plan. However, if you choose a non-Preferred Provider, the benefit level (non-preferred) will generally be less. For help in locating a Preferred Provider in another Blue Cross and/or Blue Shield Service Area , including providers outside of the U.S., you may call the special toll-free number of the Blue Cross and Blue Shield BlueCard Program (1-800-810-2583) for assistance.

Also, for help in locating a provider, you can visit the "Blue National Doctor & Hospital Finder" at the Blue Cross and Blue Shield Association website, www.bcbs.com. For worldwide medical assistance services, including help in locating hospital and doctors throughout the world, you can visit BlueCard Worldwide by clicking on the link for health care providers outside of the U.S.

Out-of-Area Services

BCBSNE has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever You obtain healthcare Services outside of BCBSNE's service area, the claims for these Services may be processed through one of these Inter-Plan Programs, which include the BlueCard® Program and may include negotiated National Account arrangements available between BCBSNE and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside BCBSNE's service area, You will obtain care from healthcare providers that have a contractual agreement (i.e., are "Participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue" or On-Site Plan"). In some instances, You may obtain care from nonparticipating healthcare providers. BCBSNE's payment practices in both instances are described in the following paragraphs.

BlueCard® Program

Under the BlueCard® Program, when You access Covered Services within the geographic area served by a Host Blue, BCBSNE will remain responsible for fulfilling BCBSNE's contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its Participating healthcare Providers.

Whenever You access Covered Services outside BCBSNE's service area and the claim is processed through the BlueCard Program, the amount You pay for Covered Services is calculated based on the lower of:

- The billed covered charges for your Covered Services, or
- The Contracted Amount that the Host Blue makes available to BCBSNE.

Often, this Contracted Amount will consist of a simple discount which reflects an actual price that the Host Blue pays to Your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with Your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for

similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over or underestimation of modifications of past pricing for the types of transaction modifications previously noted. However, such adjustments will not affect the price BCBSNE uses for Your claim because such adjustments will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to Your liability calculation methods, including a surcharge, BCBSNE would then calculate Your liability for any Covered Services according to applicable law.

Negotiated (non-BlueCard® Program) National Account Arrangements

As an alternative to the BlueCard® Program, Your claims for Covered Services may be processed through a negotiated National Account arrangement with a Host Blue.

The amount You pay for Covered Services under this arrangement will be calculated based on the lower of either billed covered charges or the Contract Amount (refer to the description of negotiated price under BlueCard® Program) made available to BCBSNE by the Host Blue.

Non-Participating Healthcare Providers Outside Our Service Area

Subscriber Liability Calculation — When Covered Services are provided outside of BCBSNE's service area by nonparticipating healthcare providers, the amount You pay for such Services will generally be based on either the Host Blue's nonparticipating healthcare provider local payment or the pricing arrangements required by applicable state law. In these situations, You may be liable for the difference between the amount that the nonparticipating healthcare provider bills and the payment BCBSNE will make for the Covered services as set forth in this paragraph.

Exceptions — In certain situations, BCBSNE may use other payment bases, such as billed covered charges, the payment BCBSNE would make if the healthcare Services had been obtained within BCBSNE's service area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount BCBSNE will pay for Services rendered by nonparticipating healthcare providers. In these situations, You may be liable for the difference between the amount that the nonparticipating healthcare provider bills and the payment BCBSNE will make for the Covered Services set forth in this paragraph.

Your I.D. Card — A Passport to Health Care

Blue Cross and Blue Shield of Nebraska will issue you an identification card. Your I.D. number is a unique alpha numeric combination including an alpha prefix (UNE) and a numeric suffix.

Always put your I.D. card in your wallet or purse, along with your driver's license, credit cards and other essential items. With your Blue Cross and Blue Shield of Nebraska I.D. card, U.S. hospitals and physicians can identify your coverage and will usually submit their claims for you.

If you want extra cards for covered family members or need to replace a lost card, please contact Blue Cross and Blue Shield of Nebraska's Customer Service Center. Remember, only persons who are eligible for coverage under your membership may use your Blue Cross and Blue Shield of Nebraska I.D. card.

Schedule of Benefits

Your Schedule of Benefits is a personalized document that provides you with a basic overview of your coverage. It also shows the membership option that applies to you.

For additional information which may be unique to your coverage, please refer to the Schedule of Benefits Summary.

Eligibility and Enrollment

Eligibility for Coverage

You are eligible for coverage through your employment with the University of Nebraska. Please contact them regarding eligibility requirements.

Types of Membership

There are several types of enrollment options offered by the University of Nebraska.

The options include:

Single Membership: Provides coverage for you only.

Subscriber-Spouse Membership: Provides coverage for you and your spouse.

Single Parent Membership: Provides coverage for you and your eligible dependent children to age 26, but not for your spouse.

Family Membership: Provides coverage for you, your spouse and your eligible children to age 26.

The Employee Plus One options include:

Employee Plus One membership: Provides coverage for you and your adult designee.

Employee Plus One Single Parent Membership: Provides coverage for you and your adult designee's eligible dependent children to age 26 and your eligible dependent children to age 26, but not your adult designee.

Employee Plus One Family Membership: Provides coverage for you, your adult designee, your adult designee's eligible dependent children to age 26, and your eligible dependent children to age 26.

Note: *In the event that two eligible persons are both employees of the University of Nebraska and are married to each other, the person hired first or who carries the most FTE shall be the primary covered person under the membership, and the spouse shall be enrolled as a dependent in that membership unit.*

Special Enrollment

An eligible person who has not previously enrolled for coverage may be able to enroll during a special enrollment period.

A special enrollment period of 31 days is allowed for:

- Enrollment of eligible persons due to marriage, birth, adoption or placement for adoption.
- Enrollment of eligible persons not previously covered under this plan due to having had other group health plan or health insurance coverage at the time it was previously offered, and who have lost that other coverage because of any of the following:

  Exhaustion of COBRA continuation coverage.

  The other coverage was not COBRA coverage, and it was terminated due to a loss of eligibility, including loss due to death, divorce, termination of employment or reduction in hours, or due to the plan no longer offering benefits to the class of individuals that includes the person. A loss of eligibility includes that due to moving out of the service area of an HMO or other arrangement that only provides benefits to individuals who reside, live or work in the service area, or exhausting the lifetime limit on all benefits.

  The other coverage was not COBRA coverage and the employer ceased to make a contribution for the coverage.

A special enrollment period of 60 days is allowed for:

- Enrollment of eligible persons who were covered under Medicaid or State Child Health Insurance Program (SCHIP), which has been terminated due to loss of eligibility.
- Enrollment of eligible persons who have become eligible for premium assistance for this group health Plan coverage under Medicaid or SCHIP.

The subscriber must enroll (or already be enrolled) in order to enroll his or her dependents in this plan. In the case of a marriage, birth or adoption, a subscriber who is eligible, but who has not previously enrolled, may enroll at this time with or without the newly eligible dependent. Likewise an eligible spouse who has not previously enrolled, may enroll as a special enrollee with or without a new dependent child. Please contact your Human Resource Department for additional information.

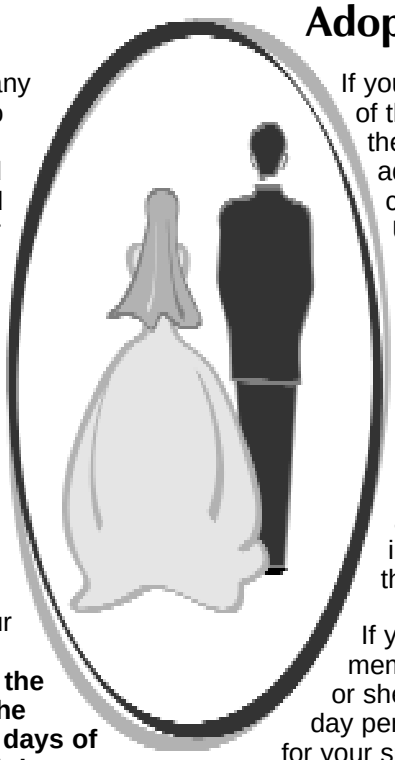
Late Enrollment

A "late enrollee" is defined as an employee or dependent who requests enrollment for coverage more than 31 days after his or her initial eligibility. An eligible person who enrolls for coverage during a "special enrollment period" is not considered a late enrollee.

Late enrollment is allowed only during the annual open enrollment period specified by the University of Nebraska. Coverage for a late enrollee will be effective January 1st following the University's open enrollment.

Additional late enrollment restrictions may apply. Please contact the University of Nebraska for information.

Marriage



When you marry, your spouse and any other new dependents are eligible to enroll for coverage under an appropriate membership unit offered by your group plan. A 31 day period is allowed to make a change to your membership if necessary, and to request coverage for the new dependents. If the request is received within 31 days of the marriage, the effective date of coverage will be no later than the first day of the first month following the receipt of the enrollment form.

Newborn Children

Coverage shall begin at birth for your newborn child. **To continue the child's coverage beyond 31 days, the covered employee must contact the Campus Benefits Office within 31 days of a dependent's date of birth to add the newborn child to his or her medical insurance policy.** The employee must complete and deliver to the Campus Benefits Office a Dependent Information Request Form (obtained from the University) to add the new dependent child to the medical insurance policy even if the Employee is currently enrolled for Single Parent (Employee & Child) or Family, (Employee & Family) coverage. If the newborn child is added, the coverage change will be effective the first of the month following the dependent's date of birth. If the Employee does not complete and deliver the properly completed Dependent Information Request Form within 31 days of the newborn's birth and then wants to cover the child, the child will be considered a late enrollee and benefits will not be provided to the child until the next annual open enrollment period.

If your spouse was not enrolled under your membership at the time of the child's birth, he or she may also enroll for coverage during this 31 day period, and the effective date of coverage for your spouse will be the date of the child's birth. The applicable premium for Family Membership must be paid for the entire month.

Late enrollment is allowed only during the annual open enrollment period specified by the University of Nebraska. Coverage for a late enrollee will be effective January 1st following the University's open enrollment.

Adopted Children

If you are adopting a child, the effective date of the child's coverage will be the earlier of the date the child is placed with you for adoption, or the date a court order grants custody to you. Please notify the University of Nebraska within 31 days of the placement, so that they may update your records and to avoid any future delay in the payment of claims.

If you have a Single or Subscriber-Spouse Membership in effect, you must request a change to Single Parent or Family Membership and enroll the child within 31 days of the placement for adoption and pay the additional premium, in order to continue the coverage beyond the initial 31 day period.

If your spouse was not enrolled under your membership at the time of the adoption, he or she may enroll for coverage during this 31 day period, and the effective date of coverage for your spouse will be the date the child is placed with you for adoption. The applicable premium must be paid. Please contact the University of Nebraska for premium information.

Late enrollment is allowed only during the annual open enrollment period specified by the University of Nebraska. Coverage for a late enrollee will be effective January 1st following the University's open enrollment.

Disabled Dependent Children

A physically or mentally disabled child may remain an eligible dependent upon reaching the limiting age under the plan if he or she is incapable of self-sustaining employment and dependent upon you for support and maintenance. The application for such coverage must be received within 31 days of reaching the limiting age, and the dependent must meet all other group eligibility requirements. An application is available through Blue Cross and Blue Shield of Nebraska's Member Services Department.

Qualified Medical Child Support Orders

A Qualified Medical Child Support Order (QMCSO) is a court order that requires an employee to provide medical coverage for his or her children (called alternate recipients) in situations involving divorce, legal separation or paternity disputes. The order may direct the group health plan to enroll the child(ren), and also creates a right for the alternate recipient to submit claims and receive benefits for services.

QMCSOs are specifically defined under the law, and are required to include certain information in order to be considered "qualified." A National Medical Support Notice received by the employer or plan from a state agency, regarding coverage for a child, will also be treated as a QMCSO. The Plan Administrator or its designee, will review the Order or Notice to determine whether it is qualified, and make a coverage determination. The Plan Administrator or its designee will notify affected employees and the alternate recipient(s) if a QMCSO is received.

You have the right to request a copy of the Plan's procedures governing QMCSO determinations from the Plan Administrator, at no charge.

Active Employees Ages 65 and Over

Federal law affects the way employers provide coverage to eligible active employees and their spouses who are 65 and over. These active employees and their spouses ages 65 and over may elect to continue full benefits under the employer group benefit plan or choose Medicare as their primary coverage. If the group plan is elected as the primary carrier (the plan which pays first), Medicare becomes the secondary coverage. If Medicare is elected as the primary carrier (the plan that pays first), coverage under the group plan is terminated.

Family Medical Leave Act (FMLA)

Public Law 103-3 (FMLA) requires that, subject to certain limitations, an employer of 50 or more persons offer continued coverage to employees and their eligible dependents, while the employee is on FMLA leave for birth, adoption or foster care placement of a child, or due to a serious health condition of the employee or his/her son, daughter, spouse or parent. In addition, an employee who has terminated his/her group health coverage while on approved FMLA leave may reenroll for group health coverage upon return to employment. **Please check with your employer for details regarding your eligibility under FMLA.**

Termination of Coverage

Coverage under your health plan will terminate on the earliest of the following dates:

- The date the entire Contract is terminated.
- The last day of the month in which you terminate employment.
- The last day of the month in which you cease to be eligible under the health plan, or a dependent ceases to be an eligible dependent.
- The last day of the month in which we receive a request from you or the employer to terminate coverage for you or a dependent, or the date requested in the notice, if later.
- The last date for which premium was paid.

You and/or your eligible dependents may be eligible to continue coverage under the health plan, or purchase a nongroup conversion policy, as detailed in the following sections.

Continuation of Coverage

COBRA Act

The Consolidated Omnibus Budget Reconciliation Act, known as COBRA, is a federal law which provides that covered employees and certain dependents may elect to continue coverage under the group health plan upon the occurrence of certain "qualifying events." Persons who are eligible to continue coverage are called "qualified beneficiaries." A qualified beneficiary also includes a child born to, or placed for adoption with you during a period of COBRA coverage. These events are described on the following pages, as well as the procedures for electing COBRA continuation coverage. **Payment for continuation coverage is at the employee's or dependent's own expense.** Adult designees and adult designee dependent children do not have an independent right to elect COBRA continuation coverage if these individuals lose coverage for any reason. However, an employee may elect to continue coverage through COBRA for himself or herself, the adult designee and the adult designee's dependent children if the employee becomes eligible for COBRA continuation coverage.

Please share the COBRA information found in this section with your eligible dependents. Note: To protect your rights under COBRA, please keep your employer informed of your current address.

Termination of Employment or Reduction in Hours

COBRA provides that if you should lose eligibility for coverage due to:

- a reduction in work hours
- termination of employment
- a layoff, or
- discharge for misconduct (other than gross misconduct),

you and your covered dependents may be able to continue the group coverage at your own expense for **up to 18 months.** Your employer is required to notify the plan administrator within 30 days. The plan administrator will send the qualified beneficiaries a COBRA notification within 14 days after receiving notice from the employer.

Special provisions regarding COBRA eligibility for certain retirees may apply if an employer files a Chapter 11 bankruptcy. Please check with your employer for details.

Disability--If a qualified beneficiary is determined by the Social Security Administration to have been disabled any time during the first 60 days of COBRA coverage, the COBRA coverage period may be extended from **18 to 29 months.** You must provide written notice of the disability determination to the plan within 60 days of the later of the Social Security Administration's determination or the qualifying event, and before the end of the initial 18-month COBRA period.

The notice to the plan must include sufficient information to enable the administrator to identify the disabled beneficiary, the date of the disability and the date of the determination. The failure to provide timely and effective notice of a disability determination may result in the loss of the right to extend COBRA coverage.

The cost for COBRA coverage for the 19th through the 29th month may be increased to 150% of the applicable premium for coverage.

Change in Dependent Status, Divorce or Separation or Medicare Entitlement

COBRA requires that continued coverage under your group plan be offered to your covered spouse and eligible dependents if they would otherwise lose coverage as the result of:

- a child losing dependent status
- divorce or legal separation, or
- you becoming entitled to Medicare.

When one of these circumstances occurs, you or the dependent are obligated to notify your employer or plan administrator within 60 days.

After receiving a timely notice of such an event, your employer or plan administrator will send the qualified beneficiaries an election form and information needed to apply for coverage, if eligible. The coverage may

be continued at his/her expense **for up to 36 months.**

If your spouse or dependent is not eligible to continue coverage under your group plan, conversion privileges may be available. Application for conversion coverage must be made no later than 31 days from the end of eligibility.

Your Death

If you should die while you are covered under this group plan, continued coverage under this group plan is available to your covered spouse and eligible dependents.

COBRA provides that subject to certain limitations, your surviving spouse and children may continue the group coverage at their own expense for up to 36 months.

Federal law requires your employer to send the surviving family members instructions as to how to apply for continued coverage, if they are eligible.

Your spouse also has the option to elect to continue coverage under the group plan until remarriage or their becoming eligible on another group policy.

Following the end of any continuation of coverage period, conversion privileges to a non-group contract may be available.

Electing COBRA Coverage

Please share the COBRA information found in this section with your eligible dependents, in the event that a qualifying event occurs.

Within 14 days after notice of a qualifying event is received by the plan administrator, you and/or your dependents (qualified beneficiaries) will be sent a written notice of the right to continue health coverage, and an election form(s).

Reminder: *In the case of a divorce or legal separation, or if a child loses dependent status, you must notify your employer or plan administrator of this qualifying event within 60 days after the later of the event or the date the coverage would be lost.*

Qualified beneficiaries must complete and return the COBRA election form in order to continue coverage. The notice will include instructions to help you complete the form, and to whom it should be sent.

The election form must be received by the later of:

- 60 days after the day health coverage would otherwise end, or
- 60 days after the notice is sent to you by the employer or plan administrator.

COBRA continuation coverage may only begin on the day after coverage under the plan would otherwise end. The required premium, including any retroactive premium, must be paid from the day coverage would have otherwise ended.

The premium must be paid within 45 days after the day continued coverage is elected. Succeeding premiums must be paid monthly within 30 days of the premium due date. The COBRA notice and election form will inform you or your dependents of the monthly premium amount, and to who such premium should be paid.

Second Qualifying Event -- In the event your family experiences another qualifying event while receiving an 18-month period of COBRA coverage (or the extended 29 month period), your covered spouse and dependents are eligible to extend the original COBRA coverage period to a maximum of 36 months, if notice of the second event is properly given to the employer or plan administrator. This extension may be available to the spouse and children receiving continuation coverage if: a) you die, b) you become entitled to Medicare, c) you get divorced or legally separated, or d) the dependent child is no longer eligible as a dependent, but only if the second event would have caused the spouse or child to lose coverage under the plan had the first qualifying event not occurred. **In all of these cases, you or the dependent must notify the employer or plan administrator within 60 days of the second qualifying event.**

Termination of COBRA Coverage

A qualified beneficiary's COBRA continuation coverage will end at midnight on the earliest of:

- the day your employer ceases to provide any group health plan to any employee,
- the day the premium is due and unpaid,

- the day the individual first becomes covered under any other group health plan (after the COBRA election), which does not exclude or limit any pre-existing conditions or to whom such an exclusion is not applicable due to creditable coverage,

- the day the individual again becomes covered as an employee or dependent under the policy,

- the day the continued health insurance is converted to conversion coverage,

- the day the individual becomes entitled to benefits under Medicare (after the COBRA election), or

- the day health insurance has been continued for the maximum period of time allowed (18, 29 or 36 months).

Note: *In the event more than one continuation provision applies, the periods of continued coverage may run concurrently, but never for more than 36 months.*

Uniformed Services Employment And Reemployment Rights (Military Leave)

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) requires that continued coverage under an employer group health plan be offered to an employee and covered dependents if coverage would otherwise be lost due to a military leave.

Continuation of Group Health Coverage:

If coverage under your employer group health plan ends because of service in the uniformed services, you may elect to continue health coverage for yourself and your covered dependents, until the earlier of:

- 24 consecutive months from the date active duty began; or

- the day after the date on which you fail to apply for, or return to employment, in accordance with USERRA.

You are responsible for payment of the required premium to continue coverage. If the leave for military service is less than 31 days, your required premium is the standard employee share of the applicable premium; for a leave in excess of 30 days, the required premium shall be no more than 102% of the total premium applicable for your membership option. Your employer will inform you of the amount and procedure for payment of premiums.

A covered person's continued coverage under these USERRA provisions will end at midnight on the earliest of:

- the day the employer ceases to provide any group health plan for its employees;

- the day premium is due and unpaid;

- the day a covered person again becomes covered under the plan;

- the day coverage has been continued for the period of time stated in the previous paragraph, above.

Reemployment:

Following service in the uniformed services, an employee may be eligible to apply for reemployment with the employer in accordance with USERRA. Such reemployment includes the right to reenroll for group health coverage provided by the employer, with no new waiting periods imposed.

Please contact your Human Resources or Personnel Department for further information regarding your rights under USERRA.

Continuation of Coverage for Children to Age 30

You may elect to continue coverage to age 30 for a dependent who would otherwise lose coverage when he or she reaches the plan's limiting age (an Eligible Dependent is defined in the Definitions section of this book) provided that the following criteria are met:

- the child remains financially dependent on you; and

- the child was covered as an Eligible Dependent at the time such coverage would have terminated.

In order to elect continuation coverage, you must

request an election form from Blue Cross and Blue Shield of Nebraska. The completed form must be returned no sooner than 31 days prior to or no later than 31 days after the date on which the child would otherwise lose coverage. You should also notify your employer of your decision to continue coverage for your child.

Payment for Continuation Coverage

The premium for continuation coverage will be equal to the full, unsubsidized single adult premium. You are responsible for paying the full premium each month. The first month's premium must be paid to the Campus Benefits Office no later than 31 days after the date the child's coverage would have terminated.

Termination of Continuation Coverage

Continuation coverage will terminate if:

1. The monthly payment is not received on a timely basis;

2. You request coverage to be terminated;

3. Your coverage under the University health plan terminates;

4. The covered child:

   a) marries;

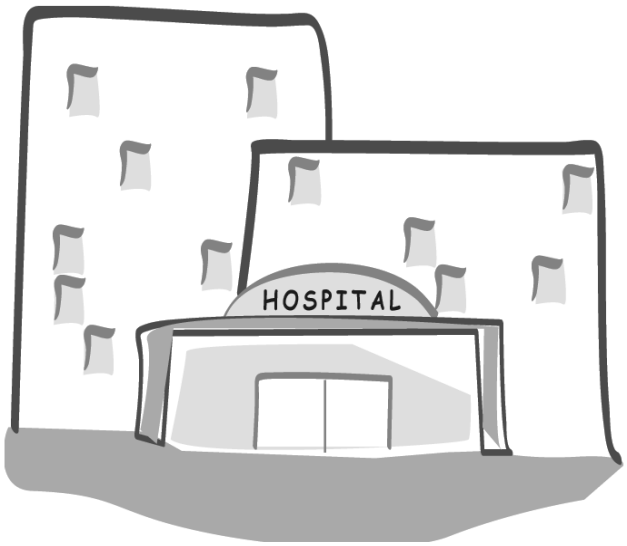
   b) is no longer a resident of Nebraska;

   c) receives coverage under another health benefit plan or self-funded employee benefit plan; or

   d) attains age 30.

Continuation coverage will terminate at the end of the month in which any event listed above occurs. Coverage may not be reinstated once it has been terminated. COBRA continuation coverage is not available when coverage terminates under this provision.

Understanding Your Health Coverage



Your group health coverage consists of a wide variety of benefits:

Hospital and Facility Benefits

Physician Medical-Surgical Benefits

Mental Illness, Drug Abuse, and Alcoholism Benefits

Organ/Tissue Transplant Benefits

Oral Surgery and Dentistry Benefits

Home Health Care, Nursing Care and Hospice Benefits

Other Benefits — Including such services as ambulance service, physical therapy, speech therapy, home medical equipment (including diabetic insulin pumps and associated supplies) and certain other services.

Remember: *With this plan, it is to your advantage to use the network of In-network or Preferred Providers, but it still remains your choice. If you use a Preferred Provider, you are eligible to receive the highest benefit level (preferred) possible under this plan for covered services. If you use a non-Preferred Provider, you are still eligible to receive benefits for covered services, but the benefit level (non-preferred) for these services will usually be less than if you had gone to a Preferred Provider.*

Exception: *If you receive initial inpatient or outpatient care for an emergency medical condition at a non-Preferred hospital or by a non-Preferred provider, benefits for covered services for the initial care will be provided at the Preferred Provider benefit level. Services for emergency care in an out-of-network hospital emergency room will be paid at the In-network benefit level.*

Please refer to the section in this booklet "Inpatient Notification, Certification and Concurrent Review" for information regarding certification of emergency admissions.

Reminder: *If more than one physician is involved in your care, it is important for you to check the preferred status of each provider. This is especially important when you are receiving services from multiple providers while hospitalized. If you wish to stay within the Preferred Provider network, make sure your attending physician knows this. Ask that you be informed, before the service is performed, if he or she is referring you to a provider outside the Preferred Provider network.*

NOTICE

Non-Preferred Providers' charges may be higher than the benefit amount allowed by this group plan. You may contact Blue Cross and Blue Shield of Nebraska's Customer Service Center concerning allowable benefit amounts for specified procedures in Nebraska. Your request must specify the service or procedure, including any service or procedure code(s) or diagnosis-related group, and the provider's estimated charge.

Utilization Review

Benefits are available under the group health plan for **medically necessary** and **scientifically validated** services. Services provided by all health care providers are subject to utilization review by Blue Cross and Blue Shield of Nebraska. Services will not automatically be considered medically necessary because they have been ordered or provided by a physician. Blue Cross and Blue Shield of Nebraska will determine whether services provided are medically necessary under the terms of the plan, and benefits available. **Please refer to the definitions in the back of this book for a description of these terms.**

Fraud or Misrepresentation

A covered person's coverage may be canceled or rescinded for fraud or misrepresentation about a claim or eligibility for this coverage.

If coverage is rescinded, the amount of premium paid will be reduced by any benefits that were paid, and will be refunded. If benefits paid exceed the premium received, we may recover the difference.

Medical Records

In consideration for the processing of claims, Blue Cross and Blue Shield of Nebraska will be entitled to receive such facts, records, and reports about the examination or treatment of Covered Persons as may be needed to process claims or to determine the appropriateness of benefit payment. The Covered Person agrees that in consideration for benefits available, he or she consents to the release of such information to Blue Cross and Blue Shield of Nebraska.

Notification, Certification and Concurrent Review Requirements

Inpatient Admission Notification Requirements

Blue Cross and Blue Shield of Nebraska must be notified of all inpatient hospitalizations, including an admission for an emergency medical condition. **When you are admitted to an In-network hospital, notification of the admission will be provided by the hospital.**

When you are hospitalized in an Out-of-Network hospital or in a hospital outside of Nebraska, it is your responsibility to notify Blue Cross and Blue Shield of Nebraska of an admission, including an admission for an emergency medical condition. Actual notification may be made by you, your physician, the hospital or someone acting on your behalf. If the anticipated admission date changes, notification of the change must also be given. If the admission is for an emergency medical condition, notification must be made within 48 hours (or the next business day). If notification of an emergency admission is not received, the 24-hour period prior to, and the 24-hour period after the admission will be reviewed to determine of the patient's condition and treatment would have hindered his or her ability to provide notice.

If you fail to provide notification of an admission to an Out-of-Network hospital or hospital outside of Nebraska, **allowable charges for all covered services associated with that stay will be reduced by $350.** Benefits for all services which are determined to be not medically necessary will be denied.

Maternity Admissions: Federal law provides for a length of stay of up to 48 hours following a normal vaginal delivery and 96 hours following a cesarean section, unless an earlier dismissal is otherwise agreed to by the patient and her physician. Notification is not required for an initial maternity admission. However, Blue Cross and Blue Shield of Nebraska must be notified if the hospitalization extends beyond the above time periods.

Inpatient Admission Certification Requirements (Specific Admissions)

All inpatient admissions for the following types of care must be precertified for benefit payment:

- Physical rehabilitation
- Long term acute care
- Skilled nursing facility care

Precertification is required regardless of the network or contracting status of the hospital or facility and whether it is in or out of the state of Nebraska. When possible, admission certification should be arranged prior to the inpatient admission. Claims may be denied if the covered person's condition or the facility does not meet the criteria for an inpatient admission.

The physician, hospital, facility, covered person or someone acting on the covered person's behalf may request certification. When Blue Cross and Blue Shield of Nebraska receives a request for certification, the appropriateness of the setting and the level of care as well as the timing and duration of the admission is assessed by Blue Cross and Blue Shield of Nebraska (or by persons designated by them). Blue Cross and Blue Shield of Nebraska will notify the provider, the covered person or someone acting on his/her behalf whether or not benefits will be certified for an inpatient admission and the number of days considered medically necessary.

If certification of an above admission was possible and not made, the allowable charges for all related covered services will be reduced by $350. In addition, benefits for services determined to be not medically necessary will be denied.

Concurrent Review Process

Concurrent review is a review of an ongoing inpatient admission to analyze the medical necessity and appropriateness for a continued inpatient stay.
If additional inpatient days are needed beyond the number of days originally certified, benefits for those days must also be certified. The hospital or other facility will be advised to call Blue Cross and Blue Shield of Nebraska to determine if additional days are medically necessary.

If inpatient care is no longer medically necessary beyond the number of days certified by Blue Cross and Blue Shield of Nebraska, benefits for all services that are determined to be not medically necessary will be denied.

If your physician does not agree with this decision, he or she may submit an appeal to Blue Cross and Blue Shield of Nebraska. Additional information may also be submitted at this time. You and you're your physician will be notified of the appeal decision. Please refer to the Appeals Procedures section of this booklet for additional information.

Note: If Medicare is the primary carrier for a covered person, the inpatient notification, certification and concurrent review requirements and penalties are waived for that person, except for an admission to a) a Veterans Administration Hospital for a condition not related to military service; or b) an admission to a medical facility owned, operated or controlled by any government agency, for care provided to a nonactive duty covered person.

Additional Information

Please remember that notification or certification of an inpatient admission or outpatient treatment does not guarantee payment of benefits. All other group plan provisions apply. For example: deductible, coinsurance, eligibility, exclusions and waiting periods.

If your benefits are reduced or denied due to failure to notify, precertify, or a denial of certification, this reduction becomes an additional amount that must be paid by you. However, if the hospital, facility or physician is an In-network provider with Blue Cross and Blue Shield of Nebraska, they are liable for their services which are determined to be not medically necessary. An exception is made if you have agreed in writing to be responsible for such services or the provider has documented in the medical record that you were notified of the determination. You will remain liable for any penalty or reduction in benefits for failure to notify or certify. Any such reductions made are not considered when computing your coinsurance liability limit.

Hospital and Facility Services

Inpatient Hospital Care

If you are hospitalized, benefits are available for the following medically necessary covered services and supplies:

A semiprivate room. If you have a private room, benefits will be based on the allowable charge for a semiprivate room, unless confined for treatment of preeclampsia, toxemia, or required isolation to prevent contagion. You are responsible for the difference.

Cardiac care or intensive care unit.

> **Note:** If you use more than one room during a 24-hour period, benefits will be provided only for one room, based on the most intensive care provided during that period.

Use of operating, recovery and other appropriate treatment rooms and equipment. Benefits are not available for separate rooms used for procedures that are customarily provided in the patient's room.

Anesthesia.

Respiratory care.

FDA-approved drugs, intravenous solutions, vaccines, biologicals and medicines which are prescribed and administered while hospitalized.

Blood, blood plasma, blood derivatives or fractionates, and their administration.

Supplies, materials and equipment except "take-home" supplies and convenience items.

Radiology (x-ray) and pathology (lab) and other diagnostic services billed by the hospital.

Radiation and chemotherapy, except that "high dose" chemotherapy is limited to procedures which are specifically listed as covered services in the section of this booklet titled: "Organ and Tissue Transplants."

Physical therapy when provided by a licensed physical therapist or a licensed physical therapist's assistant supervised by and assigned to a physical therapist.

Occupational therapy when provided by a licensed occupational therapist, or licensed occupational therapist's assistant supervised by an occupational therapist.

Speech therapy when provided by a licensed speech-language pathologist or registered communications assistant practicing under the direct supervision of a licensed speech-language pathologist.

Reminder: Blue Cross and Blue Shield of Nebraska must be notified of all inpatient admissions. Failure to provide notification of the admission to an Out-of-network facility will result in the allowable charges being reduced by $350.

Long Term Acute Care

Long Term Acute Care is specialized acute hospital care for medically complex patients who are critically ill, have multisystem complications and/or failures, and require hospitalization in a facility offering specialized treatment programs and aggressive clinical and therapeutic intervention on a 24-hour seven-day-a week basis.

Benefits must be precertified for all Long Term Acute Care admissions regardless of the facility's network or contracting status.

Physical Rehabilitation Program

Benefits for inpatient physical rehabilitation services must be precertified by Blue Cross and Blue Shield of Nebraska. The covered person must be disabled and meet specifications for coverage as determined by Blue Cross and Blue Shield of Nebraska. The inpatient rehabilitation must follow within 90 days of the acute hospitalization for the injury, illness or condition causing the disability. Benefits are not available for Custodial Care.

Physical rehabilitation is defined as the restoration of a person who was disabled as the result of an injury or an acute physical impairment to a level of function that allows a person to live as independently as possible. A person is disabled when such person has physical disabilities and needs active assistance to perform the normal activities of daily living, such as eating, dressing, personal hygiene, ambulation and changing body position.

Benefits are available for covered hospital and physician services, including:

- recreational therapy,
- social service counseling,
- prosthetic devices and fitting, and
- psychological testing.

The covered person must have intense daily involvement in two or more of the following treatment modalities:

- physical therapy,
- occupational therapy, or
- speech therapy.

Benefits for physical rehabilitation will stop when:

- further progress toward the established rehabilitation goal is minimal or unlikely,
- such progress can be achieved in a less intensive setting,
- treatment could be continued on an outpatient basis, or
- the covered person no longer meets criteria for eligibility as previously stated.

For benefits to be available for a physical rehabilitation program, the provider must be accredited for comprehensive inpatient rehabilitation by the Commission on Accreditation of Rehabilitation Facilities (CARF), or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Skilled Nursing Facility Services

Benefits are available for up to 30 days per calendar year for skilled nursing care services provided in a semi-private room of a skilled nursing facility. The covered person must be confined in a free-standing facility licensed by the state as a Nursing Facility (NF) or licensed by the state and/or certified by Medicare as a Skilled Nursing Facility (SNF) or, part of a hospital with designated beds licensed by state law and/or certified by Medicare as Skilled Nursing or Swing Beds. The facility or such part of the facility must provide room, board, and 24-hour-a-day skilled nursing care, as well as other related services for the care and rehabilitation of injured, disabled or sick persons. **Benefits must be precertified for all Skilled Nursing Facility Services. Benefits for skilled nursing facility services are not subject to the coinsurance amount.**

Confinement in the skilled nursing facility must be for an unstable health condition which:

- requires daily skilled observation of the patient's medical status;
- requires daily therapeutic treatment by a skilled professional, and
- interferes with the patient's ability to perform the activities of daily living unassisted.

The skilled nursing facility confinement must be ordered by a physician, be medically necessary and the covered person must be receiving skilled nursing care.

A skilled nursing facility does not include:

- a place that is primarily used for rest; care and treatment of mental illness, alcoholism or drug abuse;
- a place for custodial care; or
- a place for educational or non-medical personal services.

Skilled nursing facility care does not include:

- supportive services of a stabilized condition;
- care which can be learned and given by unlicensed or uncertified medical personnel;

- routine health care services;
- general maintenance or supervision of routine daily activities, or
- routine administration of oral or non-prescription drugs.

When You Use Outpatient Facilities

If you are treated in a hospital outpatient department, ambulatory surgical facility or other outpatient facility, benefits will be provided for medically necessary services. Benefits will also be provided for an observation room for a period of 24 hours, not to exceed, the average cost of a semiprivate room.

EMERGENCY ROOMS ARE EXPENSIVE

Hospital emergency rooms are very expensive because they are specifically staffed and equipped to handle accidents, injuries and other emergencies. Using them for Preventive care (or as a substitute for the family physician) can cost you time and money.

Outpatient Cardiac Or Pulmonary Rehabilitation

Benefits will be provided for medically necessary outpatient cardiac or pulmonary rehabilitation services.

Benefits are available for covered outpatient hospital and physician services, including:

- initial rehabilitation evaluation,
- exercise sessions, and
- concurrent monitoring during the exercise session for high risk patients.

Cardiac Rehabilitation — Benefits will be provided for services at any therapeutic level, limited to 18 sessions per calendar year, for the following diagnoses occurring during the preceding 12 months:

- an acute myocardial infarction,
- coronary artery angioplasty, with or without stent placement, or other scientifically validated procedure to clear blocked vessels,
- heart or coronary artery surgery,
- heart transplant,
- heart-lung transplant, or
- for treatment of congestive heart failure and stable angina initially and after significant changes in clinical status as determined by Blue Cross and Blue Shield of Nebraska.

Pulmonary Rehabilitation — Benefits must be preauthorized by Blue Cross and Blue Shield of Nebraska prior to starting the program. Benefits will be provided for services at any therapeutic level, limited to 36 sessions under the following circumstances:

- lung transplant during the preceding four months,
- heart-lung transplant during the preceding four months (only if cardiac rehabilitation benefits have not been provided), or
- preoperative and postoperative care for lung volume reduction surgery.

The patient's condition must be such that the pulmonary rehabilitation services can only be carried out safely under the direct, continuing supervision of a physician and in a hospital environment.

Preauthorization Request Procedure: A written request for preauthorization should be directed to:

Blue Cross and Blue Shield of Nebraska
Attention: Health Service Programs
P.O. Box 3248
Omaha, Nebraska 68180-0001.

Blue Cross and Blue Shield of Nebraska will notify both the covered person and the provider in writing about the approval or disapproval of coverage. If benefits are not preauthorized, claims for such benefits may be denied if the covered person's condition or the program does not meet established criteria.

Physician's Services

Benefits are available for covered services provided by a physician or oral surgeon, a certified nurse midwife, a certified nurse practitioner or certified physician's assistant, within the practitioner's scope of practice, when supervised and billed by a physician.

Covered services include:

Surgical Expenses. The amount payable for a covered inpatient or outpatient surgical procedure includes normal care before and after surgery (preoperative and postoperative care).

When multiple or bilateral surgical procedures are performed which add significant time or complexity at the same operative session, benefits for the primary procedure will be paid as determined by Blue Cross and Blue Shield of Nebraska. For any secondary procedure or additional procedure, the allowable charge will be 50% of the allowable charge had the procedure been primary. When surgery is performed in two or more steps, benefit payment will be made as a single procedure.

Surgical Assistance. Benefits of up to 20% of the amount payable for surgery will be available for surgical assistance by a physician or other approved provider, within his or her scope of practice, who actively assists the operating physician for certain procedures. Benefits for surgical assistance are available for covered procedures specified by Blue Cross and Blue Shield of Nebraska. Please contact their Customer Service Center for specific information.

OUTPATIENT SURGERY

Many surgical procedures can be performed as an outpatient. This can save you time and trouble by allowing you to return home on the same day. Ask your physician about outpatient surgery.

Anesthesia Services by a physician or certified registered nurse anesthetist. Benefits are also available for an oral surgeon or dentist with a permit issued by the state, to administer general anesthesia. The amount payable for anesthesia services will include the usual preoperative and postoperative visits and the necessary management of the patient, during and after the administration of the anesthesia.

Payment will not be made for supervision of the administration of anesthesia. Benefits will not be provided for local infiltration or the administration of anesthesia by the attending or assisting surgeon (except spinal, saddle or caudal blocks related to pregnancy or general anesthesia for covered oral surgery and dentistry procedures under this contract).

Inpatient Hospital Visits for a medical condition for which surgical care is not required.

Concurrent Inpatient Hospital Visits by two or more physicians on the same day if their services are:

- for unrelated nonsurgical medical diagnoses which require the services and skills of two or more physicians with unrelated specialties, or
- necessary because of medical complications requiring additional skills not possessed by the attending surgeon or assistant surgeon.

Consultations by providers with different specialties or sub-specialties when requested by the physician in charge of your care and when your condition requires special care or knowledge not possessed by your attending or other consulting physician(s). The consultation must include a physical examination and written report in the covered person's hospital chart or conveyed to the referring physician.

Intensive Medical Services. Unusual, repeated and prolonged attendance at the covered patient's bedside when required by the illness, injury or pregnancy.

Radiation therapy and chemotherapy, except as excluded (or not specifically listed as covered) under the section titled "Organ and Tissue Transplants."

PREADMISSION TESTING SAVES TIME AND TROUBLE

Preadmission tests are x-ray and lab tests which are performed in a hospital's outpatient department before you are admitted for surgery. This can save you extra time in the hospital.

Radiology (x-ray), pathology (laboratory) and other diagnostic services.

Tissue exams related to covered surgical procedures.

Interpretation of Pap Smears.

Screening mammograms and corresponding fees for technical and professional interpretation of mammograms. Benefits are not subject to the deductible and coinsurance.

Physician visits for nonroutine care in the patient's home, in the physician's office, the outpatient department of a hospital or an ambulatory surgical facility.

FDA-approved drugs, intravenous solutions, vaccines, biologicals, and medicines which are prescribed and administered to the covered person in the physician's office.

Allergy tests, allergy extracts and injections of allergy extracts.

ROUTINE CARE

Regular Routine Benefits

Routine Care for Covered Persons age two and above. Benefits are available for routine physical exams, routine pap smears, immunizations for age 7 and older, routine hearing examinations, radiology, laboratory testing and cardiac stress tests, up to a calendar year benefit payment maximum of $250 for each covered person. Benefits are not subject to deductible and/or coinsurance amounts. Once the maximum routine/preventive care amount has been met, benefits payable for Covered routine care Services for the remainder of the calendar year shall be subject to the applicable deductible and/or coinsurance amounts.

Routine well child care when provided to a child under 2 years of age. Benefits are available for periodic exams to determine physical development, office visits, radiology (x-ray) and pathology (laboratory) testing, up to a calendar year benefit payment maximum of $500 for each covered person. Benefits are not subject to deductible and/or coinsurance amounts. Once the maximum routine/preventive care amount has been met, benefits payable for Covered routine care Services for the remainder of the calendar year shall be subject to the applicable deductible and/or coinsurance amounts.

Enhanced Routine Benefits

Routine Care for Covered Persons age two and above. Benefits are available for routine physical exams, routine pap smears, immunizations for age 7 and older, routine hearing examinations, radiology, laboratory testing and cardiac stress tests, up to a calendar year benefit payment maximum of $300 for each covered person. Benefits are not subject to deductible and/or coinsurance amounts. Once the maximum routine/preventive care amount has been met, benefits payable for Covered routine care Services for the remainder of the calendar year shall be subject to the applicable deductible and/or coinsurance amounts.

Routine well child care when provided to a child under 2 years of age. Benefits are available for periodic exams to determine physical development, office visits, radiology (x-ray) and pathology (laboratory) testing, up to a calendar year benefit payment maximum of $600 for each covered person. Benefits are not subject to deductible and/or coinsurance amounts. Once the maximum routine/preventive care amount has been met, benefits payable for Covered routine care Services for the remainder of the calendar year shall be subject to the applicable deductible and/or coinsurance amounts.

One colonoscopy procedure and all related covered services for covered persons age 50 and above, every ten years. Benefits will also include coverage for a diagnosis of "family history". Benefits will not be subject to any applicable deductible or coinsurance amounts for services provided by a Preferred (in-network) Provider.

Benefits for covered services provided by a Preferred (in-network) Provider, up to a maximum of $2,500, will not be subject to any deductible or coinsurance amounts.

Benefits for covered services in excess of the maximum dollar amount, covered services by a non-Preferred (out-of-network) Provider and any additional colonoscopies during the ten year time span will be subject to the applicable deductible and coinsurance amounts.

Pregnancy and Maternity Care

Benefits are available for hospital, surgical and medical care for pregnancy. Benefits for prenatal and postnatal care (excluding the initial visit) are included in the payment for delivery. Benefits include care for complications of pregnancy or interruptions of pregnancy. These maternity benefits are available to you or your covered spouse or eligible dependent daughter.

Benefits are also available for obstetrical care provided by a certified nurse midwife when such obstetrical services are within their scope of practice and such services are supervised and billed for by a physician.

Benefits may not, under Federal law, be restricted for any hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, benefits may be paid for a shorter stay if the mother's or newborn's attending provider, after consulting with the mother, discharges the mother or newborn earlier. In addition, a plan may not require the provider to obtain authorization from the plan for prescribing a length of stay of up to 48 hours (or 96 hours).

Benefits are not available for voluntary abortions unless the abortion was necessary to safeguard the life of the woman.

For verification of maternity benefits, please check your Schedule of Benefits, or you may contact Blue Cross and Blue Shield of Nebraska's Customer Service Center for information.

Newborn Care

Benefits will be available at birth for covered services for an eligible newborn infant. Covered services include: room and board, screening tests including the infant hearing exam, physician's services for a newborn well infant while hospitalized including circumcision, newborn screening services for an infant born at home, and medically necessary definitive medical or surgical treatment.
The deductible shall not apply to the inpatient hospital charges for the newborn at the time of birth.

Coverage shall begin at birth for a period of 31 days. **To continue the child's coverage beyond 31 days, the covered employee must contact the Campus Benefits Office within 31 days of a dependent's date of birth to add the newborn child to his or her medical insurance policy.** The employee must complete and deliver to the Campus Benefits Office a Dependent Information Request Form (obtained from the University) to add the new dependent child to the medical insurance policy even if the Employee is currently enrolled for Single Parent (Employee & Child) or Family, (Employee & Family) coverage. If the newborn child is added, the coverage change will be effective the first of the month following the dependent's date of birth. If the Employee does not complete and deliver the properly completed Dependent Information Request Form within 31 days of the newborn's birth and then wants to cover the child, the child will be considered a late enrollee and benefits will not be provided to the child until the next annual open enrollment period.

Mental Illness, Alcoholism And Substance Dependence Or Abuse Benefits

Benefits are available for medically necessary covered services provided as treatment for mental illness, drug abuse or alcoholism (substance abuse). Benefits for covered services are subject to satisfaction of the applicable deductible and coinsurance amounts listed on the Summary page in the front of this document. Remember, the applicable amounts depend on whether the services are provided by an In-network (Preferred) or an Out-of-network (non-Preferred) Provider.

Benefits are payable for covered hospital and physician services, including mental health services, psychological therapy and/or substance abuse counseling services provided by and within the scope of practice of a:

- qualified physician or licensed psychologist,
- licensed special psychologist, licensed clinical social worker, licensed professional counselor or licensed mental health practitioner, or
- auxiliary providers who are supervised, and billed for, by a qualified physician or licensed psychologist or as otherwise permitted by state law.

All licensing or certification shall be by the appropriate state authority. Appropriate supervision and consultation requirements also shall be provided by state law.

Inpatient Care

A person shall be considered to be receiving inpatient treatment if he or she is confined to a hospital or a substance abuse treatment center that provides medical management including 24-hour nursing care. Services provided by a facility that does not meet these criteria are considered part of a residential treatment program, and are not covered under the group health plan.

Facilities must be Licensed by the Department of Health and Human Services, Regulation and Licensure (or equivalent state agency) or accredited by the Joint Commission on Accreditation of Rehabilitation Facilities (CARF) or Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Benefits for covered inpatient services are subject to the applicable deductible and coinsurance amounts indicated on your Schedule of Benefits.

Note: Blue Cross and Blue Shield of Nebraska must be notified of ALL inpatient admissions. (Please refer to the Notification, Certification and Concurrent Review Procedures section of this booklet for details.)

Outpatient Care

Benefits are also available, subject to the applicable deductible and coinsurance amount indicated on your Schedule of Benefits.

Outpatient Covered Services include:

- psychological therapy and/or substance abuse counseling/rehabilitation provided by an approved provider (see above),
- office visit or clinic visit, consultation or emergency room visit,
- an outpatient day, or partial hospitalization program for mental illness or a substance abuse treatment program that bills one charge for each outpatient treatment day,
- biofeedback training for treatment of mental illness,

- laboratory and diagnostic services;
- psychiatric/psychological testing.

Day treatment, partial care and outpatient programs must be provided in a hospital or facility which is licensed by the Department of Health and Human Services Regulation and Licensure or accredited by the Commission on the Accreditation of Rehabilitation Facilities (CARF).

Oral Surgery and Dentistry

Benefits are available for the following specific kinds of covered oral surgery or dentistry:

Evaluation and treatment of impacted teeth.

Incision and drainage of abscesses, and other nonsurgical treatment of infections. This does not include periodontic or endodontic treatment of infections.

Excision of exostoses, tumors and cysts, not related to the temporomandibular joint of the jaw.

Invasive surgical procedures of the jaw.

Bone grafts to the jaw, including preparation of the mouth for dentures.

Services, supplies or appliances for dental treatment of natural healthy teeth required as the direct result of an accidental Injury. Benefits for such Services are limited, however, to Covered Services provided within 6 months of the date of Injury. Benefits shall not be provided for such Services when the Injury occurs as the result of eating, biting or chewing.

Osteotomy performed for a gross congenital abnormality of the jaw that cannot be treated solely by orthodontic treatment or appliances.

Evaluation and treatment of myofascial pain.

Benefits will be provided for hospital inpatient, outpatient or ambulatory facility charges related to covered services for oral surgery and dentistry, if medically necessary as determined by us. In addition, benefits will be provided for hospital inpatient, outpatient or ambulatory facility charges for covered or noncovered dental procedures if such admission is essential to safeguard the health of the patient who has a specific nondental physical and/or organic impairment.

Benefits are not available for care in connection with:

- treatment, filling, removal, repositioning or replacement of teeth, including orthodontics or implants;
- root canal therapy or care;
- preparation of the mouth for dentures;
- Treatment of the dental occlusion or temporomandibular joint of the jaw, or TMJ syndrome, by any means or for any reason;
- all other procedures involving the teeth or structures directly related to or supporting the teeth, including a) the gums; b) the alveolar processes

Organ and Tissue Transplant Services

Covered Transplants

Benefits are available to a covered person who is a transplant recipient for medically necessary covered services relating to, or resulting from a transplant of these body organs or tissues:

- liver,
- heart,
- single and double lung,
- lobar lung,
- combination heart-lung,
- heart valve (heterograft),
- kidney,
- combination kidney-pancreas,
- pancreas,
- bone graft,
- cornea,
- parathyroid,
- small intestine,
- small intestine and liver,
- small intestine and multiple viscera; or
- autologous and allogeneic bone marrow transplants for certain specified conditions listed in this section.

Benefits will be provided for transportation to and from the site of the transplant procedure for the covered person. Such benefits will be limited to the reasonable cost of land or commercial air transportation, as determined by Blue Cross and Blue Shield of Nebraska.

Preauthorization Procedure

All benefit payments for organ and tissue transplant procedures must be preauthorized by Blue Cross and Blue Shield of Nebraska. A written request to Blue Cross and Blue Shield of Nebraska must be made before the procedure is performed and be accompanied by documentation from the covered person's physician demonstrating the medical necessity of the proposed procedure.
This request should also indicate at which hospital the transplant procedure will be performed and should be directed to:

Blue Cross and Blue Shield of Nebraska
Attention: Health Service Programs
P.O. Box 3248
Omaha, Nebraska 68180-0001

Blue Cross and Blue Shield of Nebraska will respond in writing advising the provider and the covered person as to whether or not benefits are available.

Autologous and Allogeneic Bone Marrow Transplants

LIMITED BENEFITS ARE AVAILABLE FOR AUTOLOGOUS BONE MARROW TRANSPLANTS AND ALLOGENEIC BONE MARROW TRANSPLANTS.

This section provides benefits for allogeneic and autologous bone marrow transplants only for certain diseases or conditions and specifically excludes benefits for those procedures for all other diseases or conditions. You should carefully review the entire contract, including the definitions of allogeneic and autologous bone marrow transplants, myeloablative chemotherapy and myeloablative radiotherapy. The limited benefits provided in this section for allogeneic and autologous bone marrow transplants are an exception to the exclusion for investigative procedures (see section titled "noncovered services and supplies").

The exception of these procedures in limited circumstances from the exclusion for investigative procedures is not intended to, and does not operate as, a waiver of the exclusion for investigative procedures. The limited benefit provided in this section for allogeneic and autologous bone marrow transplants are subject to all of the other conditions and provisions of the contract including, without limitation, the requirement that the procedure be medically necessary.

Benefits will be provided for medically necessary myeloablative chemotherapy with allogeneic stem cell support only when prescribed for:

- advanced non-Hodgkin's lymphoma.

- advanced Hodgkin’s disease (lymphoma).
- advanced neuroblastoma.
- acute lymphocytic and myelogenous (nonlymphocytic) leukemia (acute leukemia).
- germ cell tumor of testicular, ovarian, retroperitoneal or mediastinal origin.
- chronic myelogenous leukemia.
- multiple myeloma treated with up to one course of chemotherapy.
- scleroderma that is refractory to conventional therapy.

Benefits will be provided for medically necessary myeloablative chemotherapy with autologous stem cell support only when prescribed for:

- acute lymphocytic and myelogenous (nonlymphocytic) leukemia (acute leukemia).
- advanced Hodgkin's disease (lymphoma).
- advanced non-Hodgkin's lymphoma.
- advanced neuroblastoma.
- newly diagnosed multiple myeloma or other multiple myeloma responsive to chemotherapy.
- Wilms' tumor.
- germ cell tumors of testicular, ovarian, retroperitoneal or mediastinal origin.
- primitive neuroectodermal tumors:
  1) medulloblastoma,
  2) neuroblastoma arising in the central nervous system,
  3) ependymoblastoma, or
  4) pineoblastoma.
- ependymoma.
- Ewing's sarcoma.
- primary amyloidosis without widespread organ impairment or congestive heart failure.
- stage III inflammatory breast cancer and all stage IV breast cancer.
- scleroderma that is refractory to conventional therapy.

Benefits will be provided for medically necessary allogeneic stem cell transplantation for primary diseases of the bone marrow, genetic diseases and acquired anemias only when prescribed for:

- severe sickle cell disease.
- aplastic anemias:
  1) hereditary or congenital, including:
     - Farconi's anemia
     - Diamond-Blacktan syndrome
  2) acquired, due to:
     - drug exposure
     - toxin exposure
     - radiation exposure
- Wiskott-Aldrich syndrome.
- severe congenital combined immunodeficiency.
- thalassemia major (homozygous beta-thalassemia).
- infantile malignant osteopetrosis: Albers-Schonberg marble bone diseases.
- mucopolysaccharidoses: Hurler’s, Hunter’s, Sanfilippo, Maroteaux-Lamy, Morquio’s.
- mucolipidoses: Gaucher’s, metachromatic leukodystrophy, adrenoleukodystrophy; globoid cell leukodystrophy.
- Kostmann's syndrome.
- leukocyte adhesion deficiency.
- X-linked lymphoproliferative syndrome.
- Chediak-Higashi syndrome.
- myelodysplastic syndrome.
- myeloproliferative disorders: polycythemia vera, essential thrombocytopenia, agnogenic myeloid metaplasia with myelofibrosis (primary myelofibrosis); or chronic myeloid leukemia.

Benefits will be provided for medically necessary non-myeloablative allogeneic stem cell transplantation for:

- lymphomas.
- Leukemia (including CLL).
- metastatic renal cell cancer.

No benefits will be provided for any other use or application of Allogeneic Bone Marrow Transplant or Autologous Bone Marrow Transplant. Salvage or Tandem Bone Marrow Transplants will only be covered when Scientifically Validated.

Additional Benefits For Donation

Benefits are also available for the following medically necessary covered services directly related to or resulting from a covered transplant:

- Hospital, medical, surgical or other covered services provided to a donor are included as

part of the recipient's coverage.

- Services provided for the evaluation of organs or tissue including, but not limited to, the determination of tissue matches.
- Services provided for the removal of organs or tissue from nonliving donors.
- Services provided for the transportation of a living donor (reasonable cost), or the transportation and storage of donated organs or tissues.
- Services provided for life support of a donor pending the removal of an organ or tissue.

Limitations

Benefits will NOT be provided for:

- the purchase of human organs or tissues which are sold rather than donated to the recipient;
- the transplant of a nonhuman organ or tissue, or the implantation of an artificial/mechanical organ. (This provision does not apply to the implantation of pacemakers);
- myeloablative chemotherapy or radiation therapy when supported by bone marrow or stem cell transplant procedures for breast cancer, ovarian cancer or diagnoses other than those identified in the previous paragraphs, or
- services for or related to organ or tissue transplants not listed as covered in this section. Related services include administration of myeloablative chemotherapy or radiation therapy when supported by transplant procedures.
- donor charges other than those payable under the recipient's coverage.

Benefits provided for covered organ and tissue transplant services shall not be subject to the exclusion for "investigative services;" as stated in the section titled "Noncovered Services."

Definitions for Allogeneic and Autologous Bone Marrow Transplants

Allogeneic Bone Marrow Transplant: A medical and/or surgical procedure comprised of several steps or stages including, without limitation: (a) the harvest of stem cells, whether from the bone marrow or from the blood, from a third party donor; (b) processing and/or storage of the stem cells so harvested; (c) the administration of myeloablative chemotherapy and/or myeloablative radiotherapy (this step may be absent in certain applications); (d) the infusion of the harvested stem cells; and (e) hospitalization, observation, and management of reasonably anticipated complications such as graft versus host disease, infections, bleeding, organ or system toxicities and low blood counts. This definition specifically includes and encompasses transplants wherein the transplant component is derived from circulating blood in lieu of, or in addition to, harvest directly from the bone marrow. This definition further specifically includes all component parts of the procedure including, without limitation, the myeloablative chemotherapy and/or myeloablative radiotherapy.

Autologous Bone Marrow Transplant: A medical and/or surgical procedure comprised of several steps or stages including, without limitation: (a) the harvest of stem cells, whether from the bone marrow or from the blood from the patient; (b) processing and/or storage of the stem cells so harvested; (c) the administration of myeloablative chemotherapy and/or myeloablative radiotherapy; (d) the infusion of the harvested stem cells; and (e) hospitalization, observation, and management of reasonably anticipated complications such as graft versus host disease, infections, bleeding, organ or system toxicities and low blood counts. This definition specifically includes and encompasses transplants wherein the transplant component is derived from circulating blood in lieu of, or in addition to, harvest directly from the bone marrow. This definition further specifically includes all component parts of the procedure including, without limitation, the myeloablative chemotherapy and/or myeloablative radiotherapy.

Myeloablative Chemotherapy: A form of chemotherapy wherein the dose and/or manner of administration is expected to result in damage to the bone marrow or suppression of its function so as to warrant or require receipt by the patient an allogeneic bone marrow transplant or autologous bone marrow transplant.

Myeloablative Radiotherapy: A form of radiotherapy wherein the dose and/or manner of administration is expected to result in damage to the bone marrow or suppression of its function so as to warrant or require receipt by the patient an allogeneic bone marrow transplant or autologous bone marrow transplant.

Home Health Care, Nursing Care, and Hospice Services

Benefits will be provided for medically necessary preauthorized services for home health aide care, nursing care and hospice services, subject to the requirements and limitations as specified below.

Benefits are not available for home health aide, hospice, or nursing care provided by volunteers; services which are primarily for the convenience of the patient or a person other than the covered patient; pastoral services; home delivered meals; financial or legal counseling; maintenance therapy for nonhospice related home health aide services; calls or consultations by telephone or other electronic means.

Preauthorization

All benefits for home health aide care, nursing care and hospice services must be preauthorized as follows:

Initial Preauthorization — An initial notification must be made to Blue Cross and Blue Shield of Nebraska prior to or within five days of the date of initiating services. This written request for preauthorization should be directed to:

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

Documentation must be submitted which demonstrates the medical necessity of the services and indicates the location of the service. If Blue Cross and Blue Shield of Nebraska determines the care is not medically necessary, benefits will not be provided for those days prior to the receipt of the notification.

Extension of Benefits — After the initial approval by Blue Cross and Blue Shield of Nebraska, requests for an extension of benefits must be submitted to Blue Cross and Blue Shield of Nebraska by the covered person or provider of services. The request for an extension of benefits is to be submitted prior to or not later than the day through which benefits have been approved. If the extension request is not received on a timely basis and the extension is not approved by Blue Cross and Blue Shield of Nebraska, benefits will not be guaranteed beyond the previous approval date.

Blue Cross and Blue Shield of Nebraska will notify the provider of services by telephone and in writing about the initial approval or disapproval of coverage, as well as any subsequent approval or disapproval for an extension of benefits. Blue Cross and Blue Shield of Nebraska will also notify the covered person in writing about the initial decision and any subsequent approval or disapproval. **If benefits are not preauthorized, claims for such benefits may be denied if Blue Cross and Blue Shield of Nebraska determines the care is not medically necessary.**

Home Health Aide, Therapy and Nursing Services

Benefits are available for preauthorized medically necessary home health aide services and nursing care, and physical, speech and occupational therapy.

Home health aide services include personal care services related to active and specific treatment of the covered person's medical condition. Such services include, but are not limited to bathing, feeding and performing household cleaning duties directly related to the covered person. These services must be ordered by a physician, and performed under the supervision of a registered nurse (R.N.).

Benefits are available for physical, occupational or speech therapy services, provided in the home by a licensed therapist, in accord with a home health care plan.

Benefits are available for preauthorized physician-ordered nursing care in the covered person's home, provided by a registered nurse (R.N.), or a licensed practical nurse (L.P.N.). The nursing services must be medically necessary.

Benefits will not be provided for:

- nursing care which is primarily for the convenience of the patient or patient’s family;

- time spent bathing, feeding, transporting, exercising, giving oral medication or acting as a companion/ sitter to a covered person;
- nursing services provided by an immediate relative of the patient (by blood, marriage, or adoption) or a member of the patient's household, or
- nursing care provided to a patient in a hospital, skilled nursing facility, intermediate care facility or a nursing home.

Hospice Services

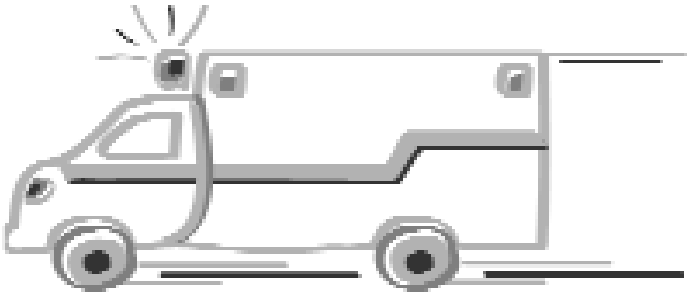
Benefits are available for preauthorized hospice services provided primarily in the patient's home by a Medicare-certified hospice.

A hospice is a program of care provided for a person diagnosed as terminally ill and their families. The patient must have a life expectancy of six months or less and the physician-ordered services must be appropriate for palliative support or management of a terminal illness.

Hospice benefits include:

- Inpatient hospice care, at a licensed hospice facility.
- Home health aide services.
- Hospice nursing services provided in the home.
- Respite care, which is short-term inpatient care of a covered hospice patient to give temporary relief to the person who regularly assists with the care at home. This respite care may be provided in the hospice program's designated inpatient unit that is affiliated with the hospice that is providing services to the patient, which may be a skilled nursing facility, or in a hospital.
- Medical social services provided by the hospice's medical social worker, which are directly related to the covered hospice patient's medical condition.
- Crisis care, which is extended skilled nursing care provided in the home for up to 24 hours per day in lieu of a medically necessary inpatient hospitalization.

Other Covered Services



Benefits are available subject to applicable deductible and/or coinsurance for the following medically necessary covered services and supplies when not covered elsewhere under your group health plan:

Ambulance service provided to a covered person for:

- transport to the nearest facility for appropriate care for an emergency medical condition.
- transfer of a covered person who has received emergent care or who is an inpatient at an acute care facility to the nearest facility where appropriate care can be provided; or for transporting a covered person who is bedridden to a facility for treatment or to his or her home.
- transporting a respirator-dependent person.
- transporting a covered person to and from the nearest appropriate facility for testing and/or procedures that cannot be performed at the present facility.

Benefits for air ambulance are available when medically necessary, subject to review.

Up to 60 outpatient or home sessions per calendar year for physical, occupational or speech therapy services, chiropractic or osteopathic physiotherapy or manipulative treatments or adjustments, or any combination of these services. A session is defined as one visit. Benefits are not available for ongoing maintenance therapy once the maximum therapeutic benefit has been achieved for a condition, and continued therapy no longer results in some functional or restorative improvement.

- Physical therapy sessions must be provided by a licensed physical therapist or licensed physical therapist assistant. To be an approved provider, the licensed physical therapist assistant must be assigned to, supervised, and billed for, by a licensed physical therapist. Physical therapy must be ordered or prescribed by a physician.
- Occupational therapy sessions must be provided by a licensed occupational therapist or licensed occupational therapist assistant under the supervision and billing of a licensed occupational therapist. Occupational therapy must be ordered or prescribed by a physician.
- Speech therapy or cognitive training must be provided by a licensed speech-language pathologist or registered speech-language pathology assistant practicing under the supervision of a licensed speech-language pathologist.
- Chiropractic or osteopathic physiotherapy or manipulative treatments or adjustments must be provided by a licensed practitioner.

Orthotic devices including the fitting of such orthotics, when prescribed by podiatrist or physician. An orthotic is a rigid or semi-rigid device which restricts or eliminates motion of a weak or diseased body member.

Routine immunizations. Routine immunizations for covered persons age 7 and older are subject to the deductible and coinsurance amounts, after the preventive care maximum is met. Pediatric immunizations for covered persons through age 6 are not subject to the deductible or coinsurance amounts. Pediatric immunizations include, but are not limited to vaccinations for measles, mumps, rubella, poliomyelitis, diphtheria, pertussis, tetanus, haemophilus influenza type B and chicken pox, and as otherwise provided by state law.

Tympanometry, for the diagnosis of chronic serous otitis media or chronic otitis media.

FDA-approved injectables (except insulin and CaremarkConnect Specialty drugs), which are prescribed by a physician or dentist and dispensed by a physician or in compliance with a permit to conduct a pharmacy or as otherwise allowed by state law.

Ostomy supplies, including, but not limited to, belts, drain pouches, adhesive tape, wafers, paste and skin barriers, when obtained at a Blue Cross Blue Shield of Nebraska Preferred Home Medical Equipment or medical supply company.

Diabetes Education provided by an approved program or a certified diabetes educator. Benefits are available for self-management training and patient management, including nutrition therapy.

Podiatric Appliances necessary for the prevention of complications associated with diabetes.

Diabetic Insulin Pumps and any associated supplies, excluding batteries.

Services for renal dialysis, including all charges for covered home dialysis equipment and covered disposable supplies.

Colorectal cancer screening. Benefits are available for screening occult blood test, flexible sigmoidoscopy, colonoscopy or barium enema, or any combination, or the most reliable, medically recognized screening test available and all related services.

Sleep Studies, when medically necessary.

Rental or initial purchase (whichever costs less) of certain items of home medical equipment and supplies, when prescribed by a physician, which is determined by Blue Cross and Blue Shield of Nebraska to be medically necessary. Benefits are not available for home medical equipment used, rented or purchased from a hospital, skilled nursing facility, intermediate care facility, a nursing home or any other facility for use during the patient's confinement.

Benefits will be available for subsequent purchases of covered home medical equipment under the following conditions:

- a significant change in the covered person's condition,
- growth of a covered person,
- the item is irreparable and/or the cost of repairs exceeds the expense of purchasing a second piece of equipment,
- the item is five or more years old. (Equipment may be replaced if it is less than five years old, but preauthorization by Blue Cross and Blue Shield of Nebraska will be required.), or
- as otherwise determined to be reasonable and necessary.

Note: *Oxygen and equipment for its administration, respiratory therapy, ventilation equipment, apnea monitors and continuous positive airway pressure devices (CPAP) may be subject to review of the rental versus purchase provision by Blue Cross and Blue Shield of Nebraska.*

In addition, limited benefits will be available for repair, adjustment and maintenance of covered home medical equipment subject to the following restrictions:

- Only **purchased** items will be eligible for benefits for repair, maintenance and adjustment.
- Benefit payment for covered repair, adjustment and maintenance of such items will be made directly to the medical supply company.

External breast prosthesis and post-surgery brassiere, including the fitting of such, when prescribed or ordered by a Physician following a mastectomy.

Women's Health Act

The Women's Health and Cancer Rights Act of 1998 (Women's Health Act) includes protections for breast cancer patients who elect to have breast reconstruction in connection with a mastectomy.

The law requires that certain coverage be provided, and that notice be given to plan participants and beneficiaries regarding coverage for this care under the group health plan. The Women's Health Act requires that:

A group health plan which provides medical and surgical benefits for mastectomies shall also provide, in the case of a participant or beneficiary who is receiving benefits in connection with a mastectomy, and who elects breast reconstruction in connection with such mastectomy, coverage for:

- reconstruction of the breast on which the mastectomy has been performed,
- surgery and reconstruction of the other breast to produce a symmetrical appearance,
- prostheses, and
- physical complications resulting from all stages of the mastectomy, including lymphedemas;

in a manner determined in consultation with the attending physician and patient.

This group health plan is in compliance with the Women's Health Act, and provides benefits as required by the Act, subject to the deductible and coinsurance amounts applicable to other benefits under the plan.

Noncovered Services and Supplies

This group health plan provides benefits for a wide variety of health care expenses. However, there are some services and supplies that are not covered.

Noncovered services include:

- Services not described as covered services in this plan's Master Group Contract.
- Services determined by Blue Cross and Blue Shield of Nebraska to be not medically necessary.
- Services which are considered by Blue Cross and Blue Shield of Nebraska to be investigative, or for any directly related services.
- Audiant bone conductors or hearing aids and their fitting; routine audiological exams and testing.
- Services by or for blood donors, except administrative charges for blood furnished to a hospital by the American Red Cross, county blood bank, or other organization that does not charge for blood, and used for a covered person.
- Routine (screening) eye examinations, eye refractions, eyeglasses or contact lenses, eye exercises or visual training (orthoptics).
- Services for or related to any surgical, laser or non-surgical procedures or alterations of the refractive character of the cornea for correction of myopia, hyperopia or astigmatism, including radial keratotomies. (Benefits are not available for eyeglasses or contact lenses following these procedures.)
- Eyeglasses or contact lenses.
- Prescription medications. For the purposes of this exclusion, prescription medications includes, but is not limited to: drugs requiring a prescription; insulin, diabetic or ostomy supplies (except as provided to an Inpatient or administered in a provider's office or as otherwise payable under the contract); over the counter drugs (including non prescription vitamins); and CaremarkConnect Specialty drugs.
- Hospital or physician charges for standby availability.
- Personal expenses while hospitalized, such as guest meals, TV rental and barber services.
- Services, drugs, medical supplies, devices or equipment which are not cost effective compared to established alternatives or which are provided for the convenience or personal use of a covered person.
- Postage or other mailing fees.
- Routine care or periodic physical examinations, except as specifically listed in the sections titled "Physician's Services" or "Other Covered Services."
- Custodial care.
- Dietary counseling, except covered diabetic nutrition management.
- Treatment and diagnostic procedures for obesity or for weight reduction, regardless of diagnosis, including surgical operations or procedures.
- Services, including related diagnostic testing, which are primarily of a recreational or educational nature, including music or art therapy, work-hardening therapy; vocational training; medical or nonmedical self-care or self-help training.
- Treatment or removal of corns, callosities, or the cutting or trimming of nails.
- Infertility treatment and related services, which includes: Assisted Reproductive Technology (ART), such as artificial insemination, sperm washing, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), and in vitro fertilization; embryo transfer procedures; drug and/or hormonal therapy for fertility enhancement; ultrasounds, lab work and other testing in conjunction with infertility treatment; and reversal of voluntary sterilization.

- Services provided for, or related to, sex transformation surgery, sexual dysfunction, or surgical sterilization.

- Interest, sales or other taxes or surcharges on covered services, drugs, supplies or home medical equipment, other than those surcharges or assessments made directly upon employers or third party payers.

- Charges made for filling out claim forms or furnishing any other records or information or special charges such as dispensing fees, admission charges, Physician's charges for hospital discharge services, after-hours charges over and above the routine charge, administrative fees, technical support or utilization review charges which are normally considered to be within the charge for a service.

- Charges made while the patient is temporarily out of the hospital.

- Genetic treatment or engineering. This includes any services performed to alter or create changes in genetic structure.

- Mental health services, psychological or alcoholism and drug abuse counseling services which are not within the scope of practice of the provider and services other than by a:

  qualified physician or licensed psychologist,

  licensed special psychologist, licensed clinical social worker, licensed professional counselor or licensed mental health practitioner, or

  auxiliary providers under the supervision of, and billed for by, a qualified physician, licensed psychologist or as otherwise provided by state law.

  All licensing or certification shall be by the appropriate state authority. Appropriate supervision and consultation requirements also shall be governed by state law.

  Programs of co-dependency, employee assistance, probation, prevention, educational or self-help programs, or programs which treat obesity, gambling, or nicotine addiction are not covered services. Benefits are not available for residential treatment programs for mental illness, or residential treatment programs, halfway house or methadone maintenance programs for substance abuse, nor will they be provided for programs ordered by the Court which are not medically necessary as determined by Blue Cross and Blue Shield of Nebraska.

- Nutrition care, supplements, supplies or other nutritional substances, including FDA-exempt formulas such as Neocate or Vivonex and other over-the-counter nutritional substances.

- Lodging or travel, even though prescribed by a physician, for the purpose of obtaining medical treatment, except for covered ambulance services and travel benefits in the section titled “Organ and Tissue Transplants.”

- Food antigens and/or sublingual therapy.

- Repairs, maintenance or adjustment of home medical equipment, except as previously described in the section "Other Covered Services," or repairs, maintenance or adjustment for home medical equipment by persons other than a medical supply company.

- Equipment for purifying, heating, cooling or otherwise treating air or water.

- Orthopedic shoes, except for podiatric appliances which are necessary for the prevention of complications associated with diabetes, or necessary to treat a congenital anomaly as determined by Blue Cross and Blue Shield of Nebraska.

- Exercise equipment.

- Services, which are considered by Blue Cross and Blue Shield of Nebraska to be obsolete, or for any related services. (Procedures will be considered to be obsolete when such procedures have been superseded by more efficacious treatment procedures, and are generally no longer considered effective in clinical medicine.)

- Services which are considered by Blue Cross and Blue Shield of Nebraska to be for cosmetic purpose, except surgery required as a result of a traumatic injury, to correct a congenital abnormality, or to correct a scar or deformity resulting from cancer or from non-cosmetic surgery.

- Services for medical treatment and/or drugs, (whether compensated or not) which are directly related to or resulting from a covered person's participation in a voluntary, investigative test or research program or study.

- Services caused directly or indirectly by war or act of war (declared or undeclared) or sustained while performing military duties.

- Services provided to or for:

  any dependent of a subscriber who has a Single Membership (except as specifically provided for limited 31-day coverage of a newborn or adopted child);

  anyone who does not qualify as an eligible dependent;

  anyone before the effective date of coverage, or after the effective date of cancellation or termination of coverage.

- Renal dialysis counseling or training.

- Spinal manipulations or adjustments, except as specifically provided under “Other Covered Services.”

- Chelation therapy, except in the treatment of acute arsenic, gold, mercury or lead poisoning.

- Services provided in or by a Veterans Administration Hospital for a condition related to military service or in a non-participating hospital owned, operated or controlled by a government agency or hospital authorities, unless for care provided to a nonactive duty covered person in medical facilities.

- Services available at governmental expense, except:

  if payment is required by state or federal law, the obligation to provide benefits will be reduced by the amount of payments a covered person is eligible for under such program (except Medicaid), or

  for persons entitled to Medicare Part A and eligible for Part B benefits, the obligation to provide benefits will be reduced by the amount of payment or benefits such person receives from Medicare. This provision will not apply if the Subscriber is still actively at work and has elected this Contract as primary.

  Services provided for renal dialysis and kidney transplant services will be provided pursuant to federal law.

- Services for which there is no legal obligation to pay, or for which no charge would be made if this coverage did not exist, or is normally furnished without charge.

- Services arising out of or in the course of employment, whether or not the covered person fails to assert or waives rights to Workers’ Compensation or Employers Liability Law. This includes services determined to be nonpayable due to noncompliance with a Workers’ Compensation Managed Care Plan.

- Services provided by a member of your immediate family (by blood, marriage or adoption).

- Services by a health care provider which are not within his or her scope of practice, or charges by a person who is not an approved provider.

- Charges in excess of the Contracted Amount or reasonable allowance.

- Charges billed separately for services, supplies and materials considered by Blue Cross and Blue Shield of Nebraska to be included within the charge for a total service payable by this group plan's Master Group Contract, or if the charge is payable to another provider.

- Services required by an employer as a condition of employment, including, but not limited to immunizations, blood testing, work physicals and drug tests.

- The building or remodeling or alteration of a residence; or the purchasing or customizing of vans or other vehicles.

- Charges for services resulting from a covered person's engagement in an illegal occupation or in the commission of or an attempt to commit a felony.

- Benefits for any services incurred while incarcerated, including but not limited to incarceration in a jail, penitentiary or correctional facility.

- Services for any allogeneic or autologous bone marrow transplant not specifically covered under “Organ and Tissue Transplants.”

- Services for elective abortions, unless the attending physician certifies that the abortion is necessary to safeguard the life of the covered person. Services for medical complications arising from an elective abortion are not excluded.

- The reduction or elimination of snoring, when that is the primary purpose of treatment.

- Massage therapy provided by a massage therapist.

- Acupuncture.

- Electron beam computed tomography for vascular screening, including but not limited to screening for cardiovascular, cerebrovascular and peripheral vascular disease.

- Automated external defibrillator.

- Charges received when there is inadequate documentation that a service was provided.

- Calls or consults by telephone or other electronic means, video or internet transmissions, telemedicine, except in conformance with Blue Cross and Blue Shield of Nebraska's policies and procedures.

- Wigs, hair prostheses and hair transplants, regardless of the reason for the hair loss.

- Hair analysis, including evaluation of alopecia or age-related hair loss.

Coordination Of Benefits

This group health coverage includes a Coordination of Benefits (COB) provision. This provision applies when a covered person has coverage under more than one heath plan. It establishes a uniform order in which the plans pay their claims, limits duplication of benefits and provides for the transfer of information between the plans.

Definitions for Coordination of Benefits

Allowable Expense: A health care expense, including deductibles, coinsurance or copayments, that is covered at least in part by any of the plans covering the person. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering the person is not an allowable expense. Any expense that a provider by law, or in accordance with a contractual agreement, is prohibited from charging a covered person is not an allowable expense. The amount of any benefit reduction by the primary plan because a covered person failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions and preferred provider arrangements.

Plan: A form of coverage with which coordination is allowed to include

- group insurance contracts and group subscriber contracts;
- group or group-type coverage (insured or uninsured);
- medical benefits coverage in automobile “no-fault” and traditional “fault” contracts;
- medical care components of long-term care contracts, such as skilled nursing care;
- group coverage through HMOs and closed panel plans;
- Medicare or other federal governmental benefits, as permitted by law;
- Individual underwritten coverage including HMO coverage or subscriber contracts.

The term “plan” as defined for the purpose of coordination of benefits does not include hospital indemnity or other fixed indemnity coverage; accident only coverage other than the medical benefits coverage in automobile “no-fault” and traditional “fault” contracts; specified disease or specified accident coverage; limited benefit health coverage ; school accident coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid coverage. Plan also does not include other federal governmental plans, except as permitted by law.

Primary Plan: The plan which will determine payment of its benefits first, without considering any other plan’s benefits.

Secondary Plan: The plan which will determine its benefits after those of another plan, and may reduce its benefit payment so that all plan benefits do not exceed 100% of the total allowable expense.

This Plan: This group coverage, under the contract administered by Blue Cross and Blue Shield of Nebraska.

Administration of Coordination of Benefits

The order of benefit determination rules govern whether this plan is a primary plan or secondary plan as to the covered person. The plan that pays first is called the primary plan, and the plan that pays after the primary plan is the secondary plan.

If this plan is the primary plan, there shall be no reduction of benefits paid under this plan--benefits will be paid without regard to the benefits of any other plan.

If this plan is the secondary plan, it may reduce its benefits so that the total benefits paid or provided by all plans for any claim are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of

other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan deductible any amount it would have credited to its deductible in the absence of other health care coverage.

Order of Benefit Determination

A plan that does not include a COB provision that is consistent with this COB provision shall be the primary plan, unless both plans state that the complying plan is primary.

If a person is covered by more than one secondary plan, the order of benefits rules decide the order in which the secondary plans pay benefits in relation to each other.

If one of the plans has prescription drug card coverage, the coverage first used by the person becomes the primary plan. If the other coverage is used first, this plan will be the secondary plan.

Each plan providing coverage to a person determines its order of benefits using the first of the following rules that applies to the covered person:

- **Subscriber/Employee or dependent.** The plan which covers the person as an employee/subscriber is the primary plan, and the plan covering that person as a dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as a subscriber, then the order of benefits between the two plans is reversed so that the plan covering the person as a subscriber is the secondary plan and the other plan is the primary plan.

- **Dependent children.** Unless a court decree states otherwise:

  For a dependent child whose parents are married or living together, whether or not ever married, the primary plan is the plan of the parent whose birthday falls earlier in the year. If both parents have the same birthday, the primary plan shall be the one which has covered the parent for the longer period of time. (Birthday Rule)

  For a dependent child whose parents are divorced or separated or not living together, whether or not ever married, if a court decree or qualified court order requires one parent to be responsible for health care expenses, and the plan of that parent has actual knowledge of those terms, that plan shall be primary. If the parent with responsibility has no health care coverage, but that parent's spouse does, the plan of that parent's spouse is primary.

  If a court decree states that both parents are responsible for the child's health care expenses or coverage, the provisions of the "birthday rule" above shall determine the order of benefits.

  If a court decree states that the parents have joint custody, without specifying that one parent has responsibility for health care expenses or coverage, the provisions of the "birthday rule" above shall determine the order of benefits.

  If there is no court decree allocating responsibility for the child's health care expenses or coverage, the order of benefits for the child are as follows:

  1) the plan covering the custodial parent,

  2) the plan covering the spouse of the custodial parent,

  3) the plan covering the non-custodial parent, and then,

  4) the plan covering the spouse of the non-custodial parent.

  For a dependent child covered under the plans of individuals who are not parents of the child, the above provisions shall apply as if those individuals were the parents.

- **Active employee or Retired/Laid Off employee.** The plan that covers a person as an active employee is primary to the plan that covers the person as a retired or laid-off employee. The same order applies if a person is a dependent of an active employee and of a retired or laid-off employee. If the other plan does not have this rule and, as a result, the plans do not agree on the order of benefits, this

rule is ignored. This rule does not apply if the first rule above can determine the order of benefits.

- **COBRA coverage.** A plan providing coverage to a person under federal (COBRA) or state continuation law is secondary to a plan providing coverage to that person as an employee, subscriber, retiree (or that person's dependent). This rule does not apply if the first rule above can determine the order of benefits.

- **Longer/Shorter time.** The plan which covered a subscriber/employee longer is the primary plan, and the secondary plan is the plan covered that person for the shorter time.

- If the above rules do not determine the order of benefits, the allowable expenses shall be shared equally between the plans. This plan will not pay more than it would have paid had it been primary.

Miscellaneous Provisions

If these COB rules do not specifically address a particular situation, this plan may, at its discretion, rely on the National Association of Insurance Commissioners Coordination of Benefits Model Regulation as an interpretive guide.

To properly administer coordination of benefits, this plan may obtain from or release to any insurance company or other organization or person, any information necessary. Any person who claims benefits under this plan agrees to furnish this plan information that may be necessary to apply COB rules and determine benefits.

If another plan pays benefits which should have been paid under this plan, then this plan may reimburse the other plan any amounts determined to be necessary. Amounts paid to other plans in this manner will be considered benefits paid under this plan, and this plan is released from liability for any such amounts paid.

If the benefits paid by this plan exceed what should have been paid, this plan has the right to recover any excess from any insurer, any other organization, or any person to or for whom such payments are made, including covered persons under this plan.

Subrogation and Contractual Right to Reimbursement

Subrogation

Subrogation is the right to recover benefits paid for covered services provided as the result of an illness or injury that was caused by another person or organization. If benefits are paid for such covered services under the Master Group Contract, the group health plan shall be subrogated to all of the covered person's rights of recovery against any person or organization to the extent of the benefits paid. The subscriber, the covered person or the person who has a right to recover for the covered person (usually a parent or spouse), agrees to make reimbursement to the plan if payment is received from the person who caused the illness or injury or from that person's liability carrier, or any other party liable for the illness or injury by contract of indemnity or otherwise. This subrogation claim shall be a first priority lien on the full or partial proceeds of any settlement, judgment or other payment recovered by or on behalf of the covered person, whether or not there has been full compensation for all his or her losses. The rights of the group health plan shall not be defeated by allocating the proceeds in whole or in part to nonmedical damages.

Contractual Right to Reimbursement

If a covered person receives full or partial proceeds from any other source for covered services for an illness or injury, group health plan has a contractual right of reimbursement to the extent benefits were paid under the Contract for the same illness or injury. This contractual right to reimbursement shall be a first priority lien against any proceeds recovered by the covered person, whether or not the covered person has been fully compensated for all his or her losses. Such proceeds may include any settlement, judgment, payments made under auto insurance, including no-fault auto insurance, medical payment, uninsured or underinsured insurance; or proceeds otherwise paid by a third party. This contractual right to reimbursement is in addition to and separate from the subrogation right. The rights of the group health plan shall not be defeated by allocating the proceeds in whole or in part to nonmedical damages.

Additional Provisions

No adult subscriber may assign any rights to recover medical expenses from any third party to any minor or other dependent of such covered person or to any other person, without the express written consent of Blue Cross and Blue Shield of Nebraska. The right to recover, whether by subrogation or reimbursement, shall apply to settlements or recoveries of deceased persons, incompetent or disabled subscribers, or their minor incompetent or disabled dependents.

The subscriber agrees to cooperate and assist in any way necessary to recover such payments, including notification to Blue Cross and Blue Shield of Nebraska of a claim or lawsuit filed on his or her behalf or on behalf of his or her dependents. He or she shall notify Blue Cross and Blue Shield of Nebraska prior to settling any claim or lawsuit to obtain an updated itemization of the amount due. Upon receiving any proceeds, the subscriber, eligible dependent or an authorized representative must hold such proceeds in trust until such time as the proceeds can be transferred to the Plan. The party holding the funds that rightfully belong to the Plan shall not interrupt or prejudice the Plan's recovery of such payments.

Special Note: *If a covered person refuses or fails to comply with this subrogation or reimbursement, coverage can be canceled, including that of any covered dependents. Blue Cross and Blue Shield of Nebraska shall also be entitled to recover any costs incurred in enforcing these provisions, including, but not limited to, attorneys' fees, litigation and court costs and other expenses.*

Workers' Compensation

Benefits are not available for services provided for illness or injury arising out and in the course of employment, whether or not the covered person fails to assert or waive his or her rights to Workers' Compensation or Employer Liability coverage. Benefits are not payable for services determined to be not payable due to noncompliance with the terms, rules and conditions under a Certified or otherwise Licensed Workers' Compensation Managed Care Plan. In addition, benefits are not payable for services that are related to work injury or illness, but are determined to be not necessary or reasonable by the employer or Workers' Compensation carrier.

If a covered person enters into a lump-sum settlement which includes compensation for past or future medical expenses for an injury or illness, payment will not be made under the group plan for services related to that injury or illness.

In certain instances, benefits for such services are paid in error under this group plan. If payment is received by the covered person for such services, reimbursement must be made. This reimbursement may be funded from any recovery made from the employer, or the employer's Workers' Compensation carrier. Reimbursement must be made directly by the subscriber when benefits are paid in error, due to his or her failure to comply with the terms, rules and conditions of Workers' Compensation laws or a Certified or Licensed Workers' Compensation Managed Care Plan.

Amounts paid subject to reimbursement shall be directly reimbursed to the group health plan in full, without reduction for attorney fees, costs or other deduction.

Claim Procedures

Filing a Claim

Contracting Providers and many other hospitals and physicians will file a claim form to Blue Cross and Blue Shield of Nebraska on your behalf. Out-of-state contracting providers will file the claim form with their local Blue Cross and Blue Shield plan, for processing through the BlueCard Program.

When Medicare is the primary insurance for you or a covered dependent, you must normally submit all claims for Medicare-eligible services to Medicare first. After Medicare pays their portion of covered expenses, a copy of your claim, along with an explanation of benefits provided by Medicare is automatically forwarded to Blue Cross and Blue Shield of Nebraska.

You must file your own claim form if your health care provider does not file for you. Claim forms are available at Blue Cross and Blue Shield of Nebraska's Customer Service Center, or at the website, www.nebraskablue.com.

All submitted claims must include:

- Correct Blue Cross and Blue Shield of Nebraska ID number, including the alpha prefix.
- Name of patient.
- The date and time of an accident or onset of an illness, and whether or not it occurred at work.
- Diagnosis.
- An itemized statement of services, including the date of service, description and charge for the service.
- Complete name, address and professional status (M.D., R.N., etc.) of the health care provider.
- The name and identification number of other insurance, including Medicare.
- The primary plan's explanation of benefits, if applicable.

Claims cannot be processed if they are incomplete, and may be denied for "lack of information" if required information is not received.

Claims should be filed as soon as possible. If a claim is not filed, or any revisions or adjustments to a claim are not filed within 18 months of the date of service, benefits will not be allowed. Claims, including revisions or adjustments, that are not filed by a Nebraska contracting provider prior to the claim filing limit, will become the Nebraska Contracting Provider's liability.

In Nebraska, claim forms should be mailed to:

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

If health care services are provided in a state other than Nebraska, claims should be filed to the Blue Cross and Blue Shield plan servicing the area where the services were received. If you need assistance in locating the plan, please contact Blue Cross and Blue Shield of Nebraska's Customer Service Center.

Claim Determinations

A "claim" may be classified as "pre-service" or "post-service."

Pre-Service Claims — In some cases, under the terms of the health plan, the covered person is required to precertify or preauthorize benefits in advance of a service being provided, or benefits will be reduced or denied for the service. This required request for a benefit is a "pre-service claim." Pre-service claim determinations will be made within 15 days, unless an extension is necessary to obtain needed information. If additional information is requested, the covered person or his or her provider may be given up to 45 days from receipt of the notification to submit the requested information. A claim determination will be made within 15 days of

receipt of the information, or the expiration of the 45-day period. You, and/or your provider will be advised of the determination, in writing.

(See also the Inpatient Notification, Certification and Concurrent Review section of this document.)

Urgent Care — If your pre-service claim is one for urgent care, the determination will be made within 72 hours of receipt of the claim, unless further information is needed to process the claim. If more information is needed to make a decision, the covered person or his or her provider will be given no less than 48 hours to provide the specified information. Notification of the decision will be provided not later than 48 hours after the earlier of: our receipt of the information, or the end of the period allowed to submit the information.

Post-Service Claims — A post-service claim is any claim that is not a pre-service claim. In most cases, a post-service claim is a request for benefits or reimbursement of expenses for medical care that has been provided to a covered person. The procedure for filing a post-service claim is outlined above, under "Filing a Claim." Upon receipt of a completed claim form, a post-service claim will be processed within 30 days, unless additional information is needed. If additional information is requested, the covered person may be given up to 45 days to submit the necessary information. A provider must submit requested information as stated in the provider agreement. A claim determination will be made within 15 days of receipt of the information, or the expiration of the 45-day period. You will receive an Explanation of Benefits when a claim is processed, which explains the manner in which your claim was handled.

Concurrent Care — If you request to extend a course of treatment beyond the care previously approved and it involves urgent care, a decision will be made within 24 hours of the request, if you submitted your request at least 24 hours before the course of treatment expires. In all other cases, the request for an extension will be decided as appropriate for pre-service and post-service claims.

Who Receives the Benefit Payment

Benefit payments for covered services provided by Preferred Providers or any providers who are participating with Blue Cross and Blue Shield of Nebraska, will be made directly to the providers unless otherwise provided under state or federal law. Benefits may also be paid to an alternate recipient or custodial parent, pursuant to a qualified medical child support order. In all other cases, payments will be made, at Blue Cross and Blue Shield of Nebraska's option, to the covered person, to his or her estate, or to the provider. No assignment, whether made before or after services are provided, of any amount payable according to this group benefit plan shall be recognized or accepted as binding upon Blue Cross and Blue Shield of Nebraska, unless otherwise provided by state or federal law.

Explanation of Benefits

Every time a claim is processed for you, an Explanation of Benefits (EOB) form will be sent to you. The front page of the EOB provides you with a summary of payment including:

- The patient's name and the claim number.
- The name of the individual or institution that was paid for the service.
- The total charge associated with the claim.
- The covered amount.
- Any amount previously processed by this plan, Medicare or another insurance company.
- The amount(s) that you are responsible to pay the Provider.
- The total Deductible and Coinsurance that you have accumulated to date.
- Other general messages.

A more detailed breakdown of the charges including provider discounts, amount paid and cost sharing amounts (e.g. noncovered charges, Deductibles and Coinsurance are shown on the back of your EOB.

Also included on your EOB is information regarding your right to appeal a benefit determination.

Save your Explanation of Benefits forms in the event that you need them for other insurance or for tax purposes.

Appeal Procedures

Blue Cross and Blue Shield of Nebraska has been granted the discretionary authority to determine eligibility for benefits under the health plan and to construe and interpret the terms of the plan, consistent withe the terms of the master group contract.

Opportunity to Request First Level Appeal

You shall have a reasonable opportunity to appeal Blue Cross Blue Shield of Nebraska's (BCBSNE) precertification or claim determination in accordance with this Appeal Rights provision. As part of the appeal, there will be a full and fair review of the precertification and/or claim determination.

The request for an appeal must be submitted within one year of the claim denial or decision. The request can be written or electronically or orally submitted, and should include the following:

- The name of the patient;
- Name of the person filing the appeal, if different from the patient;
- Covered Person's identification number;
- Date of service and claim number, if any;
- Names of all individuals, facilities and/or services involved in the appeal; and
- General description or reason for the appeal, and any information that may help resolve the issue.

The appeal should be sent to:

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

An expedited review may be requested in a case involving urgent care, or for a concurrent care denial of a hospital stay of more than 24 hours.

If the appeal involves medical judgment, BCBSNE will consult with appropriate medical personnel in order to make the appeal determination. The appeal determination shall be made by individuals who were not involved in the original determination.

Notification of Appeal Decision

A written notice of the appeal determination will be provided to you (the claimant). If the appeal determination is adverse, this written notice shall include the name and title of the reviewer, the reasons for the decision, a reference to the contract provisions upon which the determination is based, a reference to the evidence or documentation used as a basis for the decision, and a statement regarding the claimant's right for further action or appeal. In addition, when applicable, the notice will state an explanation of the scientific or clinical judgment used in making the decision will be provided to the claimant, free of charge, upon written request.

Response to First Level Appeals

The written decision will be sent no later than:

- 72 hours for claims and services involving current inpatient hospitalization in excess of 24 hours, or for claims and services involving urgent care.
- 15 calendar days for other preservice claims.
- 30 calendar days for postservice claims.

Opportunity to Request a Second Level Appeal

If you are not satisfied with the first appeal decision, you shall have the opportunity to appeal BCBSNE's determination, within 6 months of the receipt of the first appeal decision. Your request for a second level appeal should include the information set forth above.

You and/or a representative have the right to appear in person to present your case before an appeal panel appointed by BCBSNE. You may submit supporting material before and/or at the review. The majority of the panel will be health care professionals with appropriate expertise, when the case being

reviewed requires a medical judgment. No deference will be given to either the initial determination or the first level review. The second level review and decision will be made by individuals who were not involved in the prior determinations.

Preservice or Postservice Claim Appeal: Written notification of the decision will be made as follows:

- Preservice Claims, within 15 calendar days after receipt; and

- Postservice Claims, within 30 calendar days after receipt.

This is the final level of appeal to Blue Cross and Blue Shield of Nebraska.

Definitions

ALCOHOLISM OR DRUG TREATMENT CENTER: A facility licensed by the Department of Health and Human Services Regulation and Licensure, whose program is certified by the Division of Alcohol, Drug Abuse, and Addiction Services (or equivalent state agency), accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the Commission on the Accreditation of Rehabilitation Facilities (CARF). Such facility is not licensed as a hospital, but provides inpatient or outpatient care, treatment, services, maintenance, accommodation or board in a group setting primarily and exclusively for individuals having any type of dependency or addiction to the use of alcohol or drugs.

ALLOWABLE CHARGE: An amount Blue Cross and Blue Shield of Nebraska uses to determine payment for Covered Services. This amount will be based on either the Contracted Amount for In-network Providers or the Out-of-network Allowance for Out-of network Providers.

AMBULATORY SURGICAL FACILITY: A certified facility that provides surgical treatment to patients not requiring inpatient hospitalization. Such facility must be licensed as a health clinic as defined by state statutes, but shall not include the offices of private physicians or dentists whether for individual or group practice.

APPROVED PROVIDER: A licensed practitioner of the healing arts who provides Covered Services within the scope of his or her license or a licensed or certified facility or other health care provider, payable according to the terms of this Contract, Nebraska law or pursuant to the direction of Blue Cross and Blue Shield of Nebraska.

AUXILIARY PROVIDER: A certified social worker, psychiatric registered nurse, certified alcohol and drug abuse counselor or other approved provider who is performing services within his or her scope of practice and who is supervised, and billed for, by a qualified physician or licensed psychologist, or as otherwise permitted by state law. Certified master social workers or certified professional counselors performing mental health services who are not licensed mental health practitioners are included in this definition.

BLUECARD PROGRAM: This Blue Cross and Blue Shield Association (BCBSA) program is a collection of policies, provisions and guidelines that enables Blue Cross and Blue Shield of Nebraska to process claims incurred by Covered Persons residing or traveling outside its Service Area by utilizing the discounts negotiated by the On-site plan and its contracting providers.

CERTIFICATION (CERTIFY and CERTIFIED): A determination by Blue Cross and Blue Shield of Nebraska or its designee, that an admission, extension of stay or other health care service has been reviewed and, based on the information provided, meets the clinical requirements for Medical Necessity, appropriateness, level of care, or effectiveness under the auspices of the applicable health benefit plan.

Certification also refers to successful voluntary compliance with certain prerequisite qualifications specified by regulatory entities. Agencies and programs may be deemed to be in compliance when they are accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Commission on the Accreditation of Rehabilitation Facilities (CARF), American Association for Ambulatory Health Care (AAAHC), American Association for Accreditation of Ambulatory Plastic Surgery Facilities (AAAAPSF), Medicare or as otherwise provided in the Contract provisions or state law.

COGNITIVE TRAINING: A rehabilitative intervention aimed at retraining or facilitating the recovery of mental and information processing skills including perception, problem-solving, memory storage and retrieval, language organization and expression.

COINSURANCE: The percentage amount the Covered Person must pay for Covered Services is based on the lesser of the Allowable Charge or the billed charge.

COINSURANCE LIMIT: The maximum coinsurance the Covered Person must pay during each calendar year.

Certain kinds of expenses do not count toward your coinsurance liability limit. For example:

- Charges in excess of the allowable charge.

- Charges for services that are not covered by this group plan.
- The calendar year deductible.
- The reduction amount as a result of a failure to comply with inpatient notification and certification provisions.

CONSULTATIONS: Physician's services for a patient in need of specialized care requested by the attending physician who does not have that expertise or knowledge.

CONTENT OF SERVICE: Specific services and/or procedures, supplies and materials that are considered to be an integral part of previous or concomitant services or procedures, or all inclusive, to the extent that separate reimbursement is not recognized. Charges denied as "Content of Service" are the Contracting Provider's liability and may not be billed to the Covered Person.

CONTRACT: The agreement between Blue Cross and Blue Shield of Nebraska and the Board of Regents of the University of Nebraska, which includes the the Master Group Application, Administrative Services Agreement and addenda or attachments, this Master Group Benefit Contract and any endorsements, and the enrollment forms of Subscribers.

CONTRACTED AMOUNT: The payment agreed to by Blue Cross and Blue Shield of Nebraska or an On-site Plan and Contracting Providers, for Covered Services received by a Covered Person.

CONTRACTING PROVIDER: An In-network Provider, or an On-site Plan BlueCard Program Preferred or Participating Provider.

COPAYMENT: A fixed dollar amount, payable by the Covered Person for a Covered Service, as indicated in the Master Group Application. Copayments are separate from and do not accumulate to either the deductible or the coinsurance limit.

COSMETIC: Any services provided to improve the patient's physical appearance, from which no significant improvement in physiologic function can be expected, regardless of emotional or psychological factors.

COVERED PERSON: Any person entitled to benefits for Covered Services pursuant to the contract.

COVERED SERVICE: Hospital, medical or surgical procedures, treatments, drugs, supplies, home medical equipment, or other health, mental health or dental care, including any single service or combination of services, for which benefits are payable, while the contract is in effect.

CREDITABLE COVERAGE: Coverage of the individual under any of the following:

a) a group health plan, as defined by HIPAA
b) health insurance coverage consisting of medical care offered by a health insurance issuer in the group or individual market
c) Part A or Part B of Medicare
d) Medicaid, other than coverage consisting solely of benefits under section 1928 (for pediatric immunizations)
e) Title 10 U.S.C. Chapter 55 (medical and dental care of the uniformed services)
f) a medical care program of the Indian Health Service or a tribal organization
g) a State health benefits risk pool
h) the Federal Employees Health Benefits Program
i) a public health plan, which means a plan providing health coverage that is established by a State, the U.S. government, or a foreign country, or a political subdivision thereof
j) a health plan of the Peace Corps
k) a State Children's Health Insurance Program (SCHIP).

Creditable coverage does not include coverage described in HIPAA as "excepted benefits," including: coverage only for accidents; disability income coverage; liability insurance, including general liability and automobile liability and any supplement thereto; credit only insurance; or coverage for on-site medical clinics.

Other excepted benefits include: limited scope dental or vision coverage or long term care coverage; non-coordinated coverages offered separately, such as specified disease or illness policies, hospital or other fixed indemnity insurance; and supplemental benefits such as Medicare Supplemental health insurance, TRICARE supplemental programs or other similar supplemental coverage.

CUSTODIAL CARE: The level of care that consists primarily of assisting with the activities of daily living such as bathing, continence, dressing, transferring and eating. The purpose of such care is to maintain and support the existing level of care and preserve health from further decline.

Custodial Care is care given to a patient who:

1. is mentally or physically disabled; and

2. needs a protected, monitored or controlled environment or assistance to support the basics of daily living, in an institution or at home, and

3. is not under active and specific medical, surgical or psychiatric treatment, ordered by a physician which will reduce the disability to the extent necessary to allow the patient to function outside such environment or without such assistance within a reasonable time, not to exceed one year in any event.

A custodial care determination may still be made if the care is ordered by a physician or services are administered by a registered or licensed practical nurse.

DEDUCTIBLE: An amount which the Covered Person must pay each calendar year for Covered Services before benefits are payable by the contract.

The amounts applied to the deductible for covered services by either Preferred Providers or non-Preferred Providers will be credited to both deductibles. Charges for noncovered services or amounts in excess of the allowable charge do not count toward your deductible.

ELIGIBILITY WAITING PERIOD: Applicable to new Subscribers only, the period between the first day of employment and the first date of coverage under this contract.

ELIGIBLE DEPENDENT:

1. The legal spouse of the Subscriber unless the marriage has been ended by a legal, effective decree of dissolution, divorce or separation. A "spouse" shall mean only a person of the opposite sex, and who is a husband or wife as recognized under the laws of the state of Nebraska. A spouse includes a common-law spouse if the common-law marriage was contracted in a jurisdiction recognizing common law marriage.

2. An adult designee of the Subscriber, who is defined as a person of the same or opposite gender who meets the following criteria:
   - has resided in the same residence as the employee for at least the past consecutive 12 months and intends to remain so indefinitely;
   - is at least 19 years old;
   - is directly dependent upon, or interdependent with, the employee, sharing a common financial obligation that can be documented in a manner prescribed by the university; and
   - is not currently married to or legally separated from another individual under either statutory or common law.

An adult designee cannot be a parent or step parent of the Subscriber; the Subscriber's grandparents, step grandparents, or their descendants (aunts, uncles, or cousins); the child of the Subscriber or a descendent of the Subscriber's child; the Subscriber's renters, boarders, tenants, or people who are employees of the Subscriber; a person hired or directly supervised by the Subscriber in any employment setting; or a person the Subscriber may transfer, suspend, lay off, recall, promote, discharge, assign, reward, or discipline as an employee, or if the Subscriber has responsibility to direct an individual or to adjust the individual's grievances, or effectively to recommend any such action, if the exercise of such authority is not merely of a routine or clerical nature but requires the use of independent judgment.

3. Adult designee dependent child to age 26. An adult designee dependent child is a 1) natural-born or legally adopted child of the adult designee, 2) a child for whom the adult designee has legal guardianship, or 3) a child of the adult designee with a mental or physical disability who has attained the limiting age of 26 if proof of disability is provided within 31 days of attaining age 26 and he or she is incapable of self-sustaining employment by reason of a mental or physical handicap; and dependent upon the adult designee for support and maintenance.

Coverage ends when the adult designee dependent child turns age 26, unless otherwise provided above.

An adult designee dependent child who is employed at the University in a benefits-eligible position may not be covered as an adult designee dependent child under a Subscriber's benefit plans.

Please contact the University of Nebraska for additional information regarding eligibility for an adult designee, and/or adult designee dependent children.

4. Children to age 26. A Subscriber's child who is employed at the University of Nebraska in a benefits-eligible position may not be covered as a dependent on their parent's medical plan provided through the University.

   "Children" means:
   - natural born and legally adopted children
   - a child for whom the employee has legal guardianship
   * stepchild(ren)

   Coverage ends when the dependent child turns age 26.

4. A Subscriber's child with a mental or physical disability who has attained the limiting age of 26 may continue coverage beyond age 26, if proof of disability is provided within 31 days of attaining age 26, and he or she is:

   a) incapable of self-sustaining employment by reason of mental or physical handicap; and

   b) dependent upon you for support and maintenance.

Proof of the requirements of paragraphs a. and b. may be required periodically from the Subscriber (but not more often than yearly after two years of such handicap). Any extended coverage under this paragraph will be subject to all other provisions of the Contract.

EMERGENCY CARE: Covered services provided in a hospital emergency room setting.

EMERGENCY MEDICAL CONDITION: A medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including, but not limited to, severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in: 1) placing the health of the person afflicted with such condition in serious jeopardy or, in the case of a behavioral condition, placing the health of such persons or others in serious jeopardy, 2) serious impairment to such person's bodily functions, 3) serious impairment of any bodily organ or part of such person, or 4) serious disfigurement of such person.

EMPLOYEE: An individual hired by the employer, and determined to be an employee per their eligibility guidelines.

EMPLOYER: The Group Applicant (Board of Regents of the University of Nebraska) who signs the Master Group Application for health coverage on behalf of its employees.

FAMILY MEMBERSHIP: Membership option providing benefits for Covered Services provided to the subscriber and his or her eligible dependents.

GROUP APPLICANT: The Employer (Board of Regents of the University of Nebraska) making application for administration of health coverage under this Contract.

HOME (DURABLE) MEDICAL EQUIPMENT: Equipment and supplies medically necessary to treat an illness or injury, to improve the functioning of a malformed body member, or to prevent further deterioration of the patient's medical condition. Such equipment and supplies must be designed and used primarily to treat conditions which are medical in nature, and able to withstand repeated use. Home medical equipment includes such items as prosthetic devices, orthopedic braces, crutches and wheelchairs. It does not include sporting or athletic equipment or items purchased for the convenience of the family.

HOMEBOUND: An individual will be considered to be essentially Homebound if he or she has a condition due to an Illness or Injury which considerably restricts the ability to leave his or her residence without the assistance of another person, and either the aid of supportive devices or the use of special transportation.

The patient who does leave the residence may still be considered homebound if the absences from the place of residence are infrequent or for periods of relatively short duration and attributable to the need to receive medical treatment that cannot be provided in the home.

Residence is defined as a home, an apartment, a relative's home or retirement center where nursing services are not provided.

HOSPITAL: A hospital is an institution or facility licensed by the State of Nebraska or the state in which it is located, which provides medical and surgical diagnostic and treatment services with 24-hour per day nursing services to two or more nonrelated persons with an illness, injury or pregnancy, under the supervision of a staff of physicians licensed to practice medicine and surgery.

ILLNESS: A condition which deviates from or disrupts normal bodily functions or body tissues in an abnormal way, and is manifested by a characteristic set of signs or symptoms.

INJURY: Physical harm or damage inflicted to the body from an external force.

IN-NETWORK HOSPITAL, PHYSICIAN or OTHER PROVIDER: A Licensed practitioner of the healing arts, a Licensed facility or other qualified provider of health care Services who has contracted with Blue Cross and Blue Shield of Nebraska to provide Services as part of a Preferred Provider network in Nebraska.

INPATIENT: 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.

INVESTIGATIVE: A technology, a drug, biological product, device, diagnostic, treatment or procedure is investigative if it has not been Scientifically Validated pursuant to all of the factors set forth below:

1. Technologies, drugs, biological products, devices and diagnostics must have final approval from the appropriate government regulatory bodies. A drug or biological product must have final approval from the Food and Drug Administration (FDA). A device must have final approval from FDA for those specific indications and methods of use that are being evaluated. FDA or other governmental approval is only one of the factors necessary to determine Scientific Validity.

2. Evidence must permit conclusions concerning the effect of the technology on health outcomes. The evidence should consist of well-designed and well-conducted investigations published in peer-reviewed journals. The quality of the body of studies and the consistency of the results are considered in evaluating the evidence.

The evidence should demonstrate that the technology can measure or alter the physiological changes related to a disease, injury, illness or condition. In addition there should be evidence based on established medical facts that such measurement or alteration improves the health outcomes.

Opinions and evaluations by national medical associations, consensus panels or other technology evaluation bodies are evaluated according to the scientific quality of the supporting evidence and rationale. Our evidence includes, but is not limited to: Blue Cross and Blue Shield Association Technology Evaluation Center technology evaluations; Hayes Directory of New Medical Technologies' Status; Centers for Medicare and Medicaid Services (CMS) Technology Assessments, and United States Food and Drug Administration (FDA) approvals.

3. The technology must improve the net health outcome.

4. The technology must improve the net health outcome as much as or more than established alternatives.

5. The improvement must be attainable outside the investigational settings.

Blue Cross and Blue Shield of Nebraska will determine whether a technology is Investigative.

LATE ENROLLEE: An individual who does not enroll for coverage during the first period in which he or she is eligible, or during a Special Enrollment Period.

LICENSURE (LICENSED): Permission to engage in a health profession which would otherwise be unlawful in the state where services are performed, and which is granted to individuals who meet prerequisite qualifications. Licensure protects a given scope of practice and the title.

LONG TERM ACUTE CARE (LTAC) Specialized acute hospital care for medically complex patients who are critically ill, have multi-system complications and/or failures, and require hospitalization in a facility offering specialized treatment programs and aggressive clinical and therapeutic intervention on a 24-hour/seven-day-a-week basis.

MEDICALLY NECESSARY: Health care Services ordered by a Treating Physician exercising prudent clinical judgment, provided to a Covered Person for the purposes of prevention, evaluation, diagnosis or treatment of that Covered Person's Illness, Injury or Pregnancy, that are:

1. consistent with the prevailing professionally recognized standards of medical practice; and, known to be effective in improving health care outcomes for the condition for which it is recommended or prescribed. Effectiveness will be determined by validation based upon scientific evidence, professional standards and consideration of expert opinion, and

2. clinically appropriate in terms of type, frequency, extent, site and duration for the prevention, diagnosis or treatment of the Covered Person's Illness, Injury or Pregnancy. The most appropriate setting and the most appropriate level of Service is that setting and that level of Service, considering the potential benefits and harms to the patient. When this test is applied to the care of an Inpatient, the Covered Person's medical symptoms and conditions must require that treatment cannot be safely provided in a less intensive medical setting; and

3. not more costly than alternative interventions, including no intervention, and are at least as likely to produce equivalent therapeutic or diagnostic results as to the prevention, diagnosis or treatment of the patient's IIlness, Injury or Pregnancy, without adversely affecting the Covered Person's medical condition; and

4. not provided primarily for the convenience of the following:

a. the Covered Person;
b. the Physician;
c. the Covered Person's family;
d. any other person or health care provider; and

5. not considered unnecessarily repetitive when performed in combination with other prevention, evaluation, diagnoses or treatment procedures. Blue Cross and Blue Shield of Nebraska will determine whether services are Medically Necessary. Services will not automatically be considered Medically Necessary because they have been ordered or provided by a Treating Physician.

MENTAL HEALTH SERVICES PROVIDER: A qualified physician, licensed psychologist, licensed special psychologist, or a licensed mental health practitioner. A mental health practitioner may also be a licensed professional counselor or a licensed clinical social worker who is duly certified/licensed for such practice by state law. It also includes, for purposes of this contract, auxiliary providers supervised, and billed for, by a professional as permitted by state law. All mental health services must be provided under appropriate supervision and consultation requirements as set forth by state law.

Licensed Psychologist: Psychologist shall mean a person licensed to engage in the practice of psychology in this or another jurisdiction. The terms certified, registered, chartered, or any other term chosen by a jurisdiction to authorize the autonomous practice of psychology shall be considered equivalent terms.

Licensed Special Psychologist: A person who has a doctoral degree in psychology from an institution of higher education accredited by the American Psychological Association but who is not certified in clinical psychology. Such person shall be issued a special License to practice psychology that continues to require supervision by a licensed psychologist or qualified physician for any practice that involves major mental and emotional disorders. This psychologist may provide mental health services without supervision.

Licensed Mental Health Practitioner: A person licensed to provide treatment, assessment, psychotherapy, counseling, or equivalent activities to individuals, families or groups for behavioral, cognitive, social, mental, or emotional disorders, including interpersonal or personal situations. Mental health practice shall include the initial assessment of organic mental or emotional disorders (as defined by state law), for the purpose of referral to, or consultation with a qualified physician or a licensed psychologist. Mental health practice shall not include the practice of psychology or medicine, prescribing drugs or electroconvulsive therapy, treating physical disease, injury, or deformity, diagnosing major mental illness or disorder except in consultation with a qualified physician or a licensed psychologist, measuring personality or intelligence for the purpose of diagnosis or treatment planning, using psychotherapy with individuals suspected of having major mental or emotional disorders except in consultation with a qualified physician or licensed psychologist, or using psychotherapy to treat the concomitants of organic illness except in consultation with a qualified physician or licensed psychologist.

MENTAL ILLNESS: A pathological state of mind producing clinically significant psychological or physiological symptoms (distress) together with impairment in one or more major areas of functioning (disability) wherein improvement can reasonably be anticipated with therapy, and which is a condition listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM IV).

NONCOVERED PERSON: A person for whom benefits are not available under the Contract.

NONCOVERED SERVICES: Services which are not payable under the Contract.

ON-SITE OR HOST PLAN: A Blue Cross and/or a Blue Shield Plan in another Blue Cross and Blue Shield Association Service Area, which administers claims through the BlueCard Program for Nebraska Covered Persons residing or traveling in that service area.

OUT-OF-NETWORK ALLOWANCE: An amount used by Blue Cross and Blue Shield of Nebraska to calculate the payment for Covered Services to an Out-of-network Provider. This amount will be based on the Contracted Amount for Nebraska providers or an amount determined by the On-site Plan for out-of-area Providers.

OUT-OF-NETWORK PROVIDER: A provider of health care Services who has not contracted with Blue Cross and Blue Shield of Nebraska to provide Services as a part of a Preferred network in Nebraska.

OUTPATIENT: A person who is not admitted for Inpatient care, but is treated in the Outpatient department or emergency room of a Hospital, an observation room, in an Ambulatory Surgical Facility, an Urgent Care Facility, or a Physician's office, or at home.

OUTPATIENT PROGRAM: An organized set of resources and services for a substance abusive or mentally ill population, administered by a certified provider, which is directed toward the accomplishment of a designed set of objectives. Day treatment, partial care and outpatient programs which provide primary treatment for mental illness or substance abuse must be provided in a facility which is licensed by the Department of Health and Human Services Regulation and Licensure and whose program is certified by the Division of Alcoholism, Drug Abuse and Addiction Services (or equivalent state agency) or accredited by JCAHO or CARF.

This definition does not include programs of co-dependency, family intervention, employee assistance, probation, prevention, educational or self-help programs, or programs which treat obesity, gambling, or nicotine addiction. It also does not include residential services for mental illness, or halfway house or methadone maintenance programs for substance abuse. Benefits will not be provided for programs ordered by the court which are not medically necessary as determined by Blue Cross and Blue Shield of Nebraska.

PARTICIPATING PROVIDER: A licensed practitioner of the healing arts, or qualified provider of health care services, who has contracted with Blue Cross and Blue Shield of Nebraska, under its traditional program, or who is a participating provider in the BlueCard Program network.

PHYSICAL REHABILITATION: The restoration of a person who was totally disabled as the result of an injury or an acute physical impairment to a level of function which allows that person to live as independently as possible. A person is totally disabled when such person has physical disabilities and needs active assistance to perform the normal activities of daily living, such as eating, dressing, personal hygiene, ambulation and changing body position.

PHYSICIAN: Any person holding an unrestricted license and duly authorized to practice medicine and surgery and prescribe drugs.

PREAUTHORIZATION: Preauthorization of benefits is prior written approval of benefits for certain services such as organ transplants, cardiac and pulmonary rehabilitation, subsequent purchases of home medical equipment, and home health and hospice care. This Preauthorization is based on the information submitted to Blue Cross and Blue Shield of Nebraska the terms of this Contract. It may be effective for a limited period of time.

PREFERRED PROVIDER: A health care provider (hospital, physician or other health care provider) who has contracted to provide services as a part of the network in Nebraska, or if in another state, who is a Preferred Provider with the BlueCard Program PPO network.

PREFERRED PROVIDER ORGANIZATION: A panel of hospitals, physicians and other health care providers who belong to a network of Preferred Providers, which agrees to more effectively manage health care costs.

PREGNANCY: Includes obstetrics, threatened abortions, miscarriages, premature deliveries, ectopic pregnancies, or other conditions or complications caused by pregnancy. A complication caused by pregnancy is a condition that occurs prior to the end of the pregnancy, distinct from the pregnancy, but caused or adversely affected by it. Postpartum depression and similar diagnoses are not considered complications of pregnancy.

PRIMARY CARE PHYSICIAN: A Physician who has a majority of his or her practice in the field of internal or general medicine, obstetrics/gynecology, general pediatrics or family practice.

RESIDENTIAL TREATMENT PROGRAM: Services or a program organized and staffed to provide both general and specialized nonhospital-based interdisciplinary services 24 hours a day, seven days a week for persons with behavioral health disorders. Residential treatment may be provided in freestanding, nonhospital-based facilities or in units of larger entities such as a wing of a hospital. Residential Treatment Programs may include nonhospital substance abuse treatment centers, intermediate care facilities, psychiatric treatment centers or other nonmedical settings.

SCHEDULE OF BENEFITS: A summarized personal document which provides information about deductibles, percentages payable, special benefits, maximums and limitations of coverage. It also indicates the type of membership unit selected.

SCIENTIFICALLY VALIDATED: A technology, a drug, biological product, device, diagnostic, treatment or procedure is scientifically validated if it meets all of the factors set forth below:

- Technologies, drugs, biological products, devices and diagnostics must have final

approval from the appropriate government regulatory bodies. A drug or biological product must have final approval from the Food and Drug Administration (FDA). A device must have final approval from FDA for those specific indications and methods of use that is being evaluated. FDA or other governmental approval is only one of the factors necessary to determine Scientific Validity.

- The Scientific Evidence must permit conclusions concerning the effect of the technology on health outcomes. The evidence should consist of well-designed and well-conducted investigations published in peer-reviewed journals. The quality of the body of studies and the consistency of the results are considered in evaluating the evidence.

  The evidence should demonstrate that the technology can measure or alter the physiological changes related to a disease, injury, illness or condition. In addition there should be evidence based on established medical facts that such measurement or alteration improves the health outcomes.

  Opinions and evaluations by national medical associations, consensus panels or other technology evaluation bodies are evaluated according to the scientific quality of the supporting evidence and rationale. Our evidence includes, but is not limited to: Blue Cross and Blue Shield Association Technology Evaluation Center technology evaluations; Hayes Directory of New Medical Technologies' Status; Health Care Financing Administration (HCFA) Technology Assessments and United States Food and Drug Administration (FDA) approvals.

- The technology must improve the net health outcome.

- The technology must improve the net health outcome as much as or more than established alternatives.

- The improvement must be attainable outside the investigational settings.

Blue Cross and Blue Shield of Nebraska will determine whether a technology is Scientifically Validated.

SERVICES: Hospital, medical or surgical procedures, treatments, drugs, supplies, home medical equipment, or other health, mental health or dental care, including any single service or combination of such services.

SINGLE MEMBERSHIP: Membership option providing benefits for Covered Services provided to the subscriber only.

SINGLE PARENT MEMBERSHIP: Membership option providing benefits for Covered Services provided to the subscriber and his or her eligible dependent children, but not to a spouse.

SKILLED NURSING CARE: Medically Necessary Skilled Nursing Services for the treatment of an illness or injury which must be ordered by a Physician, and performed under the supervision of a registered nurse (R.N.) or a Licensed practical nurse (L.P.N.). The classification of a particular nursing Service as skilled is based on the technical or professional health training required to effectively perform the Service.

SUBSCRIBER: An eligible individual who enrolls for health coverage and is named on an identification card issued pursuant to this Contract, and who is an Employee hired by the Group Employer, or a retiree qualified to receive benefits as defined in the Master Group Application.

SUBSCRIBER-SPOUSE MEMBERSHIP: Membership option providing benefits for Covered Services provided to the subscriber and his or her spouse.

SUBSTANCE DEPENDENCE AND ABUSE: For purposes of this Contract, this term is limited to alcoholism and drug abuse. The term does not include tobacco dependence or addiction, unless otherwise included in an attached endorsement.

TREATING PHYSICIAN: A physician who has personally evaluated the patient. This may include a physician or oral surgeon, a certified nurse midwife, a certified nurse practitioner or certified physician's assistant, within the practitioner's scope of practice, when supervised and billed for, by a physician.

URGENT CARE: Medical care or treatment for which the application of time periods for making non-urgent care determinations: a) could seriously jeopardize the life or health of the Covered Person or his or her ability to regain maximum function; or b) would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

URGENT CARE FACILITY: A facility, other than a Hospital, that provides covered health Services that are required to prevent serious deterioration of the person's health, and that are required as a result of an unforeseen Illness, Injury or the onset of acute or severe symptoms.

UTILIZATION REVIEW: The evaluation by Blue Cross and Blue Shield of Nebraska or its designees, of the use of services, including medical, diagnostic or surgical procedures or treatments, the utilization of medical supplies, drugs, or home medical equipment or treatment of mental illness, alcoholism and drug abuse or other health or dental care, compared with established criteria in order to determine benefits. Benefits may be excluded for such services if found to be not medically necessary.

WORK-HARDENING: Physical therapy or similar services provided primarily for strengthening an individual for purposes of his or her employment.

- Charges for services that are not covered by this group plan.
- The calendar year deductible.
- The reduction amount as a result of a failure to comply with inpatient notification and certification provisions.

CONSULTATIONS: Physician's services for a patient in need of specialized care requested by the attending physician who does not have that expertise or knowledge.

CONTENT OF SERVICE: Specific services and/or procedures, supplies and materials that are considered to be an integral part of previous or concomitant services or procedures, or all inclusive, to the extent that separate reimbursement is not recognized. Charges denied as "Content of Service" are the Contracting Provider's liability and may not be billed to the Covered Person.

CONTRACT: The agreement between Blue Cross and Blue Shield of Nebraska and the Board of Regents of the University of Nebraska, which includes the the Master Group Application, Administrative Services Agreement and addenda or attachments, this Master Group Benefit Contract and any endorsements, and the enrollment forms of Subscribers.

CONTRACTED AMOUNT: The payment agreed to by Blue Cross and Blue Shield of Nebraska or an On-site Plan and Contracting Providers, for Covered Services received by a Covered Person.

CONTRACTING PROVIDER: An In-network Provider, or an On-site Plan BlueCard Program Preferred or Participating Provider.

COPAYMENT: A fixed dollar amount, payable by the Covered Person for a Covered Service, as indicated in the Master Group Application. Copayments are separate from and do not accumulate to either the deductible or the coinsurance limit.

COSMETIC: Any services provided to improve the patient's physical appearance, from which no significant improvement in physiologic function can be expected, regardless of emotional or psychological factors.

COVERED PERSON: Any person entitled to benefits for Covered Services pursuant to the contract.

COVERED SERVICE: Hospital, medical or surgical procedures, treatments, drugs, supplies, home medical equipment, or other health, mental health or dental care, including any single service or combination of services, for which benefits are payable, while the contract is in effect.

CREDITABLE COVERAGE: Coverage of the individual under any of the following:

a) a group health plan, as defined by HIPAA
b) health insurance coverage consisting of medical care offered by a health insurance issuer in the group or individual market
c) Part A or Part B of Medicare
d) Medicaid, other than coverage consisting solely of benefits under section 1928 (for pediatric immunizations)
e) Title 10 U.S.C. Chapter 55 (medical and dental care of the uniformed services)
f) a medical care program of the Indian Health Service or a tribal organization
g) a State health benefits risk pool
h) the Federal Employees Health Benefits Program
i) a public health plan, which means a plan providing health coverage that is established by a State, the U.S. government, or a foreign country, or a political subdivision thereof
j) a health plan of the Peace Corps
k) a State Children's Health Insurance Program (SCHIP).

Creditable coverage does not include coverage described in HIPAA as "excepted benefits," including: coverage only for accidents; disability income coverage; liability insurance, including general liability and automobile liability and any supplement thereto; credit only insurance; or coverage for on-site medical clinics.

Other excepted benefits include: limited scope dental or vision coverage or long term care coverage; non-coordinated coverages offered separately, such as specified disease or illness policies, hospital or other fixed indemnity insurance; and supplemental benefits such as Medicare Supplemental health insurance, TRICARE supplemental programs or other similar supplemental coverage.

CUSTODIAL CARE: The level of care that consists primarily of assisting with the activities of daily living such as bathing, continence, dressing, transferring and eating. The purpose of such care is to maintain and support the existing level of care and preserve health from further decline.

Custodial Care is care given to a patient who:

1. is mentally or physically disabled; and

2. needs a protected, monitored or controlled environment or assistance to support the basics of daily living, in an institution or at home, and

3. is not under active and specific medical, surgical or psychiatric treatment, ordered by a physician which will reduce the disability to the extent necessary to allow the patient to function outside such environment or without such assistance within a reasonable time, not to exceed one year in any event.

A custodial care determination may still be made if the care is ordered by a physician or services are administered by a registered or licensed practical nurse.

DEDUCTIBLE: An amount which the Covered Person must pay each calendar year for Covered Services before benefits are payable by the contract.

The amounts applied to the deductible for covered services by either Preferred Providers or non-Preferred Providers will be credited to both deductibles. Charges for noncovered services or amounts in excess of the allowable charge do not count toward your deductible.

ELIGIBILITY WAITING PERIOD: Applicable to new Subscribers only, the period between the first day of employment and the first date of coverage under this contract.

ELIGIBLE DEPENDENT:

1. The legal spouse of the Subscriber unless the marriage has been ended by a legal, effective decree of dissolution, divorce or separation. A "spouse" shall mean only a person of the opposite sex, and who is a husband or wife as recognized under the laws of the state of Nebraska. A spouse includes a common-law spouse if the common-law marriage was contracted in a jurisdiction recognizing common law marriage.

2. An adult designee of the Subscriber, who is defined as a person of the same or opposite gender who meets the following criteria:
   - has resided in the same residence as the employee for at least the past consecutive 12 months and intends to remain so indefinitely;
   - is at least 19 years old;
   - is directly dependent upon, or interdependent with, the employee, sharing a common financial obligation that can be documented in a manner prescribed by the university; and
   - is not currently married to or legally separate from another individual under either statutory or common law.

An adult designee cannot be a parent or step parent of the Subscriber; the Subscriber's grandparents, step grandparents, or their descendants (aunts, uncles, or cousins); the child of the Subscriber or a descendent of the Subscriber's child; the Subscriber's renters, boarders, tenants, or people who are employees of the Subscriber; a person hired or directly supervised by the Subscriber in any employment setting; or a person the Subscriber may transfer, suspend, lay off, recall, promote, discharge, assign, reward, or discipline as an employee, or if the Subscriber has responsibility to direct an individual or to adjust the individual's grievances, or effectively to recommend any such action, if the exercise of such authority is not merely of a routine or clerical nature but requires the use of independent judgment.

3. Adult designee dependent child to age 26. An adult designee dependent child is a 1) natural-born or legally adopted child of the adult designee, 2) a child for whom the adult designee has legal guardianship, or 3)a child of the adult designee with a mental or physical disability who has attained the limiting age of 26 if proof of disability is provided within 31 days of attaining age 26 and he or she is incapable of self-sustaining employment by reason of a mental or physical handicap; and dependent upon the adult designee for support and maintenance.

Coverage ends when the adult designee dependent child turns age 26, unless otherwise provided above.

An adult designee dependent child who is employed at the University in a benefits-eligible position may not be covered as an adult designee dependent child under a Subscriber's benefit plans.

Please contact the University of Nebraska for additional information regarding eligibility for an adult designee, and/or adult designee dependent children.

4. Children to age 26. A Subscriber's child who is employed at the University of Nebraska in a benefits-eligible position may not be covered as a dependent on their parent's medical plan provided through the University.

   "Children" means:
   - natural born and legally adopted children
   - a child for whom the employee has legal guardianship

   Coverage ends when the dependent child turns age 26.

4. A Subscriber's child with a mental or physical disability who has attained the limiting age of 26 may continue coverage beyond age 26, if proof of disability is provided within 31 days of attaining age 26, and he or she is:

   a) incapable of self-sustaining employment by reason of mental or physical handicap; and

   b) dependent upon you for support and maintenance.

Proof of the requirements of paragraphs a. and b. may be required periodically from the Subscriber (but not more often than yearly after two years of such handicap). Any extended coverage under this paragraph will be subject to all other provisions of the Contract.

EMERGENCY CARE: Covered services provided in a hospital emergency room setting.

EMERGENCY MEDICAL CONDITION: A medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including, but not limited to, severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in: 1) placing the health of the person afflicted with such condition in serious jeopardy or, in the case of a behavioral condition, placing the health of such persons or others in serious jeopardy, 2) serious impairment to such person's bodily functions, 3) serious impairment of any bodily organ or part of such person, or 4) serious disfigurement of such person.

EMPLOYEE: An individual hired by the employer, and determined to be an employee per their eligibility guidelines.

EMPLOYER: The Group Applicant (Board of Regents of the University of Nebraska) who signs the Master Group Application for health coverage on behalf of its employees.

FAMILY MEMBERSHIP: Membership option providing benefits for Covered Services provided to the subscriber and his or her eligible dependents.

GROUP APPLICANT: The Employer (Board of Regents of the University of Nebraska) making application for administration of health coverage under this Contract.

HOME (DURABLE) MEDICAL EQUIPMENT: Equipment and supplies medically necessary to treat an illness or injury, to improve the functioning of a malformed body member, or to prevent further deterioration of the patient's medical condition. Such equipment and supplies must be designed and used primarily to treat conditions which are medical in nature, and able to withstand repeated use. Home medical equipment includes such items as prosthetic devices, orthopedic braces, crutches and wheelchairs. It does not include sporting or athletic equipment or items purchased for the convenience of the family.

HOMEBOUND: An individual will be considered to be essentially Homebound if he or she has a condition due to an Illness or Injury which considerably restricts the ability to leave his or her residence without the assistance of another person, and either the aid of supportive devices or the use of special transportation.

The patient who does leave the residence may still be considered homebound if the absences from the place of residence are infrequent or for periods of relatively short duration and attributable to the need to receive medical treatment that cannot be provided in the home.

Residence is defined as a home, an apartment, a relative's home or retirement center where nursing services are not provided.

HOSPITAL: A hospital is an institution or facility licensed by the State of Nebraska or the state in which it is located, which provides medical and surgical diagnostic and treatment services with 24-hour per day nursing services to two or more nonrelated persons with an illness, injury or pregnancy, under the supervision of a staff of physicians licensed to practice medicine and surgery.

ILLNESS: A condition which deviates from or disrupts normal bodily functions or body tissues in an abnormal way, and is manifested by a characteristic set of signs or symptoms.

INJURY: Physical harm or damage inflicted to the body from an external force.

IN-NETWORK HOSPITAL, PHYSICIAN or OTHER PROVIDER: A Licensed practitioner of the healing arts, a Licensed facility or other qualified provider of health care Services who has contracted with Blue Cross and Blue Shield of Nebraska to provide Services as part of a Preferred Provider network in Nebraska.

INPATIENT: 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.

INVESTIGATIVE: A technology, a drug, biological product, device, diagnostic, treatment or procedure is investigative if it has not been Scientifically Validated pursuant to all of the factors set forth below:

1. Technologies, drugs, biological products, devices and diagnostics must have final approval from the appropriate government regulatory bodies. A drug or biological product must have final approval from the Food and Drug Administration (FDA). A device must have final approval from FDA for those specific indications and methods of use that are being evaluated. FDA or other governmental approval is only one of the factors necessary to determine Scientific Validity.

2. Evidence must permit conclusions concerning the effect of the technology on health outcomes. The evidence should consist of well-designed and well-conducted investigations published in peer-reviewed journals. The quality of the body of studies and the consistency of the results are considered in evaluating the evidence.

   The evidence should demonstrate that the technology can measure or alter the physiological changes related to a disease, injury, illness or condition. In addition there should be evidence based on established medical facts that such measurement or alteration improves the health outcomes.

   Opinions and evaluations by national medical associations, consensus panels or other technology evaluation bodies are evaluated according to the scientific quality of the supporting evidence and rationale. Our evidence includes, but is not limited to: Blue Cross and Blue Shield Association Technology Evaluation Center technology evaluations; Hayes Directory of New Medical Technologies' Status; Centers for Medicare and Medicaid Services (CMS) Technology Assessments, and United States Food and Drug Administration (FDA) approvals.

3. The technology must improve the net health outcome.

4. The technology must improve the net health outcome as much as or more than established alternatives.

5. The improvement must be attainable outside the investigational settings.

Blue Cross and Blue Shield of Nebraska will determine whether a technology is Investigative.

LATE ENROLLEE: An individual who does not enroll for coverage during the first period in which he or she is eligible, or during a Special Enrollment Period.

LICENSURE (LICENSED): Permission to engage in a health profession which would otherwise be unlawful in the state where services are performed, and which is granted to individuals who meet prerequisite qualifications. Licensure protects a given scope of practice and the title.

LONG TERM ACUTE CARE (LTAC) Specialized acute hospital care for medically complex patients who are critically ill, have multi-system complications and/or failures, and require hospitalization in a facility offering specialized treatment programs and aggressive clinical and therapeutic intervention on a 24-hour/seven-day-a-week basis.

MEDICALLY NECESSARY: Health care Services ordered by a Treating Physician exercising prudent clinical judgment, provided to a Covered Person for the purposes of prevention, evaluation, diagnosis or treatment of that Covered Person's Illness, Injury or Pregnancy, that are:

1. consistent with the prevailing professionally recognized standards of medical practice; and, known to be effective in improving health care outcomes for the condition for which it is recommended or prescribed. Effectiveness will be determined by validation based upon scientific evidence, professional standards and consideration of expert opinion, and

2. clinically appropriate in terms of type, frequency, extent, site and duration for the prevention, diagnosis or treatment of the Covered Person's Illness, Injury or Pregnancy. The most appropriate setting and the most appropriate level of Service is that setting and that level of Service, considering the potential benefits and harms to the patient. When this test is applied to the care of an Inpatient, the Covered Person's medical symptoms and conditions must require that treatment cannot be safely provided in a less intensive medical setting; and

3. not more costly than alternative interventions, including no intervention, and are at least as likely to produce equivalent therapeutic or diagnostic results as to the prevention, diagnosis or treatment of the patient's IIlness, Injury or Pregnancy, without adversely affecting the Covered Person's medical condition; and

4. not provided primarily for the convenience of the following:

a. the Covered Person;
b. the Physician;
c. the Covered Person's family;
d. any other person or health care provider; and

5. not considered unnecessarily repetitive when performed in combination with other prevention, evaluation, diagnoses or treatment procedures. Blue Cross and Blue Shield of Nebraska will determine whether services are Medically Necessary. Services will not automatically be considered Medically Necessary because they have been ordered or provided by a Treating Physician.

MENTAL HEALTH SERVICES PROVIDER: A qualified physician, licensed psychologist, licensed special psychologist, or a licensed mental health practitioner. A mental health practitioner may also be a licensed professional counselor or a licensed clinical social worker who is duly certified/licensed for such practice by state law. It also includes, for purposes of this contract, auxiliary providers supervised, and billed for, by a professional as permitted by state law. All mental health services must be provided under appropriate supervision and consultation requirements as set forth by state law.

Licensed Psychologist: Psychologist shall mean a person licensed to engage in the practice of psychology in this or another jurisdiction. The terms certified, registered, chartered, or any other term chosen by a jurisdiction to authorize the autonomous practice of psychology shall be considered equivalent terms.

Licensed Special Psychologist: A person who has a doctoral degree in psychology from an institution of higher education accredited by the American Psychological Association but who is not certified in clinical psychology. Such person shall be issued a special License to practice psychology that continues to require supervision by a licensed psychologist or qualified physician for any practice that involves major mental and emotional disorders. This psychologist may provide mental health services without supervision.

Licensed Mental Health Practitioner: A person licensed to provide treatment, assessment, psychotherapy, counseling, or equivalent activities to individuals, families or groups for behavioral, cognitive, social, mental, or emotional disorders, including interpersonal or personal situations. Mental health practice shall include the initial assessment of organic mental or emotional disorders (as defined by state law), for the purpose of referral to, or consultation with a qualified physician or a licensed psychologist. Mental health practice shall not include the practice of psychology or medicine, prescribing drugs or electroconvulsive therapy, treating physical disease, injury, or deformity, diagnosing major mental illness or disorder except in consultation with a qualified physician or a licensed psychologist, measuring personality or intelligence for the purpose of diagnosis or treatment planning, using psychotherapy with individuals suspected of having major mental or emotional disorders except in consultation with a qualified physician or licensed psychologist, or using psychotherapy to treat the concomitants of organic illness except in consultation with a qualified physician or licensed psychologist.

MENTAL ILLNESS: A pathological state of mind producing clinically significant psychological or physiological symptoms (distress) together with impairment in one or more major areas of functioning (disability) wherein improvement can reasonably be anticipated with therapy, and which is a condition listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM IV).

NONCOVERED PERSON: A person for whom benefits are not available under the Contract.

NONCOVERED SERVICES: Services which are not payable under the Contract.

ON-SITE OR HOST PLAN: A Blue Cross and/or a Blue Shield Plan in another Blue Cross and Blue Shield Association Service Area, which administers claims through the BlueCard Program for Nebraska Covered Persons residing or traveling in that service area.

OUT-OF-NETWORK ALLOWANCE: An amount used by Blue Cross and Blue Shield of Nebraska to calculate the payment for Covered Services to an Out-of-network Provider. This amount will be based on the Contracted Amount for Nebraska providers or an amount determined by the On-site Plan for out-of-area Providers.

OUT-OF-NETWORK PROVIDER: A provider of health care Services who has not contracted with Blue Cross and Blue Shield of Nebraska to provide Services as a part of a Preferred network in Nebraska.

OUTPATIENT: A person who is not admitted for Inpatient care, but is treated in the Outpatient department or emergency room of a Hospital, an observation room, in an Ambulatory Surgical Facility, an Urgent Care Facility, or a Physician's office, or at home.

OUTPATIENT PROGRAM: An organized set of resources and services for a substance abusive or mentally ill population, administered by a certified provider, which is directed toward the accomplishment of a designed set of objectives. Day treatment, partial care and outpatient programs which provide primary treatment for mental illness or substance abuse must be provided in a facility which is licensed by the Department of Health and Human Services Regulation and Licensure and whose program is certified by the Division of Alcoholism, Drug Abuse and Addiction Services (or equivalent state agency) or accredited by JCAHO or CARF.

This definition does not include programs of co-dependency, family intervention, employee assistance, probation, prevention, educational or self-help programs, or programs which treat obesity, gambling, or nicotine addiction. It also does not include residential services for mental illness, or halfway house or methadone maintenance programs for substance abuse. Benefits will not be provided for programs ordered by the court which are not medically necessary as determined by Blue Cross and Blue Shield of Nebraska.

PARTICIPATING PROVIDER: A licensed practitioner of the healing arts, or qualified provider of health care services, who has contracted with Blue Cross and Blue Shield of Nebraska, under its traditional program, or who is a participating provider in the BlueCard Program network.

PHYSICAL REHABILITATION: The restoration of a person who was totally disabled as the result of an injury or an acute physical impairment to a level of function which allows that person to live as independently as possible. A person is totally disabled when such person has physical disabilities and needs active assistance to perform the normal activities of daily living, such as eating, dressing, personal hygiene, ambulation and changing body position.

PHYSICIAN: Any person holding an unrestricted license and duly authorized to practice medicine and surgery and prescribe drugs.

PREAUTHORIZATION: Preauthorization of benefits is prior written approval of benefits for certain services such as organ transplants, cardiac and pulmonary rehabilitation, subsequent purchases of home medical equipment, and home health and hospice care. This Preauthorization is based on the information submitted to Blue Cross and Blue Shield of Nebraska the terms of this Contract. It may be effective for a limited period of time.

PREFERRED PROVIDER: A health care provider (hospital, physician or other health care provider) who has contracted to provide services as a part of the network in Nebraska, or if in another state, who is a Preferred Provider with the BlueCard Program PPO network.

PREFERRED PROVIDER ORGANIZATION: A panel of hospitals, physicians and other health care providers who belong to a network of Preferred Providers, which agrees to more effectively manage health care costs.

PREGNANCY: Includes obstetrics, threatened abortions, miscarriages, premature deliveries, ectopic pregnancies, or other conditions or complications caused by pregnancy. A complication caused by pregnancy is a condition that occurs prior to the end of the pregnancy, distinct from the pregnancy, but caused or adversely affected by it. Postpartum depression and similar diagnoses are not considered complications of pregnancy.

PRIMARY CARE PHYSICIAN: A Physician who has a majority of his or her practice in the field of internal or general medicine, obstetrics/gynecology, general pediatrics or family practice.

RESIDENTIAL TREATMENT PROGRAM: Services or a program organized and staffed to provide both general and specialized nonhospital-based interdisciplinary services 24 hours a day, seven days a week for persons with behavioral health disorders. Residential treatment may be provided in freestanding, nonhospital-based facilities or in units of larger entities such as a wing of a hospital. Residential Treatment Programs may include nonhospital substance abuse treatment centers, intermediate care facilities, psychiatric treatment centers or other nonmedical settings.

SCHEDULE OF BENEFITS: A summarized personal document which provides information about deductibles, percentages payable, special benefits, maximums and limitations of coverage. It also indicates the type of membership unit selected.

SCIENTIFICALLY VALIDATED: A technology, a drug, biological product, device, diagnostic, treatment or procedure is scientifically validated if it meets all of the factors set forth below:

- Technologies, drugs, biological products, devices and diagnostics must have final

approval from the appropriate government regulatory bodies. A drug or biological product must have final approval from the Food and Drug Administration (FDA). A device must have final approval from FDA for those specific indications and methods of use that is being evaluated. FDA or other governmental approval is only one of the factors necessary to determine Scientific Validity.

- The Scientific Evidence must permit conclusions concerning the effect of the technology on health outcomes. The evidence should consist of well-designed and well-conducted investigations published in peer-reviewed journals. The quality of the body of studies and the consistency of the results are considered in evaluating the evidence.

  The evidence should demonstrate that the technology can measure or alter the physiological changes related to a disease, injury, illness or condition. In addition there should be evidence based on established medical facts that such measurement or alteration improves the health outcomes.

  Opinions and evaluations by national medical associations, consensus panels or other technology evaluation bodies are evaluated according to the scientific quality of the supporting evidence and rationale. Our evidence includes, but is not limited to: Blue Cross and Blue Shield Association Technology Evaluation Center technology evaluations; Hayes Directory of New Medical Technologies' Status; Health Care Financing Administration (HCFA) Technology Assessments and United States Food and Drug Administration (FDA) approvals.

- The technology must improve the net health outcome.

- The technology must improve the net health outcome as much as or more than established alternatives.

- The improvement must be attainable outside the investigational settings.

Blue Cross and Blue Shield of Nebraska will determine whether a technology is Scientifically Validated.

SERVICES: Hospital, medical or surgical procedures, treatments, drugs, supplies, home medical equipment, or other health, mental health or dental care, including any single service or combination of such services.

SINGLE MEMBERSHIP: Membership option providing benefits for Covered Services provided to the subscriber only.

SINGLE PARENT MEMBERSHIP: Membership option providing benefits for Covered Services provided to the subscriber and his or her eligible dependent children, but not to a spouse.

SKILLED NURSING CARE: Medically Necessary Skilled Nursing Services for the treatment of an illness or injury which must be ordered by a Physician, and performed under the supervision of a registered nurse (R.N.) or a Licensed practical nurse (L.P.N.). The classification of a particular nursing Service as skilled is based on the technical or professional health training required to effectively perform the Service.

SUBSCRIBER: An eligible individual who enrolls for health coverage and is named on an identification card issued pursuant to this Contract, and who is an Employee hired by the Group Employer, or a retiree qualified to receive benefits as defined in the Master Group Application.

SUBSCRIBER-SPOUSE MEMBERSHIP: Membership option providing benefits for Covered Services provided to the subscriber and his or her spouse.

SUBSTANCE DEPENDENCE AND ABUSE: For purposes of this Contract, this term is limited to alcoholism and drug abuse. The term does not include tobacco dependence or addiction, unless otherwise included in an attached endorsement.

TREATING PHYSICIAN: A physician who has personally evaluated the patient. This may include a physician or oral surgeon, a certified nurse midwife, a certified nurse practitioner or certified physician's assistant, within the practitioner's scope of practice, when supervised and billed for, by a physician.

URGENT CARE: Medical care or treatment for which the application of time periods for making non-urgent care determinations: a) could seriously jeopardize the life or health of the Covered Person or his or her ability to regain maximum function; or b) would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

URGENT CARE FACILITY: A facility, other than a Hospital, that provides covered health Services that are required to prevent serious deterioration of the person's health, and that are required as a result of an unforeseen Illness, Injury or the onset of acute or severe symptoms.

Claims Administration by

BlueCross BlueShield of Nebraska

An Independent Licensee of the Blue Cross and Blue Shield Association.

nebraskablue.com