A Guide to Your Health Benefits

University of Nebraska

$450 Deductible

Basic Option

UNIVERSITY OF Nebraska

98-507 1/2017

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.

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IMPORTANT TELEPHONE NUMBERS

Member Services
Omaha and Toll-free 1-888-592-8963
TTY/TTD (for the hearing impaired) 402-390-1888

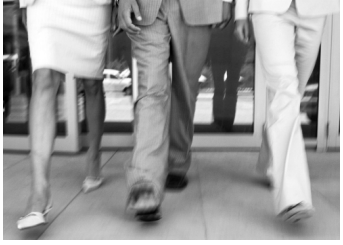
Coordination of Benefits
Omaha 402-390-1840
Toll-free 1-800-462-2924

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

Workers' Compensation
Omaha 402-398-3615
Toll-free 1-800-821-4786

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

BlueCard Provider Information
Toll-free 1-800-810-BLUE (2583)
Website . . . . . www.bcbs.com



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INTRODUCTION

Welcome

This document is your Certificate of Coverage (COC). It has been written to provide an easy way to obtain information about your Group health plan.

Please note that the information provided in this COC is only a summary and it is not intended to be a complete description of every detail of the Plan. Your Group health care plan is administered in accordance with the provisions set forth in the Master Group Contract and the Administrative Services Agreement between the Group and Blue Cross and Blue Shield of Nebraska (BCBSNE), an independent licensee of the Blue Cross and Blue Shield Association.

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

How To Use This Document

For your convenience, defined terms are capitalized throughout this document. For an explanation of a defined term, refer to the Section titled "Definitions."

Please take some time to read this document and become familiar with it. We especially encourage you and your Eligible Dependents to review the benefit limitations by reading the Schedule of Benefits Summary and the Section titled "Benefit Descriptions." As you read this COC you will find that many of the sections of the document are related to other sections of the document. You may not have all the information you need by reading just one section. If, after reading this COC you have a question about your coverage or Claim, please contact the BCBSNE Member Services Department.

About Your I.D. Card

BCBSNE will issue you an identification card (I.D. card). Your I.D. number is a unique alpha numeric combination.

Present your I.D. card to your health care provider when you receive Services. With your BCBSNE 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 the BCBSNE Member Services Department.

What's A 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.

We also provide a Schedule of Benefits Summary. For additional information which may be unique to your coverage, please refer to the Section of this document titled "Schedule of Benefits Summary."

Your Rights And Responsibilities As A Blue Cross And Blue Shield Of Nebraska Member

You have the right to:

- Be treated with respect and dignity.
- Privacy of your personal health information that we maintain, following state and federal laws.
- Receive information about the benefits, limitations and exclusions of your health plan, including how to access our network of hospitals, physicians and other health care providers.
- Work with your doctor and other health care professionals about decisions regarding your treatment.
- Discuss all of your treatment options, regardless of cost or benefits coverage.
- Make a complaint or file an appeal about your health plan, any care you receive or any benefit determination your health plan makes.
- Make recommendations to us about this rights and responsibility policy.
- Give us suggestions about how we can better serve you and other members.

You have the responsibility to:

- Read and be familiar with your health plan coverage information and what your plan covers and doesn't cover, or ask for help if you need it.
- If your plan has different In-network and Out-of-network benefits, understand how your choice of an In-network or Out-of-network Provider will impact what you pay out of your own pocket, or ask for help if you need it.
- Give us all the information we need to process your claims and provide you with the benefits you're entitled to under your plan.
- Give all health care providers the information they need to appropriately treat you.
- Advise us of any changes that affect you or your family, such as birth, marriage/divorce or change of address.

About The Plan

This Group health plan is a Preferred Provider Organization (PPO) health benefit plan. Claims administration is provided by Blue Cross and Blue Shield of Nebraska (BCBSNE).

NEtwork BLUE is a PPO (In-network) Provider network established by BCBSNE 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 (Host Blue Plans) have also contracted with health care providers in their geographic areas who are referred to as "Preferred Providers."

Use of the network is voluntary, but you should be aware that when you choose to use providers who do not participate in the local plan's network for non-emergency situations, you can expect to pay more than your applicable Coinsurance, Copayment and/or Deductible amounts. After this health plan pays its required portion of the bill, Out-of-network Providers may bill you for any amount not paid. This balance billing does not happen when you use In-network or Preferred Providers because these providers have agreed to accept a discounted payment for Services with no additional billing to you other than your applicable Coinsurance, Copayment and Deductible amounts. In-network Providers will also file claims for you.

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. card 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.

For help in locating a Preferred Provider in another Blue Cross and/or Blue Shield Service Area, including providers outside 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.

Using Your Benefits Wisely

BCBSNE wants 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.

How The Network Works

Using In-network Providers:

- Present I.D. card and pay Copayment (when applicable)
- Receive highest level of benefit
- Provider files claims for you
- Provider accepts insurance payment as payment in full (except Deductible, Copayment and/or Coinsurance amounts)
- No balance billing

Using Out-of-network Providers:

- You may be required to pay full cost at time of Service
- You may be reimbursed at a lower benefit level
- You may have to file claims
- You're responsible for amounts that exceed the Allowable Charge

Remember, if more than one Physician is involved in your care, it is important for you to check the status of each provider.

Exception

If you receive initial Inpatient or Outpatient care for an Emergency Medical Condition at an Out-of-network Hospital or by an Out-of-network Provider, benefits for Covered Services for the initial care will be provided at the In-network benefit level. Benefits for Inpatient Covered Services will continue to be paid at the In-network level, as long as they are for an Emergency Medical Condition.

To continue to receive the In-network level of benefits after the initial care has been provided, you must use an In-network Provider. In addition, any Covered Services provided by an Out-of-network Urgent Care Physician and/or other Out-of-network professional Provider will be paid at the In-network level when the corresponding facility charges are paid subject to the In-network benefit level.

NOTE: You will still be responsible for amounts in excess of the Allowable Charge when you receive Services from an Out-of-network Provider.

Be Informed

Out-of-network Providers' charges may be higher than the benefit amount allowed by this health plan. You may contact BCBSNE Member Services Department concerning allowable benefit amounts in Nebraska for specific procedures. 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.

Out-Of-Area Services

BCBSNE has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. These relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross and Blue Shield Association ("Association"). Whenever you access health care services outside the geographic area BCBSNE serves, the claim for those services may be processed through one of these Inter-Plan Arrangements.

When you access care outside BCBSNE's service area, you will receive it from one of two kinds of providers. Most providers ("participating providers") contract with the local Blue Cross and Blue Shield Licensee in that geographic area ("Host Blue"). Some providers ("non-participating providers") don't contract with the Host Blue. We explain below how we pay both kinds of providers.

Inter-Plan Arrangements Eligibility - Claim Types — All claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for dental care benefits (except when paid as medical benefits), and any prescription drug programs or vision care benefits that may be administered by a third party contracted by BCBSNE to provide the specific services or services.

BlueCard® Program

Under the BlueCard® Program, when you receive Covered Services within the geographic area served by a Host Blue, BCBSNE will remain responsible for doing what we agreed to in our agreement with the Group. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating providers.
When you receive 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 charges for your Covered Services, or
- The negotiated price that the Host Blue makes available to BCBSNE.

Often, this "negotiated price" will consist of a simple discount which reflects an actual price that the Host Blue pays to your health care provider. Sometimes, it is an estimated price that takes into account special arrangements with your health care 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 health care providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price BCBSNE used for your claim because they will not be applied after a claim has already been paid.

Negotiated (non-BlueCard® Program) National Account Arrangements

With respect to one or more Host Blues, instead of using the BlueCard Program, BCBSNE may process your claims for Covered Services through Negotiated Arrangements for National Accounts.

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

If reference-based benefits, which are service-specific benefit dollar limits for specific procedures, based on a Host Blue's local market rates, are made available to you, you will be responsible for the amount that the health care provider bills above the specific reference benefit limit for the given procedure. For a participating provider, that amount will be the difference between the negotiated price and the reference benefit limit. For a non--participating provider, that amount will be the difference between the provider's billed charge and the reference benefit limit. Where a reference benefit limit is greater than either a negotiated price or a provider's billed charge, you will incur no liability, other than related patient cost-sharing under the Plan.

Special Cases – Value-Based Programs

- BlueCard Program: If you receive Covered Services under a Value-Based Program inside a Host Blue's service area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement except when a Host Blue passes these fees to BCBSNE through average pricing or fee schedule adjustments.
- Negotiated (non-BlueCard Program) Arrangements: If BCBSNE has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to your Group on your behalf, BCBSNE will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees noted above for the BlueCard Program.

Inter-Plan Programs – Federal/State Taxes/ Surcharges/Fees

Federal or state laws or regulations may require a surcharge, tax or other fee that applies to insured accounts. If applicable, BCBSNE will include any such surcharge, tax or fee as part of the claim charge passed on to you.

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 normally 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 provider bills and the payment BCBSNE will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

If you need emergency care, BCBSNE will cover you at the highest level that federal regulations allow. You will have to pay any Deductibles, Coinsurance, Copayments, charges for Noncovered Services, and any excess charge over the amount payable under the Contract.

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

BlueCard Worldwide

If you are outside the United States, (hereinafter "BlueCard service area"), you may be able to take advantage of BCBS Worldwide Coverage when accessing Covered Services. The BCBS Worldwide Coverage is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the BCBS Worldwide Coverage assists you with accessing a network of inpatient, outpatient and professional providers, the network is not served by Host Blue. As such, when you receive care from providers outside the BlueCard service area, you will typically have to pay the providers and submit the claims yourself to obtain reimbursement for these services. If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, you should call the BCBS Worldwide Coverage Service Center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

Inpatient Services: In most cases, if you contact the BlueCard Worldwide Coverage Service Center for assistance, hospitals will not require you to pay for covered inpatient services, except for your cost-share amounts. In such cases, the hospital will submit your claim to the Service Center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for Covered Services. You must contact BCBSNE to obtain certification for non-emergency inpatient services.

Outpatient Services: Physicians, urgent care centers and other outpatient providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for Covered Services.

Submitting a BlueCard Worldwide Coverage Claim: When you pay for Covered Services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a BlueCard Worldwide Coverage claim form and send the claim form with the provider's itemized bill(s) to the BCBS BlueCard Worldwide Coverage Service Center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from BCBSNE, the BlueCard Worldwide Coverage Service Center or online at www.bluecardworldwide.com. If you need assistance with your claim submission, you should call the BCBS BlueCard Worldwide Coverage Service Center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week.

How The Plan Components Work

Your Deductible, Copayment, Coinsurance and Coinsurance Limit are shown on your Schedule of Benefits Summary. The following is an explanation of each of those components.

Allowable Charge — An amount BCBSNE uses to calculate the payment of 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.

Coinsurance — This is the percentage you must pay for Covered Services, after the Deductible is applied.

Copayment (Copay) — A fixed dollar amount payable by the Covered Person for a Covered Service.

Deductible* — You are responsible for your annual expenses until you reach the Plan's Deductible. After the Deductible is met, benefits for the rest of that calendar year will not be subject to any further Deductible. The amount applied to the Deductible for Covered Services by either In-network or Out-of-network Providers will be credited to both In-network and Out-of-network Deductibles.

Copays and charges for Non-covered Services or amounts in excess of the Allowable Charge do not count toward your Deductible.

Out-of-pocket Limit* — The maximum amount of cost-sharing each Covered Person or Membership Unit must pay in a calendar year.

The following charges do not count toward your Out-of-pocket Limit:

- amounts in excess of the Allowable Charge;
- charges for noncovered Services; and
- penalties for failure to comply with Certification requirements.

*****_If you have a family or multiple party membership, your plan has an Embedded Deductible and/or Out-of-pocket Limit. Your Schedule of Benefits Summary will indicate whether your plan has an Aggregate or an Embedded amount._

Embedded Deductible and/or Out-of-pocket Limit means no one family member contributes more than the individual amount. Family members may combine their covered expenses to satisfy the family Deductible and Out-of-pocket amounts.

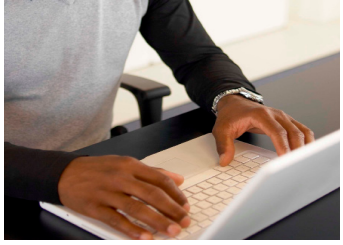
Utilization Review — Benefits are available under this Group health plan for **Medically Necessary** and **Scientifically Validated** Services. Services provided by all health care providers are subject to utilization review by BCBSNE. Services will not automatically be considered Medically Necessary because they have been ordered or provided by a Physician. BCBSNE will determine whether Services provided are Medically Necessary under the terms of the plan, and benefits available.

Certification Requirements — Prior Certification is required for all Inpatient Hospital admissions, as well as certain surgical procedures, and specialized Services and supplies. In-network Hospitals will notify BCBSNE of an Inpatient admission. However, when you are admitted as an Inpatient to an Out-of-network Hospital, or to a Hospital outside the state of Nebraska, it is your responsibility to see that BCBSNE is notified of your admission. For more information, please refer to the section of this book titled "Certification Requirements."

Expansion of Benefits —The scope of benefits may be expanded on a concurrent/prospective basis as determined by BCBSNE, to include payment for specific Services which would not ordinarily be included as Covered Services. It must appear that the use of such Services will: 1) equal or reduce costs; 2) improve the quality of medical care; and 3) be medically more appropriate than an alternate Covered Service. BCBSNE will advise the Covered Person and the provider in writing to what extent payment will be allowed for such Services. Any such expansion of the scope of benefits does not constitute an amendment to the Plan, or provide a continuing right to receive such Services.

Continuity of Care — In the event a Covered Person is receiving an active course of treatment for certain types of care from an In-network Provider on the date that BCBSNE's contracting agreement with that provider is terminated, the provider will continue to render Covered Services to the Covered Person, and the contracting agreement shall continue to apply to those Covered Services after the termination takes effect, for a defined period of time. The types of care that qualify and the length of time that the contracting agreement shall continue to apply are stated in the BCBSNE Provider Policies and Procedures Manual. The terms of the Provider Policies and Procedures Manual may be updated by BCBSNE from time to time.

For more definitions, please refer to the section of this book titled "Definitions."



SCHEDULE OF BENEFITS SUMMARY

Section 2

Payment for Services	In-network Provider	Out-of-network Provider
Covered Services are reimbursed based on the Allowable Charge. Blue Cross and Blue Shield of Nebraska In-network Providers have agreed to accept the benefit payment as payment in full, not including Deductible, Coinsurance and/or Copayment amounts and any charges for non-covered services, which are the Covered Person's responsibility. That means In-network providers, under the terms of their contract with Blue Cross and Blue Shield, can't bill for amounts over the Contracted Amount. Out-of-network Providers can bill for amounts over the Out-of-network Allowance.		
Deductible (the amount the Covered Person pays each Calendar Year for Covered Services before the Coinsurance is payable) • Individual • Family (Embedded*)	 $450 $900	 $650 $1,300
Coinsurance (the percentage amount the Covered Person must pay for most Covered Services after the Deductible has been met) • Covered Person Pays	 30%	 45%
Coinsurance Limit: (the maximum Coinsurance the Covered Person must pay each Calendar Year (this amount does not include the Deductible). • Individual • Family	 $1,600 $3,200	 $2,000 $4,000
Out-of-pocket Limit (combination of the deductible and coinsurance amounts only; does not include any copayments or amounts not covered by the plan) • Individual • Family	 $2,050 $4,100	 $2,650 $5,300
Once the annual Out-of-pocket Limit is reached, most Covered Services are payable by the plan at 100% for the rest of the Calendar Year.		
In-network and Out-of-network Deductible and Out-of-pocket Limits cross accumulate. All other limits (days, visits, sessions, dollar amounts, etc.) do cross accumulate between In-network and Out-of-network, unless noted differently.		
*Embedded – If you have single coverage, you only need to satisfy the individual Deductible and Out-of-pocket Limit amounts. If you have family coverage, no one family member contributes more than the individual amount. Family members may combine their covered expenses to satisfy the required family Deductible and Out-of-pocket amounts.		

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

- This plan has no medical Copays

Out-of-pocket Limit includes:

- Deductible
- Coinsurance

Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Physician Office • Primary Care Physician Office Visit and other Covered Services • Other Injections	Deductible and Coinsurance Deductible and Coinsurance	Deductible and Coinsurance Deductible and Coinsurance
Telehealth Services (by a designated Provider)	Deductible and Coinsurance	Not Covered
Convenient Care/Retail Clinics (Quick Care)	Deductible and Coinsurance	Deductible and Coinsurance
Urgent Care Facility Services	Deductible and Coinsurance	Deductible and Coinsurance
Emergency Care Services (services received in a Hospital emergency room setting) • Facility • Professional Services	 Deductible and Coinsurance Deductible and Coinsurance	 In-network level of benefits In-network level of benefits
Outpatient Hospital or Facility Services Services such as surgery, laboratory and radiology, cardiac and pulmonary rehabilitation, observation stays, and other services provided on an outpatient basis	Deductible and Coinsurance	Deductible and Coinsurance
Inpatient Hospital or Facility Services Charges for room and board, diagnostic testing, rehabilitation and other ancillary services provided on an inpatient basis	Deductible and Coinsurance	Deductible and Coinsurance

Preventive services	In-network Provider	Out-of-network Provider
Preventive Services (Regular Benefits) • Under age 2 Services include periodic exams, office visits, radiology, x-rays, pathology and laboratory	Plan Pays 100% up to $500 per person per Calendar Year, then applicable Deductible and Coinsurance	
• Age 2 and above Services include physical exams, pap smears, hearing examinations, radiology, laboratory testing, cardiac stress tests and immunizations for age 7 and older	Plan Pays 100% up to $250 per person per Calendar Year, then applicable Deductible and Coinsurance	
Preventive Services (Enhanced Benefits) • Under age 2 Services include periodic exams, office visits, radiology, x-rays, pathology and laboratory	Plan Pays 100% up to $600 per person per Calendar Year, then applicable Deductible and Coinsurance	
• Age 2 and above Services include physical exams, pap smears, hearing examinations, radiology, laboratory testing, cardiac stress tests and immunizations for age 7 and older	Plan Pays 100% up to $300 per person per Calendar Year, then applicable Deductible and Coinsurance	
Immunizations up to age 7	Plan Pays 100%	Plan Pays 100%
Colonoscopy and related Services (Enhanced Benefits) (limited to one every 10 years for Covered Persons age 50 and above)	Plan Pays 100%	Deductible and Coinsurance
NOTE: Covered Services for colonoscopies in excess of one every 10 years by either an In-network or Out-of-network provider will be subject to the applicable Deductible and Coinsurance.		
Mammograms including technical and professional interpretation fees		
• Preventive	See Preventive Services	See Preventive Services
• Diagnostic	Deductible and Coinsurance	Deductible and Coinsurance

Mental Illness and/or Substance Dependence and Abuse covered services	In-network Provider	Out-of-network Provider
Inpatient Services	Deductible and Coinsurance	Deductible and Coinsurance
Outpatient Services		
• Office Services	Deductible and Coinsurance	Deductible and Coinsurance
• Telehealth Services (by a designated Provider)	Deductible and Coinsurance	Not Covered
• All Other Outpatient Items & Services	Deductible and Coinsurance	Deductible and Coinsurance
Emergency Care Services (services received in a Hospital emergency room setting)		
• Facility	Deductible and Coinsurance	In-network level of benefits
• Professional Services	Deductible and Coinsurance	In-network level of benefits

Other Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Acupuncture	Not Covered	Not Covered
Advanced Diagnostic Imaging (CT, MRI, MRA, MRS, PET & SPECT scans and other Nuclear Medicine)	Deductible and Coinsurance	Deductible and Coinsurance
Allergy Injections and Serum	Deductible and Coinsurance	Deductible and Coinsurance
Ambulance (to the nearest facility for appropriate care) • Ground Ambulance • Air Ambulance	Deductible and Coinsurance Deductible and Coinsurance	In-network level of benefits Deductible and Coinsurance (In-network level of benefits if due to an emergency)
Autism spectrum disorders (for Covered Persons up to 21 years of age)	See Mental Illness Services	See Mental Illness Services
Biofeedback	Deductible and Coinsurance	Deductible and Coinsurance
Bone Anchored Hearing Aids (BAHA) and Cochlear implants	Deductible and Coinsurance	Deductible and Coinsurance
Dermatological Services	Deductible and Coinsurance	Deductible and Coinsurance
Diabetic Services Services include education, self-management training, podiatric appliances and equipment.	Deductible and Coinsurance	Deductible and Coinsurance
Durable Medical Equipment and Supplies (including Prosthetics) (rental or purchase, whichever is least costly; rental shall not exceed the cost of purchasing)	Deductible and Coinsurance	Deductible and Coinsurance
Eye Glasses or Contact Lenses	Not Covered	Not Covered

Other Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Hearing Aids	Not Covered	Not Covered
Home Health Care Home Health Aide and Nursing Care	Deductible and Coinsurance	Deductible and Coinsurance
Home Infusion Therapy	Deductible and Coinsurance	Deductible and Coinsurance
Hospice Services	Deductible	Deductible
Independent Laboratory • Diagnostic • Preventive	Deductible and Coinsurance Same as Preventive Services	Deductible and Coinsurance Same as Preventive Services
Infertility • Services to diagnose • Treatment to promote fertility	Deductible and Coinsurance Not Covered	Deductible and Coinsurance Not Covered
Nicotine Addiction • Medical services and therapy • Nicotine addiction classes & alternative therapy, such as acupuncture	Not Covered Not Covered	Not Covered Not Covered
Obesity • Non-surgical treatment • Surgical Treatment	Not Covered Not Covered	Not Covered Not Covered
Oral Surgery and Dentistry Services such as incision and drainage of abscesses and excision of tumors and cysts. Dental treatment when due to an accidental injury to naturally healthy teeth (treatment related to accidents must be provided within 6 months of the date of injury).	Deductible and Coinsurance	Deductible and Coinsurance
Organ and Tissue Transplantation • Transplant procedures • Transportation of Covered Person (to and from transplant site)	Deductible and Coinsurance Deductible and Coinsurance Reasonable cost of land or commercial air transportation as determined by BCBSNE	Deductible and Coinsurance Deductible and Coinsurance
Orthotics (prescription only)	Deductible and Coinsurance	Deductible and Coinsurance
Ostomy Supplies	Deductible and Coinsurance	Deductible and Coinsurance
Other Injections	Deductible and Coinsurance	Deductible and Coinsurance

Other Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Physician Professional Services Inpatient and Outpatient services, such as, surgery, surgical assistant, anesthesia, inpatient hospital visits and other non-surgical services	Deductible and Coinsurance	Deductible and Coinsurance
Pregnancy, Maternity and Newborn Care • Pregnancy and maternity (Payment for prenatal and postnatal care is included in the payment for the delivery)	Deductible and Coinsurance	Deductible and Coinsurance
• Newborn care - Initial newborn facility - Physician	Coinsurance Deductible and Coinsurance	Coinsurance Deductible and Coinsurance
NOTE: Newborns are covered at birth, subject to the plan's enrollment provisions.		
• Breastfeeding Services		
- Breast pump and supplies (limited to one per pregnancy)	Plan Pays 100%	
- Lactation support and counseling	Plan Pays 100% Out-of-network Providers can bill for amounts over the Out-of-network Allowance.	
Radiation Therapy and Chemotherapy	Deductible and Coinsurance	Deductible and Coinsurance
Radiology (x-ray) Services and other Diagnostic Test	Deductible and Coinsurance	Deductible and Coinsurance
Rehabilitation Services – Inpatient Facility (must follow within 90 days of discharge from acute hospitalization)	Deductible and Coinsurance	Deductible and Coinsurance
Rehabilitation Services • Cardiac rehabilitation (limited to 18 sessions per Calendar Year during the preceding 12 months of certain cardiac diagnosis) • Pulmonary Rehabilitation (is limited to 36 sessions per diagnosis for certain diagnoses under the following circumstances:	Deductible and Coinsurance	Deductible and Coinsurance
- chronic lung disease	Deductible and Coinsurance	Deductible and Coinsurance
- lung transplant during the preceding four months,	Deductible and Coinsurance	Deductible and Coinsurance
- heart-lung transplant during the preceding four	Deductible and Coinsurance	Deductible and Coinsurance
- preoperative and postoperative care for lung reduction volume surgery	Deductible and Coinsurance	Deductible and Coinsurance
Renal Dialysis, excluding counseling and training	Deductible and Coinsurance	Deductible and Coinsurance
Respiratory Care	Deductible and Coinsurance	Deductible and Coinsurance

Other Covered Services – Illness or Injury	In-network Provider	Out-of-network Provider
Sexual Dysfunction	Not Covered	Not Covered
Skilled Nursing Facility (limited to 30 days per Calendar Year)	Deductible	Deductible
Sleep Studies	Deductible and Coinsurance	Deductible and Coinsurance
Surgical Sterilization	Not Covered	Not Covered
Temporomandibular and Craniomandibular Joint Disorder	Not Covered	Not Covered
Therapy & Manipulations • Physical, occupational or speech therapy services, chiropractic or osteopathic physiotherapy and chiropractic or osteopathic manipulative treatments or adjustments (combined limit to 60 sessions per Calendar Year)	Deductible and Coinsurance	Deductible and Coinsurance
Vision Exams • Diagnostic (to diagnose an illness) • Preventive (routine exam including refraction)	Deductible and Coinsurance Not Covered	Deductible and Coinsurance Not Covered
Wigs	Not Covered	Not Covered
All Other Covered Services	Deductible and Coinsurance	Deductible and Coinsurance

Certification Process

BCBSNE requires that all Hospital stays, certain surgical procedures, and specialized Services and supplies be Certified prior to receipt of such Services or supplies. Ultimately, it is your responsibility to see that Certification occurs; however, a Hospital or Provider may initiate the Certification.

When BCBSNE receives a request for Certification, the appropriateness of the setting and the level of medical care as well as the timing and duration of the admission is assessed by BCBSNE (or by persons designated by BCBSNE).

To initiate the Certification process, BCBSNE must be contacted by you, your family member, the Physician, the Hospital or someone acting on behalf of you or your family member. Notification of the intended receipt of Services may be made by telephone or in writing. We may require that the Certification include written documentation from the attending Physician, dentist or other medical provider demonstrating the Medical Necessity of the procedure or Service and the location where the Service will be provided.

In the case of an ongoing Inpatient admission, the care should continue to be Certified in order to assure that it is being provided in the most appropriate setting.

Please remember that Certification does not guarantee payment. All other Group plan provisions apply. For example: Copayments, Deductibles, Coinsurance, eligibility and exclusions.

Benefits Requiring Certification

The following Services, supplies or drugs must be Certified:

- Durable Medical Equipment (subsequent purchases);
- Home Health Care;
- Hospice Care;
- Inpatient Hospital admissions;
- Inpatient Physical Rehabilitation;
- Long Term Acute Care;
- organ and tissue transplants;
- pulmonary rehabilitation;
- Services specifically stated elsewhere in this booklet;
- Skilled nursing facility care; and
- Surgical and other preauthorization programs as defined by BCBSNE.

NOTE: *For additional information on surgical procedures, specialized Services and supplies requiring Certification, you may call BCBSNE using the number on your I.D. card or refer to the Important Telephone Numbers in the front of this book. A list of Services subject to Certification or preauthorization may be obtained at www.nebraskablue.com. Certification and preauthorization requirements are subject to change.*

Certification Exceptions

Maternity

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 otherwise agreed to by the Covered Person and her Physician. Certification is not required for an initial maternity admission. However, Certification is required if the hospitalization extends beyond these times.

Emergencies

BCBSNE must be notified of an admission for an Emergency Medical Condition within 48 hours of the admission or the next business day. If Certification is not received, the 24-hour period prior to the time of admission and the 48-hour period after such admission will be reviewed to determine if the Covered Person's condition and treatment would have hindered his or her ability to provide notice.

NOTE: *Admission through the emergency room does not necessarily constitute an emergency admission.*

Avoid Weekend Admissions

Ask your Physician to avoid nonemergency weekend admissions as most Hospitals do not perform surgical or other nonemergency procedures on weekends. Benefits may be denied if this kind of admission is not Medically Necessary.

Unanticipated Costs

Failure to comply with the Certification requirements may result in unanticipated costs associated with the incurred expenses.

Certain surgical or other preauthorization programs may require that benefit approval be obtained prior to the Service being provided, with failure to do so resulting in a denial of benefits for the Service.

If Services are not properly Certified and benefits are reduced or denied, you are responsible for paying any amount due. However if the Hospital, Inpatient facility or Physician is an In-network Provider with BCBSNE, they are liable for their Services which are determined by BCBSNE to be not Medically Necessary (or for denial due to failure to Certify/preauthorize if required), unless 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 Certification determination. Any reductions made are not considered when computing your Deductible or your Out-of-pocket Limit.

This section provides a general overview of covered health care Services. Your Schedule of Benefits Summary shows your actual benefits.

What's Covered

The following list includes examples of the Services that are covered when Medically Necessary care is provided by an Approved Provider:

- *Advanced diagnostic imaging;*
- *Allergy testing, serum and injections;*
- *Ambulance Services;*
- *Anesthesia;*
- *Assistant surgeon* benefits for surgical procedures specifically identified by BCBSNE;
- *Autism spectrum disorders, for individuals up to age 21* (see Additional Information in this section):
- *Blood, blood plasma, blood derivatives or blood fractionates, including administration and processing,* unless donated and for which there is not a charge;
- *Cardiac rehabilitation* when in an accredited program and approved by BCBSNE;
- *Chemotherapy***,** except as excluded (or not identified as covered) for or related to transplant procedures;
- *Chiropractic care* (subject to scope of practice regulations)*;*
- *Circumcision;*
- *Cochlear implants and bone anchored hearing aids (BAHA);*
- *Colorectal cancer screening and related Services;*
- *Dialysis;*
- *Diabetic education* including self-management training and patient management*;*
- *Durable Medical Equipment (DME) rental or initial purchase (whichever costs less) of certain items of DME and supplies,* when prescribed by a Physician and determined by BCBSNE to be Medically Necessary. (See Durable Medical Equipment included in this section for additional information);
- *Emergency care;*
- *Home health aide Services* when ordered by a Physician and are part of a treatment plan developed by the home health agency and approved by BCBSNE (additional information about Home Health Aide Services is included in this section);
- *Hospice Services* when Certified by BCBSNE and provided primarily in the patient's home by a Medicare-Certified Hospice (additional information about Hospice Services can be found in this section);
- *Hospital Services* such as nursing care, drugs, medicines, therapies, x-rays (radiology) and laboratory (pathology) tests;
- *Immunizations;*
- *Inpatient Physician care;*
- *Inpatient Physical Rehabilitation* when the provider is accredited for comprehensive inpatient rehabilitation;
- *Mammography;*
- *Manipulative treatment or adjustments;*
- *Maternity care*, including services by a certified nurse midwife (see Maternity Care included in this section for additional information);
- *Mental Illness care on an Inpatient, Outpatient and Emergency Care basis*;
- *Newborn care,* (additional information about newborn care is included in this section);
- *Nursing Services* in the home (see Skilled Nursing Care included in this section for additional information);
- *Occupational therapy*;
- *Oral surgery and dental treatment* (see Oral Surgery and Dentistry included later in this section for more information);
- *Orthotics*, including their fitting;
- *Osteopathic care;*
- *Outpatient (ambulatory) surgery;*
- *Outpatient x-ray, radiology, laboratory and pathology charges*;
- *Oxygen;*
- *Pacemakers;*
- *Pap smears*;
- *Physical therapy;*
- *Physician visits;*
- *Podiatric appliances necessary for the prevention of complications associated with diabetes;*
- *Preadmission testing;*
- *Preventive/routine Services* (see Preventive/Routine Services including in this section for additional information);
- *Prosthetic appliances;*
- *Pulmonary rehabilitation* when in an accredited program and when approved by BCBSNE;
- *Radiation therapy,* except as excluded (or not identified as covered) for or related to transplant procedures;
- *Renal dialysis*, including all charges for covered home dialysis equipment and covered disposable supplies;
- *Respiratory care;*
- *Room and board*, including cardiac care and intensive care room for an Inpatient stay;
- *Sleep studies;*
- *Speech therapy;*
- *Substance Dependence and Abuse Treatment;*
- *Surgical care* (the Allowable Charge may include reductions for procedures involving multiple Physicians or multiple or bilateral surgical procedures);
- *Surgical dressings;*

- *telehealth services;*
- *Transplants* (for more information about Organ and Tissue Transplants see the additional information found in this section);
- *Urgent Care Facility Services.*

ADDITIONAL INFORMATION ON COVERED SERVICES

This section provides general information with regard to Covered Services. If your benefits differ from what is described in this section, those differences will be described on your Schedule of Benefits Summary and/or at the end of this section, or the amendment at the back of this book.

Ambulance Services

Benefits are available, subject to the Copay, Deductible and/or Coinsurance amounts outlined in the Schedule of Benefits Summary, when ambulance services are provided to a Covered Person for:

- transportation to the nearest facility for appropriate care for an Emergency Medical Condition;
- transportation from a facility where emergent care was obtained or from an Inpatient acute care facility to the nearest facility where appropriate care can be provided, whether it is a lesser or greater level of specific care. Benefits are also available for transporting the Covered Person who is bedridden, to a facility for treatment or to his or her place of residence;
- transporting a respirator-dependent person; and
- transportation to and from the nearest appropriate facility for testing and/or procedures that are not available at the present facility.

Autism Spectrum Disorders

Benefits are available for Covered Services for the screening, diagnosis and treatment of autism spectrum disorders for Covered Persons up to age 21 which may include behavioral health treatment such as applied behavior analysis. Benefits are subject to the applicable Copay, Deductible and/or Coinsurance amounts for other Mental Illness Services. Autism Spectrum Disorder Services must be Certified.

Definitions

The following definitions apply to autism spectrum disorders.

Applied behavior analysis: the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior.

Autism spectrum disorder: any of the pervasive developmental disorders or autism spectrum disorder as defined by the most recent Diagnostic and Statistical Manual of Mental Disorders. Behavior analyst: a Certified provider, which may include a Board Certified Behavior analyst approved by the Behavioral Analyst Certification Board, as defined in BCBSNE's medical policy.

Behavioral health treatment: counseling and treatment programs, including applied behavior analysis that are: necessary to develop, maintain, or restore to the maximum extent practicable, the functioning of an individual; and provided or supervised by a behavior analyst certified by a national certifying organization or a Licensed Psychologist if the Services performed are within the boundaries of the psychologist's competency.

Treatment: evidence-based care, including related equipment, that is prescribed or ordered for an individual diagnosed with an autism spectrum disorder by a Licensed Physician or a Licensed Psychologist, within the scope of his or her practice, including:

- behavioral health treatment;
- pharmacy care;
- psychiatric care;
- psychological care; and
- therapeutic care.

NOTE: Except in the case of Inpatient Services, BCBSNE reserves the right to request a review of treatment of autism spectrum disorders once every six months, unless the Covered Person's Licensed Physician or Licensed Psychologist agrees to more frequent reviews.

Durable Medical Equipment (DME)

Benefits are available for rental or initial purchase (whichever costs less) of covered DME. Benefits for rental of DME shall not exceed the cost of purchasing the equipment unless otherwise approved by BCBSNE. In addition, benefits will be available for subsequent purchases of covered DME when: there is a significant change in the Covered Person's condition; the Covered Person grows; 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 earlier if preauthorized by BCBSNE); or as otherwise determined to be reasonable and necessary. In addition, limited benefits may be available for repair, adjustment and maintenance of covered DME as determined appropriate by BCBSNE.

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 BCBSNE.

Emergency Care

When you receive care in the emergency room, benefits will be provided subject to the applicable Copay, Deductible and/or Coinsurance shown on your Schedule of Benefits Summary. If you receive care at an Out-of-network Hospital emergency room or by an Out-of-network Provider, benefits for Covered Services may be provided at the In-network benefit level. You will still be responsible for amounts in excess of the Allowable Charge when you receive services from an Out-of-network Provider.

If Emergency Care results in a Covered Person being admitted to the Hospital, BCBSNE must be notified of the admission in accordance with the Certification requirements for emergencies. (Please refer to the section of this book titled "Certification Requirements.")

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.

Home Health Aide, Nursing Care And Hospice

Unless otherwise stated in this document or an amendment to this document, benefits are available subject to the Copay, Deductible and/or Coinsurance and benefit limits outlined in the Schedule of Benefits Summary for the following Medically Necessary home health aide, Nursing Care, physical, occupational or speech therapy Services and Hospice Services provided to a Covered Person.

Home Health Aide

Benefits are available for Medically Necessary Physician ordered home health aide Services provided in the home by a licensed or Medicare-Certified home health agency. Covered Services include:

- bathing;
- feeding; and
- household cleaning duties.

Benefits are only available for personal care Services when they are related to active and specific medical, surgical or psychiatric treatment and when such Services are part of the treatment of the Covered Person and require the skills of a registered nurse.

Nursing Care

Nursing care must be Physician ordered and medically necessary.

Benefits will not be provided for:

- nursing care which is primarily for the convenience of the patient or the patient's family;
- time spent bathing, feeding, transporting, exercising or moving the patient, giving oral medication or acting as a companion, sitter, or homemaker;
- care provided by a nurse who is an immediate relative by blood, marriage or adoption, or a member of the Covered Person's household; and
- care provided in a Hospital, a skilled nursing facility, intermediate care facility, or a sub-acute care or rehabilitation facility.

Physical, Occupational or Speech Therapy Services

Therapy Services when provided in the home, by a Licensed therapist, in accord with a Home Health Care treatment plan.

Hospice Services

Hospice is a program of care provided for a person diagnosed as terminally ill and his/her family. The Covered Person 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.

The following Services are covered under a Hospice care program:

- Home health aide Services;
- Hospice nursing Services provided in the home;
- Inpatient Hospice care;
- Respite care, which is short-term Inpatient care necessary in order to give temporary relief to the person who regularly assists with the care at home;
- Medical social Services, provided by a medical social worker employed by the Hospice, which are directly related to the Covered Person's medical condition;
- Crisis care, which is extended skilled nursing care for up to 24 hours per day in lieu of a Medically Necessary Inpatient hospitalization.

Remember To Certify

Home health care and hospice care must be Certified by BCBSNE. Please refer to the section of the book titled "Certification Requirements" for more details.

Maternity and Newborn Care

Maternity Care

Maternity benefits are available to you, a covered spouse or an Eligible Dependent daughter. Please contact your Human Resource Department for additional eligibility information.

Benefits for covered Hospital, surgical and medical care related to Pregnancy are subject to the Deductible, Coinsurance and/or Copay amounts outlined in the Schedule of Benefits Summary. This includes all related Services for prenatal care, postnatal care, delivery, and complications of Pregnancy or interruptions of Pregnancy.

In addition, benefits are available for obstetrical care provided by and within the scope of practice of a certified nurse midwife.

Postpartum depression, psychosis or any other Mental Illness are not considered complications of Pregnancy under this part. Benefits for this type of condition are provided in the same manner as all other Mental Illness Services.

Newborn Care

Benefits are available at birth for Covered Services for an eligible newborn infant. Your Schedule of Benefits Summary shows the applicable Copay, Deductible and/or Coinsurance amounts. Covered Services include:

- room and board, including any ancillary Services;
- screening tests, including the initial newborn hearing exam;
- Physician 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.

For information on adding a newborn to your coverage, please refer to the section titled "Eligibility and Enrollment."

Statement of Rights Under The Newborns' and Mothers' Health Protection Act

Under federal law, benefits may not 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.

Also, under federal law, a plan may not set the level of benefits or out-of-pocket costs so that any later portion of the 48 hour (or 96 hour) stay is treated in a manner less favorable than any earlier portion of the stay. 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).

Mental Illness, Substance Dependence And Abuse Benefits

Benefits are payable for covered Hospital and Physician Services, including mental health Services, psychological or alcoholism and drug counseling Services 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

Benefits for covered Inpatient Services are subject to the applicable Copay, Deductible and/or Coinsurance, as indicated on your Schedule of Benefits Summary.

A person shall be considered to be receiving Inpatient treatment if he or she is confined to a Hospital or a Substance Dependence and Abuse treatment center that provides medical management including 24-hour nursing care. Services provided by a facility that does not meet this 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).

Remember To Certify

Inpatient Services for Mental Illness or Substance Dependence and Abuse must be Certified by BCBSNE. Please refer to the section of the book titled "Certification Requirements" for more details.

Residential Treatment Services
Benefits are available for Covered Services and room and board provided as part of a Residential Treatment Program, for treatment of Mental Illness and Substance Dependence and Abuse.

The Residential Treatment Program and/or facility must be Licensed, accredited or Certified to provide such Services by the appropriate state agency, or accredited by CARF or JCAHO.

Benefits are available subject to Certification and BCBSNE Medical Necessity criteria.

In addition to the EXCLUSIONS stated in this document, benefits are not available for:

- Services that are not Medically Necessary, including:
  - treatment not necessarily directed toward alleviation or prevention of an acute condition, and
  - expected to be of long duration without any reasonably predictable date of termination;
- education, socialization, delinquency or Custodial Care;
- stress reduction classes and pastoral counseling;
- foster homes, halfway houses, group homes and treatment group homes;
- Inpatient confinement for environmental change or similar treatment;
- support therapies, including personal counseling, cruises, wilderness programs, adventure therapy, residential therapeutic camps, and bright light therapy; and
- autism spectrum disorders or pervasive developmental conditions, developmental delays or sensory integration disorders, unless otherwise required by law or as specifically covered under the Plan.

Outpatient Care
Benefits are available, subject to the applicable Copay, Deductible and/or Coinsurance amount indicated on your Schedule of Benefits Summary for Outpatient treatment of Mental Illness and Substance Dependence and Abuse.

A person who is not admitted for Inpatient care, but is receiving treatment in the Outpatient department of a Hospital, in an observation room, in an Ambulatory Surgical Facility, Urgent Care Facility, a Physician's office, or home shall be considered to be receiving Outpatient Care.

Outpatient Covered Services include:

- individual, family or group therapy provided by an Approved Provider;
- office visit or clinic visit, Consultation, or emergency room visit;
- an evaluation and assessment;
- medication checks;
- a Certified Alcoholism and Drug treatment program provided by a facility that offers all-inclusive services for each Outpatient treatment day;
- biofeedback training for treatment of Mental Illness;
- ambulance services provided for the treatment of Mental Illness and Substance Dependence and Abuse;
- laboratory and diagnostic Services; and
- 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 Joint commission on Accreditation of Healthcare Organizations (JCAHO) or the Commission on the Accreditation of Rehabilitation Facilities (CARF).

Emergency Care
Benefits are also available, subject to the applicable Emergency Care Copay, Deductible and/or Coinsurance indicated in your Schedule of Benefits Summary, for any Covered Services provided in a Hospital emergency room setting for the treatment of Mental Illness and Substance Dependence and Abuse.

Oral Surgery and Dentistry

Limited benefits are available for oral surgery and dentistry. Benefits for Covered Services are available subject to any benefit maximums and the Copay, Deductible and/or Coinsurance as indicated on your Schedule of Benefits Summary.

Oral Surgery and Dentistry Services
Unless otherwise stated in this document, an amendment to this document, or your Schedule of Benefits Summary, the Plan provides benefits for the following Medically Necessary Services:

- Evaluation and treatment of impacted teeth;
- Incision and drainage of abscesses, and other non-surgical treatment of infections *(excluding periodontic or endodontic treatment of infections)*;
- Excision of exostoses, tumors and cysts, *not related to the temporomandibular joint of the jaw (TMJ)*;
- Invasive surgical procedures of the jaw;
- Bone grafts to the jaw, including preparation of the mouth for dentures;
- Osteotomies, for treatment of a gross congenital abnormality of the jaw that cannot be treated solely by orthodontic treatment or appliances;

- Services, supplies or appliances for dental treatment of natural healthy teeth required as the direct result of an accidental injury*. *Benefits are limited to treatment provided within 6 months of the injury*;
- Evaluation and treatment of myofascial pain;
- Medically Necessary hospitalization and general anesthesia in order for the Covered Person to safely receive dental care, including Covered Persons who are under eight years of age or developmentally disabled.

**Please note*, damage to teeth that occurs as a result of eating, chewing or biting is not considered an "accident." Benefits are not available for Services resulting from these types of injuries.

Dental Related Hospital Charges
Benefits are also available for the following charges if determined by BCBSNE to be Medically Necessary when related to Covered Services for oral surgery and dentistry or when the Services are essential to safeguard the health of the patient who has a specific nondental physical and/or organic impairment, regardless of whether the admission is for covered or noncovered dental procedures:

- Hospital Inpatient Services;
- Hospital Outpatient Services; or
- Ambulatory facility Services.

Organ and Tissue 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;
- heart-lung;
- heart valve (heterograft);
- kidney;
- kidney-pancreas;
- pancreas;
- bone graft;
- cornea;
- parathyroid;
- small intestine;
- small intestine and liver;
- small intestine and multiple viscera; or
- bone marrow transplants, including autologous and allogeneic stem cell transplants, for lymphomas, leukemia including CLL, and metastatic renal cell carcinoma.

The applicable Copay, Deductible and/or Coinsurance are indicated on your Schedule of Benefits Summary.

Remember To Certify
All transplants must be Certified by BCBSNE prior to the procedure being performed. Please refer to the section of the book titled "Certification Requirements" for more details.

Donation of Organs and Tissue
Benefits are available for Services arising from an organ donation from either a live or non-living donor, including acquisition costs, when the recipient is a Covered Person. Benefits are included as part of the recipient's coverage, and are covered for the duration of the Covered Person's coverage under the Plan. Benefits for donation include Covered Services for treatment of complications resulting from the organ/tissue donation. Covered Services include:

- Hospital, medical, surgical or other Covered Services;
- Services provided for the evaluation of organs or tissue;
- Services provided for the removal of organs or tissue from nonliving donors; and
- Services provided for the transportation and storage of donated human organs or tissues.

Exclusions and Limitations
Benefits will not be provided for:

- donor charges other than those identified as covered under "Donations of Organ and Tissue;"
- purchase of organs or tissue, that are sold rather than donated to the recipient; or
- transplantation of any nonhuman organ or tissue, or the implantation of an artificial/mechanical organ into a human recipient. This does not apply to pacemakers, LVADs, or other devices specifically approved by BCBSNE.

Outpatient Hospital Or Facility Services

Benefits are available, subject to the Copay, Deductible and/or Coinsurance and benefit limits shown in your Schedule of Benefits Summary for covered Outpatient Services provided by a Hospital, Ambulatory Surgical Facility, Urgent Care Facility or other Outpatient facility.

Outpatient Rehabilitation Services

Cardiac or Pulmonary Rehabilitation is defined as the use of various modalities of treatment to improve cardiac or pulmonary function as well as tissue perfusion and oxygenation through which selected patients are restored to and maintained at either a pre-illness level of activity or a new and appropriate level of adjustment.

Covered Outpatient Cardiac or Pulmonary Rehabilitation
The following Services are covered when provided as part of a rehabilitation program:

- Initial rehabilitation evaluation;
- Exercise sessions;
- Concurrent monitoring during the exercise session for high risk patients; and
- Physician services which are otherwise defined as Covered Services.

Cardiac Rehabilitation Criteria
The patient must have one of the following diagnoses occurring during the preceding twelve months:

- An acute myocardial infarction;
- Coronary artery angioplasty, with or without stent placement, or other Scientifically Validated procedure to clear blocked vessels;
- Heart surgery, or coronary artery surgery;
- Heart transplant;
- Heart-lung transplant; or
- Cardiac rehabilitation for treatment of congestive heart failure and stable angina initially and after significant changes in clinical status as determined by BCBSNE.

Cardiac Rehabilitation Limits
Benefits for Covered Services are subject to any limits indicated on your Schedule of Benefits Summary.

Pulmonary Rehabilitation Criteria
Benefits are available when Services are provided under one of the circumstances stated on the Schedule of Benefits Summary.

Pulmonary Rehabilitation Limits
Benefits for Covered Services are subject to any limits indicated on your Schedule of Benefits Summary.

Remember To Certify
Pulmonary Rehabilitation Services must be Certified by BCBSNE prior to the Services being provided. Please refer to the section of the book titled "Certification Requirements" for more details.

Physician Office

Benefits are available, subject to the applicable Copay, Deductible and/or Coinsurance shown in the Schedule of Benefits Summary, for Medically Necessary Covered Services provided in a Physician's office.

Covered Physician Office Visits
The office visit benefit provision of this plan includes:

- a Physician office visit;
- an initial visit to diagnose Pregnancy;
- Consultations;
- psychological therapy and/or Substance Dependence and Abuse counseling/rehabilitation; and
- medication checks.

Other Covered Office Services
Unless otherwise stated in this document or an amendment to this document, Services and supplies covered under the office services benefit provision of this plan include, but are not limited to:

- x-ray, laboratory and pathology services, including diagnostic pap smears and mammograms, performed in the Physician's office;
- supplies used to treat the patient during the office visit;
- drugs administered to the patient during the office visit;
- renal dialysis, except when billed under another provision of this plan;
- injections;
- infusion therapy;
- chemotherapy;
- radiation therapy and/or Advanced Diagnostic Imaging;
- hearing examination due to illness or injury performed in the office;
- surgical procedures and anesthesia, performed in the Physician office;
- vision examination, excluding eye refrations, due to illness or injury performed in the office; and
- allergy testing.

Non-Covered Under Office Service Benefit
Although these Services may be covered under other provisions, generally the office service benefit provision does not include:

- Preventive Services;
- Services for Pregnancy, except the initial office visit to diagnose Pregnancy;
- manipulations and adjustments;
- physical, occupational or speech therapy, including cognitive training, chiropractic or osteopathic physiotherapy;

- sleep studies;
- Durable Medical Equipment;
- biofeedback;
- psychological evaluations, assessments and testing; and
- Outpatient Services received at a place of service other than a Physician's office.

Telehealth Services

Physician's Services include telehealth Services as a delivery of care method, for the diagnosis and treatment of a Covered Person's medical condition. Telehealth Services means a web-based, video or telephonic visits, calls or consultations between a Covered Person and an Approved Provider.

An Approved Provider for telehealth Services is a Licensed Physician or other professional provider that has a written agreement with BCBSNE or its third party vendor, as a designated telehealth Services network provider. The delivery and scope of telehealth Services are subject to applicable state and federal laws and regulations.

Telehealth Services are not applicable to or available for:

- reporting lab or other test results;
- office appointment requests;
- communication primarily educational in nature;
- billing, insurance or payment questions;
- Certification procedures;
- Physician to Physician consultations;
- calls or consults by telemedicine, telephone or other electronic means to another health care provider during a Covered Person's visit in a provider's office;
- Services, treatment or conditions outside the scope of the agreement between BCBSNE and its designated third-party Telehealth Service vendor.

Telehealth Services are subject to the cost-sharing amounts shown on the Benefit Summary.

NOTE: If a Covered Person receives telehealth Services which may be covered under more than one health plan or contract, and identifies to the telehealth Services provider at the time of service that this Plan is to be used for coverage, this Plan will provide benefits as the primary coverage. When another health plan or contract is used or identified at the time of service, this Plan will become the secondary coverage pursuant to Coordination of Benefits. The Covered Person must submit a claim form and itemized statement and the other plan's Explanation of Benefits to BCBSNE reflecting the charges and cost-sharing amount paid pursuant to the other plan for benefit consideration under this Plan as the secondary coverage.

Preventive/Routine Services

Benefits will be provided for covered preventive/routine Services, subject to any applicable benefit maximums and Copay, Deductible and/or Coinsurance shown on your Schedule of Benefits Summary, when such Services are provided by either In-network Providers or Out-of-network Providers.

Therapy and Manipulations

The following outpatient and/or home therapies and manipulative treatments or adjustments are covered subject to the applicable Copay, Deductible and/or Coinsurance amounts and benefit maximums shown on your Schedule of Benefits Summary:

- Chiropractic or osteopathic manipulative treatments or adjustments by an Approved Provider;
- Chiropractic or osteopathic physiotherapy;
- Occupational therapy by a Licensed occupational therapist or Licensed occupational therapist assistant under the supervision and billing of a Licensed occupational therapist;
- Physical therapy by a Licensed physical therapist or Licensed physical therapist assistant who is an Approved Provider; and
- Speech therapy provided by a Licensed speech-language pathologist or registered communication assistant practicing under the supervision of a Licensed speech-language pathologist.

Therapy Services described iabove include habilitative Services, which are Services designed to help a person keep, learn or improve skills and functions of daily living.

NOTE: A benefit maximum may apply to all the above Services or any combination of these Services. Check your Schedule of Benefits Summary to determine how any applicable benefit maximum will be calculated.

A session is defined as one visit. Ongoing preventative/maintenance therapy sessions and ongoing preventative/maintenance treatments or adjustments are not covered once the maximum therapeutic benefit has been achieved for a given condition and continued therapy or continued treatments or adjustments no longer result in some functional or restorative improvement.

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.

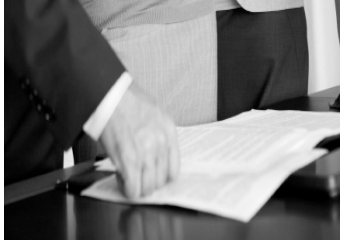
The law requires that certain coverage be provided, and that notice be given to Covered Persons regarding coverage for this care under the Group health plan. The Women's Health Act requires that:

A Group health plan which provides medical and surgical benefits for mastectomies shall also provide, in the case of a Covered Person 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 Copay, Deductible and Coinsurance amounts applicable to other benefits under the plan.



EXCLUSIONS—WHAT'S NOT COVERED

Section 5

Although this plan provides benefits for a wide variety of Services, there are some expenses that are not covered. This section gives you examples of some Services and supplies that are not covered by the plan.

Using Headings In This Section

To help you find specific exclusions more easily, we have provided headings for types of Services, treatments or supplies that fall into a similar category. The actual exclusion appears under the heading.

Plan Exclusions

Benefits are not available for the Services, treatments or supplies described in this section, even if:

- recommended or prescribed by a Physician; and/or
- it is the only treatment available for the Covered Person's condition.

The Services, treatments and supplies listed as exclusions in this section are not covered, except when specifically provided for under another section of this Certificate of Coverage; or by an amendment to this Certificate of Coverage.

A. Alternative Treatments

- Alternative therapies:
  - Massage therapy, including rolfing;
  - Acupuncture;
  - Aromatherapy;
  - Light therapy;
  - Naturopathy; and
  - Vax-D therapy (vertebral axial decompression).
- Chelation therapy, except in the treatment of acute arsenic, gold, mercury or lead poisoning.
- 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 the Covered Person.

B. Comfort Or Convenience

- Batteries and battery chargers unless the device is covered by BCBSNE;
- Beauty/barber service;
- Equipment for purifying, heating, cooling or otherwise treating air or water;
- Exercise Equipment;
- Guest meals;
- Hot tubs;
- Humidifiers;
- Jacuzzis;
- Medical alert systems;
- Music devices;
- Personal computers;
- Pillows;
- Radios;
- Safety equipment;
- Saunas;
- Strollers;
- Television;
- The building, remodeling or alteration of a residence;
- The purchasing or customizing of vans or other vehicles;
- Video players; and
- Whirlpools.

C. Dental

Except as specifically described as covered, benefits are not available for:

- dental care in connection with the treatment, filling, removal, repositioning or replacement of teeth, including orthodontics or implants;
- preparation of the mouth for dentures;
- root canal therapy or care;
- treatment of the dental occlusion by any means or for any reason;
- treatment of the temporomandibular joint of the jaw by any means or for any reason, except when specifically identified elsewhere as a Covered Service; and
- other procedures involving the teeth or structures directly related to or supporting the teeth, including the gums and the alveolar processes.

D. Durable Medical Equipment (DME) And Supplies

- Automated external defibrillator;
- Enuresis alarm, even if prescribed by a Physician;
- Mouth guard, even if prescribed by a Physician;
- Non-wearable external defibrillator;
- Rental or purchase from or use of DME while the patient is confined to a Hospital, skilled nursing facility, an intermediate care facility, a nursing home or any other licensed residential facility if such equipment is usually supplied by the facility;
- Repair, maintenance or adjustment of DME, except as specifically identified as covered, or provided by other than a DME or medical supply company; and
- Repair or replacement of an item of DME due to misuse, malicious damage, gross neglect or to replace lost or stolen items.

E. Experimental Or Investigative

- Services considered by BCBSNE to be Investigative, or for any directly related Services.
- Services for medical treatment and/or drugs, whether compensated or not, that are directly related to, or resulting from the Covered Person's participation in a voluntary, investigative test or research program or study, unless authorized by BCBSNE.

F. Foot Care

- Orthopedic shoes, except as provided for complications associated with diabetes; and
- Treatment or removal of corns, callosities, or the cutting or trimming of nails.

G. Mental Illness And Substance Dependency/Abuse

- Custodial care;
- Programs for co-dependency; employee assistance; probation; prevention; educational or self-help;
- Programs ordered by the Court that are determined by BCBSNE to be not medically necessary;
- Programs that treat obesity, gambling or nicotine addiction, except when specifically identified elsewhere as a Covered Service;
- Residential treatment programs, except as specifically covered under the Plan;
- Services by a non-approved provider;
- Services not within the scope of practice of the provider. (Licensing or certification is by the appropriate state authority. Supervision and consultation requirements are governed by the state law.); and
- Services, supplies, equipment, procedures, drugs or programs for treatment of nicotine addiction, except when identified elsewhere as a Covered Service.

H. Nutrition

- Dietary counseling, except diabetes management as provided by the plan;
- Enteral feedings, even if the sole source of nutrition; and
- Nutrition care, nutritional supplements, FDA-exempt infant formulas, supplies, electrolytes or other nutritional substances, including but not limited to neocate, Vivonex, Elecare, Cyclinex-1, ProPhree, vitamins, minerals, elements, foods of any kind (including high protein and low carbohydrate foods) and other over-the-counter nutritional substances.

I. Physical Appearance

- Cosmetic Services, or any complications thereof. Examples include:
  - Breast augmentation;
  - Breast reduction (unless Medically Necessary);
  - Breast replacement;
  - Dermabrasion;
  - Liposuction;
  - Protruding ears;
  - Spider veins;
  - Tattoo removal or revision; and
  - Telangiectasias.

NOTE: Benefits for treatment of complications of Cosmetic Services are only payable if such treatment is normally covered under the plan. In addition, benefits are available for Services that are normally covered under the plan if Services otherwise considered to be Cosmetic are required: as a direct result of a traumatic injury; to correct a Congenital Abnormality when the defect severely impairs or impedes normal essential functions; or to correct a scar or deformity resulting from cancer or from non-Cosmetic surgery.

- Treatment and monitoring for obesity or weight reduction, regardless of diagnosis. Examples include:
  - Health and athletic club memberships;
  - Physical conditioning programs such as athletic training, body-building exercise, fitness, flexibility and diversion or general motivation; and
  - Weight loss programs.
- Weight reduction surgery.

J. Providers

- Canceled appointment: Charges for failure to cancel a scheduled appointment.
- Claim forms/records/administrative fees: Charges made for filling out claim forms or furnishing any records or information; special charges such as dispensing fees; admission charges. Physician's charges for Hospital discharge Services; after-hour 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.
- Custodial care, domiciliary care, rest cures, or Services provided by personal care attendants.
- Immediate family: Charges for Services provided by a person who is a member of the Covered Person's immediate family by blood, marriage or adoption.

- Hospital/institution Services provided in or by:
  a) a Veterans Administration Hospital where the care is for a condition related to military service, or
  b) any non-Participating Hospital or other institution which is owned, operated or controlled by any federal government agency, except where care is provided to nonactive duty Covered Persons in medical facilities.
- Inadequate documentation: Charges received when there is inadequate documentation that a Service was provided.
- Non-approved facility: A health care facility that does not meet the licensing or Accreditation Standards required by BCBSNE.
- Non-approved provider: Charges for Services by a non-approved provider.
- Out-of-Hospital: Charges made while the patient is temporarily out of the Hospital.
- Overhead expenses: Charges for any office or facility overhead expenses including, but not limited to, staff charges, copying fees, facsimile fees and office supplies.
- Scope of practice: Charges for Services by a health care provider which are not within the scope of practice of such provider.
- Services provided by a massage therapist.
- Standby: Hospital or Physician charges for standby availability.

K. Reproductive Services

- Pregnancy assistance treatments, which include but are not limited to, infertility treatment and related Services, in addition to:
  - 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.
- Voluntary abortions, unless the attending physician certifies the abortion was necessary to safeguard the life of the woman or the unborn child's viability was threatened by continuation of the Pregnancy.

L. Services Payable Under Another Plan

- Services available at government expense, except as follows:
  If payment is required by state or federal law, the obligation to provide benefits will be reduced by the amount of payments the patient is eligible for under such program (except Medicaid).

  With respect to 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 patient is still actively at work or is an Eligible Dependent of a Subscriber who is actively at work and has elected this Plan as primary, or as otherwise provided by federal law. Services provided for renal dialysis and kidney transplant Services will also be provided pursuant to federal law.

- Services arising out of the course of employment, whether or not the patient fails to assert or waives his or her right to Workers' Compensation or Employers' Liability Law. This includes Services determined to be work-related under a Workers' Compensation law, or under a Workers' Compensation Managed Care Plan, but which are not payable because of noncompliance with such law or Plan. Any charges incurred as a result of or in the course of employment for an employer that is not legally required to carry Workers' Compensation coverage and that does not provide Workers' Compensation coverage will be covered.

M. Transplants

- Donor charges other than those identified as covered under "Organ and Tissue Transplants" in the section titled "Benefit Descriptions;"
- Purchased human organs or tissue;
- Implantation of an artificial/mechanical organ into a human recipient, excluding pacemakers, LVADs, or other devices when specifically approved by BCBSNE; and
- Transplantation of any nonhuman organ or tissue to a human recipient.

N. Travel

- Lodging or travel expenses incurred by the patient or the provider, even though directed by a Physician for the purpose of obtaining medical treatment, except covered ambulance Services or other expenses specifically identified as covered by the plan.

O. Vision And Hearing

- Eyeglasses or contact lenses, eye exercises, or visual training (orthoptics);
- Screening audiological tests (except as covered under Preventive Services); external and surgically implantable devices (except cochlear implants and bone anchored hearing aids as otherwise covered under this plan) and combination external/implantable devices to improve hearing, including audiant bone conductors or hearing aids and their fitting; and
- Screening eye examinations, including eye refractions;
- Surgical, laser or nonsurgical procedures or alterations of the refractive character of the eye including but not limited to correction of myopia, hyperopia or astigmatismm including radial deratomies. In addition, benefits are not available for:
  - Charges for related Services; and
  - Eyeglasses or contact lenses following the surgery.

P. Other Exclusions And Limitations

- Services not covered by the plan;
- Services which are determined by BCBSNE to be not Medically Necessary;
- Services, including related diagnostic testing, which are primarily:
  - recreational, such as music or art therapy;
  - educational;
  - work-hardening therapy; vocational training;
  - medical and nonmedical self-care;
  - self-help training;
- Sexual dysfunction;
- Surgical sterilization;
- Interest, sales or other taxes or surcharges on Covered Services, drugs, supplies or DME, other than those surcharges or assessments made directly upon employers or third party payers;
- Genetic treatment or engineering. Any service performed to alter or create changes in genetic structure;
- Genetic testing, unless scientifically validated by BCBSNE medical policy;
- Food antigens and/or sublingual therapy;
- Snoring, the reduction or elimination of, when that is the primary purpose of treatment;
- Calls or consults by telephone or other electronic means, video or internet transmissions, and telemedicine, except in conformance with BCBSNE policies and procedures;
- Blood, blood plasma or blood derivatives or fractionates, or Services by or for blood donors, except administrative and processing charges for blood used for a Covered Person furnished to a Hospital by the American Red Cross, county blood bank, or other organization that does not charge for blood;
- 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;
- Services provided to or for:
  - any dependent when coverage is provided by a Single Membership, except when benefits are specifically provided by the plan for a newborn or adopted child;
  - any person who does not qualify as an Eligible Dependent;
  - any Covered Person before his or her effective date of coverage, or after the effective date of cancellation or termination of coverage.
- Military service related illness or injury;
- Services for which there is no legal obligation to pay, including:
  - Services for which no charge would be made if coverage did not exist;
  - any charge above the charge that would have been made if no coverage existed; or
  - any service which is normally furnished without charge.
- Charges in excess of the Contracted Amount;
- Charges made separately for Services and/or procedures, supplies and materials when they are considered to be included within the charge for a total Service payable, or if the charge is payable to another provider;

  EXCEPTION: If such charges are made separately when they are considered to be included within the charge for a total Service performed by a BCBSNE In-network Provider, then this amount is not the patient's liability.

- Employer required Services as a condition of employment including, but not limited to immunizations, blood testing, work physicals and drug tests;
- Services incurred while a Covered Person is incarcerated;
- Charges made pursuant to a Covered Person's engagement in an illegal occupation or commission of or attempt to commit a felony;

- Electron beam computed tomography for vascular screening, including but not limited to screening for cardiovascular, cerebrovascular and peripheral vascular disease;
- Private Duty Nursing;
- Respite care when not covered as part of a covered Hospice benefit;
- Home health aide, skilled nursing care or Hospice related Services as follows:
  - Services performed by volunteers;
  - pastoral Services, or legal or financial counseling Services;
  - Services primarily for the convenience of the Covered Person, or a person other than the Covered Person;
  - home delivered meals;
  - maintenance therapy for nonhospice related home health aide Services;
- Shipping and handling charges;
- Places of Service as follows, excluding Covered Services provided at a health fair approved by BCBSNE:
  - day care;
  - school;
  - library;
  - church; or
  - employee worksite.
- Otherwise Covered Services when:
  - required solely for purposes of camp, travel, career, employment, insurance, marriage or adoption;
  - related to judicial or administrative proceedings or orders;
  - conducted for the purpose of medical research; or
  - required to obtain or maintain a license of any type.
- Foreign language and sign language Services;
- Driving tests or exams;
- Autopsies;
- Obsolete Services, including any related Services;
- Preventive Services, except as specifically identified as covered under this plan;
- Renal dialysis counseling or training;
- Spinal manipulations and adjustments, except as specifically identified as covered under this plan;
- long-term rehabilitation therapy, including residential Cognitive Training programs;
- Daycare; and
- Prescription medications, including but not limited to drugs requiring a prescription, insulin, diabetic supplies, over-the-counter drugs (including non-prescription vitamins); and CaremarkConnect Specialty Drugs, except when administered in an Inpatient or Outpatient setting and otherwise covered under another provision of this plan.

Who's Eligible

You are eligible for coverage through your employment with the University of Nebraska. Coverage will be effective the first of the month following the date of hire, provided that employee enrolls for coverage within 31 days.

If an otherwise eligible employee is not actively at work on the effective date of coverage for other than personal health reasons, his or her coverage will not be effective until the first of the month following his/her return to work, subject to receipt of an enrollment form within 31 days of the employee's return to work date.

NOTE: *If two eligible Employees are married to each other, the Employee 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.*

A Subscriber's or Adult Designee's Eligible Dependent child who is also employed at the University of Nebraska in a benefits-eligible position may be covered as a dependent on his or her parent's medical plan provided through the University, or enroll as an Employee in her or her own right, but not both.

Please contact your Human Resource Department for additional information regarding eligibility requirements.

Initial Enrollment

Subscribers and dependents must enroll within 31 days of their initial eligibility or late enrollment provisions may apply.

Special Enrollment

A 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 coverage at the time it was previously offered, and who have lost that other coverage due to:
  - exhaustion of COBRA continuation coverage; or
  - a loss of eligibility, including loss due to death, divorce, legal separation, 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 (when the other coverage was not COBRA); or
  - 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
  - the employer ceasing to make contribution for the other coverage (when the other coverage was not COBRA).

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 a Subscriber or dependent who does not timely enroll, or does not enroll for coverage within the first period in which he or she is eligible to enroll. Late enrollment is only allowed during an open enrollment period. A person who enrolls for coverage during a "special enrollment period" is not considered a "late enrollee".

Open Enrollment

Eligible persons who did not enroll for coverage during the initial enrollment period or special enrollment period ("late enrollee"), may do so during the annual open enrollment period. Coverage for a late enrollee will be effective January 1st following the open enrollment. For additional information on open enrollment, please contact your Human Resource Department.

Adding A Dependent

Dependents cannot enroll unless you, the eligible employee, are covered under the Plan. In order to add a dependent, he or she must meet the definition of an Eligible Dependent.

Effective Date of Coverage

Provided that an appropriate membership option is in place and, if applicable, any additional premium is paid, the effective date of coverage will be as follows:

Marriage: The first day of the month following receipt of the enrollment form, or the date the University advises BCBSNE to make coverage effective.

Newborn Children: Coverage will be provided from the date of birth for a child who meets the definition of an Eligible Dependent provided that the University is notified of the birth of the child and any enrollment procedures required by the Group are met. To continue coverage beyond 31 days, the Employee must contact the Campus Benefits Office within 31 days of the date of birth to add the newborn child to his or her medical insurance. The Employee must complete and deliver to the Campus Benefits Office a Dependent Information Request Form (obtained from the University) in order to add the newborn to the medical insurance policy even if the Employee is currently covered on a membership option that provides coverage for dependents. If the newborn child is added within 31 days, 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 add the child at a later date, the child will be considered a late enrollee.

For additional information on adding newborn children, including any requirements that are specific to the University, please contact your Human Resource Department.

Adopted Children: Coverage will be provided from the earlier of the date the child is placed for adoption or the date a court order grants custody to the adoptive parents provided that the Employee notifies the University and any enrollment procedures required by the University are met. (In order to avoid claim delays, the University must be notified of the adoption within 31 days of placement)

NOTE: *When adding a dependent, you must be enrolled under a membership option that provides coverage for your dependents. For an explanation of the membership options, please see the section of this book titled "Definitions".*

If your spouse was not enrolled under your membership at the time of the child's birth or 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 of the child's birth or the date the child is place for adoption. The applicable premium for a Family Membership must be paid for the entire month.

If your Adult Designee qualifies as your spouse under the law of another state or jurisdiction, he or she may enroll for coverage during the 31 day period following the date of birth of a newborn child or the date the child is placed for adoption in the event the Adult Designee was not enrolled under your membership at the time of the child's birth or at the time of the adoption.

Qualified Medical Child Support Orders (QMCSO)

A 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 receive plan information, 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 Age 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, coverage under the Group plan will be terminated.

Family Medical Leave Act (FMLA)

The Family Medical Leave Act of 1993, as amended, requires that subject to certain limitations, most employers of 50 or more persons must offer continued coverage to eligible employees and their covered dependents, while the employee is on an approved FMLA leave of absence. In addition, an employee who has terminated his/her Group health coverage while on an approved FMLA leave is entitled to reenroll for Group health coverage upon return to work. Please check with your employer for details regarding your eligibility under FMLA.

If You Receive Covered Services From An In-network Provider

Contracting Providers and many other Hospitals and Physicians will file the Claim to BCBSNE on your behalf. Out-of-state Contracting Providers will file a Claim with their local Blue Cross and Blue Shield plan for processing through the BlueCard Program. When we receive a Claim from a Contracting Provider, payment will be made directly to the provider, unless otherwise provided under state or federal law. Even when you use a Contracting Provider, you are responsible for meeting any applicable Deductible and paying any applicable Copay and/or Coinsurance amounts. You may be asked to pay amounts that are your liability at the time of service, or the provider may bill you for those amounts.

Filing A Claim

You must file your own Claim if your health care provider is not a Contracting Provider and does not file for you. You can obtain a Claim form by contacting BCBSNE's Member Services Department, or you can find a form on the website: www.nebraskablue.com.

All submitted Claims must include:

- correct BCBSNE 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;
- prescription number, if applicable;
- the name and identification number of other insurance, including Medicare; and
- the primary plan's explanation of benefits (EOB), 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 by a Provider or a Covered Person within 90 days after the date of Service. If a Nebraska Contracting Provider does not file a claim within 90 days, the Claim will be the Provider's liability. If a claim for a non-Contracting Provider is not filed within 90 days, benefits will be denied; if the claim is not filed by the Covered Person within 15 months of the date of Service (except in the absence of legal capacity), benefits will not be allowed. All claims for Services by non-Contracting Providers that are filed beyond the claim filing time are the Covered Person's responsiblity.

In Nebraska, Claim forms should be sent 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 BCBSNE's Member Services Department.

Payment Of Benefits For Non-Contracting Provider Claims

Payment will be made, at BCBSNE's option, to the Covered Person, to his or her estate, to the provider, or as required by state or federal law. Benefits may also be paid to an alternate recipient or custodial parent, if pursuant to a QMCSO.

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 BCBSNE, unless otherwise provided by state or federal law.

Payment For Services That Are The Covered Person's Responsibility

Under certain circumstances, if BCBSNE pays the provider amounts that are your responsibility, such as Copays, Deductibles, or Coinsurance, we may collect such amounts from you. You agree that BCBSNE has the right to collect such amounts from you.

Claim Determinations

A "Claim" may be classified as a "Preservice" or "Postservice."

Preservice Claims - In some cases, under the terms of the health plan, the Covered Person is required to certify benefits in advance of a Service being provided, or benefits for the Service may be reduced or denied. This required request for a benefit is a "Preservice Claim." Preservice Claim determinations that are not Urgent Care Claims will be made with 15 calendar days of receipt, unless an extension is needed to obtain necessary information. If an extension is needed, BCBSNE will provide the Covered Person and/or his or her provider with notice prior to the expiration of the initial 15-day period. If additional information is requested, the Covered Person or his or her provider may be given up to 45 calendar days from receipt of notice to submit the specified information. A Claim determination will be made within 15 days of receipt of the information, or the end of the extension period.

(See the section of this book titled "Certification Requirements" for more information on certifying benefits.)

Urgent Care - If your Preservice Claim is one for Urgent Care, the determination will be made within 72 hours of receipt of the Claim, unless further information is needed. If additional information is necessary, 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.

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 the 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 Preservice and Postservice Claims.

Postservice Claims - A Postservice Claim is any Claim that is not a Preservice Claim. In most cases, a Postservice Claim is a request for benefits or reimbursement of expenses for medical care that has been provided to a Covered Person. The instructions for filing a Postservice Claim are outlined earlier in this section. Upon receipt of a completed Claim form, a Postservice Claim will be processed within 30 days, unless additional information is needed. If additional information is requested, the Covered Person may be given not less than 45 days to submit the necessary information. A Claim determination will be made within 15 days of receipt of the information, or the expiration of the 45-day extension period. You will receive an EOB when a Claim is processed which explains the manner in which your Claim was handled.

Explanation Of Benefits

Every time a Claim is processed for you, an Explanation of Benefits (EOB) form will be sent. The front page of the EOB provides you with a summary of the 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/or Coinsurance that you have accumulated to date; and
- other general messages.

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

Also included on your EOB is information regarding your right to appeal a benefit determination, or request additional information.

Save your EOBs in the event that you need them for other insurance or for tax purposes.

APPEAL PROCEDURES

Section 8

BCBSNE has the discretionary authority to determine eligibility for benefits under the health Plan, and to construe and interpret the terms of the Plan, consistent with the terms of the master group contract.

You have the right to seek and obtain a review of "adverse benefit determinations" arising under this health Plan.

Appeal Procedure Definitions

Adverse Benefit Determination: A determination by BCBSNE or its Utilization Review designee, of the denial, reduction, or termination of a benefit, or a failure to provide or make payment (in whole or in part) of a benefit. This includes any such determination that is based on:

- the application of Utilization Review;
- a determination that the Service is Investigative;
- a determination that the Service is not Medically Necessary or appropriate;
- an individual's eligibility for coverage or to participate in a plan.

An Adverse Benefit Determination also includes any rescission of coverage, which is defined as a cancellation or discontinuance of coverage that has a retroactive effect, except if for failure to timely pay required premiums or contribution for coverage.

Final Internal Adverse Benefit Determination: An Adverse Benefit Determination that has been upheld by BCBSNE, or its Utilization Review designee, at the completion of the internal appeal process as described in this document.

Preservice Claim(s): Any Claim for a benefit under the Plan with respect to which the terms of the Contract require approval of the benefit in advance of obtaining medical care, and failure to do so will cause benefits to be denied or reduced.

Postservice Claim(s): Any Claim that is not a Preservice Claim.

Urgent Care Claim: A Claim for medical care or treatment for which the application of the time periods for making non-urgent care determinations:

- could seriously jeopardize the life or health of the Covered Person or the ability of the Covered Person to regain maximum function; or
- 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.

How To Appeal An Adverse Benefit Determination

A Covered Person or a person acting on his/her behalf (the "claimant") is entitled to an opportunity to appeal initial or final Adverse Benefit Determinations.

Internal Appeal

A request for an internal appeal must be submitted within 6 months of the date the Claim was processed, or Adverse Benefit Determination was made. The written request for an appeal should state that it is a request for an appeal and, if possible, include a copy of the Explanation of Benefits (EOB). The appeal should also include:

- the name of the person submitting the appeal and his/her relationship to the patient;
- the reason for the appeal;
- any information that might help resolve the issue; and
- the date of service/Claim.

The written appeal should be sent to:

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

We will provide the claimant notice of receipt of the request within 3 days. The notice will include the name, address and telephone number of a person to contact regarding coordination of the review. The claimant does not have the right to attend the appeal review, but may submit additional information for consideration.

Preservice or Postservice Claim Appeal: A written notice of the appeal determination will be provided to the claimant as follows:

- Preservice Claims (other than Urgent Care), within 15 calendar days after receipt.
- Postservice Claims involving an Adverse Benefit Determination based on Medical Necessity, Investigative determination or utilization review, within 15 calendar days after receipt.
- All other Post Service Claims, within 15 calendar days after receipt, unless additional time is needed and written notice is provided to the claimant on or before the 15th day, in which case the decision will be provided within 30 calendar days after receipt.

The decision made pursuant to this appeal will be considered a Final Adverse Benefit Detemination.

Expedited Appeal: When the appeal is related to an Urgent Care Claim, an expedited appeal may be requested. In the case of an expedited appeal, the request may be submitted in writing or orally. All information, including the decision, will be submitted by the most expeditious method available. BCBSNE will make an expedited review decision within 72 hours after the appeal is requested. Written notification of the decision will be sent within the 72-hour period.

Concurrent Care denials must be appealed within 24 hours of the denial. A Concurrent Care denial will be handled as an expedited appeal. If the appeal is requested within the 24-hour time period, coverage will continue for health care services pending notification of the review decision.

NOTE: When an adverse appeal determination involves medical judgment, upon receipt of a written request, the identity of the health care professionals who reviewed the appeal will be provided to the claimant.

Rights To Documentation

You have the right to have access to, and request copies of, the documentation relevant to the Claim and Adverse Benefit Determination(s), including any new evidence or rationale considered or relied upon in connection with the Claim on review. In addition, supporting material or additional comments, may be submitted by the claimant for consideration during the appeal process.

External Review

If the claimant has exhausted internal appeal reviews, an external review by an Independent Review Organization (IRO) may be requested for review of an Adverse Benefit Determination or Final Internal Adverse Benefits Determination which was based on a judgment as to the Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of the health care Service or treatment. The request must be submitted in writing within four months after receipt of the Final Internal Adverse Benefit Determination. (An Adverse Benefit Determination based on an individual's eligibility for coverage or to participate in a plan is not eligible for External Review.)

The Covered Person will be required to authorize the release of any of his or her protected health information , including medical records, which may be needed for the purposes of the External Review.

The request for an External Review may be submitted electronically, by facsimile, or U.S. mail, as stated on the Final Internal Adverse Benefit Determination notice (letter). The request should be submitted to:

Nebraska Department of Insurance
P.O.Box 82089
Lincoln, Nebraska 68501-2089
www.doi.nebraska.gov

Upon receipt of the request, the Nebraska Department of Insurance (NDOI) will forward the request to BCBSNE to conduct a preliminary review to determine if it is complete and whether it is eligible for external review, consistent with applicable law. BCBSNE will conduct this review within 5 business days of receipt, and notify the NDOI and the Covered Person of the outcome within one business day. If it is determined that the request is not complete, or is not eligible for external review, the claimant will be notified of the reason for ineligibility, or advised of the information needed to make the request complete. The NDOI may determine that the request is eligible notwithstanding BCBSNE's determination, consistent with state law.

If the external review request is eligible for review, the NDOI will assign an IRO to conduct the review, and notify BCBSNE and the claimant of the assignment within one business day. BCBSNE will forward all documentation and information used to make the initial Adverse or Final Internal Adverse Benefit Determination to the IRO within 5 business days. If the claimant wishes to submit additional information to the IRO for consideration, they will be given the opportunity to do so. The IRO will provide BCBSNE with any information submitted by the claimant, to allow BCBSNE an opportunity to reconsider its original determination.

The IRO will complete its review and provide the claimant with written notification of its decision within 45 calendar days of receipt. No deference shall be given to the prior internal appeal determination made by BCBSNE.

Expedited External Review: An expedited External Review of an Adverse Benefit Determination for an Urgent Care Claim may be requested at the same time a claimant requests an expedited internal appeal if the denial:

- involves an Urgent Care Claim; or
- it was based on a determination that the requested Service or treatment is Investigative, if the Covered Person's treating Physician certifies in writing that the Service or treatment would be significantly less effective if not promptly initiated.

However, the claimant must first exhaust the internal appeal process unless BCBSNE agrees to waive this requirement, or as otherwise directed by the IRO, consistent with state law.

An expedited External Review may also be requested following a Final Internal Adverse Benefit Determination, if:

- the Covered Person has a medical condition where the time frame for completion of a standard External Review would seriously jeopardize his/her life, health, or ability to regain maximum function.
- the Final Internal Adverse Benefit Determination concerns an admission; availability of care; continued stay, or heath care Service for which the Covered Person has received emergency services, but has not been discharged from a facility.
- the Final Internal Adverse Benefit Determination is based on a determination that the requested Service or treatment is Investigative, if the Covered Person's Treating Physician certifies in writing that the Service or treatment would be significantly less effective is not promptly initiated.

The process for coordination of the expedited request between the NDOI and BCBSNE and the IRO will be done promptly upon receipt, by telephone, facsimile, or the most expeditious manner available. The expedited external review decision will be made by the IRO within 72 hours after receipt of the request. If notification of the decision was not in writing, the IRO will provide the decision in writing within 48 hours after the notification.

The decision of the IRO is the final review decision and is binding on BCBSNE and the claimant, except to the extent that the claimant may have other remedies available under applicable federal or state law. Once an external review decision has been made, the Covered Person or his/her representative may not file a subsequent request for an external review involving the same Adverse Benefit Determination.

Nebraska Department Of Insurance Assistance

The Nebraska Department of Insurance may be contacted for assistance with the appeal and external review process at any time at:

Nebraska Department of Insurance
P.O. Box 82089
Lincoln, Nebraska 68501-2089
(877) 564-7323

If you have a general complaint or inquiry regarding your coverage with BCBSNE, you may call our Member Services Department at the number on your I.D. card. If you feel that your complaint is not resolved through our internal complaint process, or if our performance does not meet your expectations, you may contact the Nebraska Department of Insurance at the address or phone number listed above.

COORDINATION OF BENEFITS

Section 9

When You Have Coverage Under More Than One Plan

This Plan includes a Coordination of Benefits (COB) provision. This provision establishes a uniform order in which the Plans pay their claims, limits duplication of benefits and provides for transfer of information between the Plans.

When Coordination Of Benefits Applies

COB provisions apply when a Covered Person has coverage under more than one health Plan. The order of benefit determination rules described in this section determine which Plan will pay as the primary Plan without regard to any benefits that might be payable by another Plan.

Definitions

For the purpose of this section, the terms are defined as:

Allowable Expense: A health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan 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. In addition, 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 has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of Plan provisions include second surgical options, recertification of admissions, and preferred provider arrangements.

Closed Panel Plan: A Plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

Custodial Parent: The parent awarded custody by a court decree or, in the absence of a court decree, the parent with whom the child resides more than one half of the calendar year excluding temporary visitation.

Plan: Any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

a. Plan includes: group insurance and non-group insurance contracts and subscriber contracts, health maintenance organization (HMO) contracts, Closed Panel Plans; other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits coverage in automobile "no-fault" and traditional "fault" type contracts; group and non-group insurance contracts and subscriber contract that pay or reimburse for the cost of dental care; and Medicare or any other federal governmental Plan, as permitted by law.

b. Plan does not include: hospital indemnity coverage 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 policies; and coverage under other federal governmental Plans, unless permitted by law.

Each contract for coverage under a. or b. is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

NOTE: *When a Covered Person's individual automobile coverage provides medical benefits under an "underinsured" or "uninsured" provision, the COB provisions are not applicable.*

Primary Plan: The Plan that will determine payment for its benefits first before those of any other Plan without considering any other Plan's benefits.

Secondary Plan: The Plan that will determine its benefits after those of another Plan and may reduce the benefits so that all Plan benefits do not exceed 100% of the total Allowable Expense.

This Plan: The part of the contract providing health care benefits to which the COB provision applies and which may be reduced because of the benefits of other Plans. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

Order Of Benefit Determination Rules

1. The Primary Plan pays or provides its benefits according to its terms or coverage and without regard to the benefits under any other Plan.
2. If a Covered Person has prescription drug coverage under more than one health plan, the coverage first used by the Covered Person becomes the primary coverage.
3. A Plan that does not contain a coordination of benefits provision that is consistent with this Part is always primary unless the provisions of both Plans stated that the complying Plan is primary.
4. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.
5. Each Plan determines its order of benefits using the first of the following rules that apply:

Subscriber And Dependent. The Plan that covers the person as other than a dependent, such as a subscriber/policyholder/employee, is the Primary Plan and the Plan that covers the 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 Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:

For a dependent child whose parents are married or are living together, whether or not they have ever been married, the Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan. If both parents have the same birthday, the Plan that has covered the parents the longest is the Primary Plan (birthday rule).

For a dependent child whose parents are divorced, or separated or not living together, whether or not they have ever been married, if a court decree states that one of the parents is responsible for the child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, the Plan of that parent's spouse is primary. This rule applies to Plan years beginning after the Plan is given notice of the court decree.

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

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

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

- The Plan covering the Custodial Parent;
- The Plan covering the spouse of the Custodial Parent;
- The Plan covering the non-custodial parent; and then
- The Plan covering the spouse of the non-custodial parent.

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

For a dependent child covered under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule before for "Longer or Shorter Length of Coverage" applies. In the event the dependent child's coverage under the spouse's plan began on the same date as his or her coverage under the parent's plan(s), the order of benefits shall be determined by applying the "birthday rule" above, to the dependent child's parent(s) and the dependent's spouse.

Active Employee, Retired Or Laid-Off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither retired nor laid off, is the Primary Plan. The Plan covering that same person as a retired or laid-off employee is the Secondary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent 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 (Subscriber and Dependent) can determine the order of benefits.

COBRA Or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as a subscriber/member/employee/retiree or covering the person as a dependent of a subscriber/member/employee/retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. 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 (Subscriber and Dependent) can determine the order of benefits.

Longer Or Shorter Length Of Coverage. The Plan that has covered the person longer is the Primary Plan and the Plan that has covered the person the shorter period of time is the Secondary Plan. The start of a new Plan does not include a change in the amount or scope of a Plan's benefits; a change in the entity that pays, provides or administers the Plan's benefits; or a change from one type of Plan to another, such as from a single employer Plan to a multiple employer Plan.

If The Above Rules Do Not Determine The Order Of Benefits. The Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition,This Plan will not pay more than it would have paid had it been the Primary Plan.

Administration Of Coordination Of Benefits

The order of benefit determination rules govern the order in which each Plan will pay a Claim for benefits. The Plan that pays first is called the Primary Plan. The Plan that pays after the Primary Plan is called the Secondary Plan.

If This Plan is the Primary Plan, there shall be no reduction of benefits. 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 amounts it would have credited to its Deductible in the absence of other health coverage.

Miscellaneous Provisions

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

To properly administer these COB rules, certain facts are needed. This Plan may obtain or release information to any insurance company, organization or person. Any person who claims benefits under This Plan agrees to furnish the information that may be necessary to apply COB rules and determine benefits.

If another Plan pays benefits that should have been paid under This Plan, This Plan may reimburse the other Plan 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.

If the amount of the benefits paid by This Plan exceeds the amount it should have paid, This Plan has the right to recover any excess from any other insurer, any other organization, or any person to or for whom such amounts were paid, including Covered Persons under This plan.

Termination Of Coverage

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

- The date the entire Contract is terminated.
- When you are no longer eligible for coverage due to termination of employment.
- The last day of the month when you cease to be eligible under the health plan; or a dependent ceases to be an Eligible Dependent.
- When BCBSNE receives a request from you or the employer to terminate coverage for you or a dependent.
- The last date for which premium is paid.
- Another date as specified by your employer.

Please contact your employer for details regarding the specific date coverage under the Group health plan will be terminated.

You and/or your Eligible Dependents may be eligible to continue coverage under the Group health plan as detailed in this section.

Continuation Of Coverage Under The Federal Continuation Law

If you terminate your employment, or if a dependent loses coverage due to certain "Qualifying Events," continued coverage under the Group health plan may be available. Payment for continued coverage under the federal continuation law is at the employee's or dependent's own expense. Please contact your employer for details regarding eligibility.

What Is The Federal Continuation Law?

The Consolidated Omnibus Budget Reconciliation Act (COBRA), is a federal law which provides that a Covered Person who would lose coverage due to the occurrence of a "Qualifying Event," may elect to continue coverage under the Group health plan. A person who is eligible to continue coverage is called a "Qualified Beneficiary." A Qualified Beneficiary also includes a child born to, or placed for adoption with the Covered Person during the period of COBRA coverage. Please share the information found in this section with your Eligible Dependents.

Termination Of Employment Or Reduction In Hours — COBRA provides that if you should lose eligibility for coverage due to:

- voluntary termination of employment;
- a lay-off for economic reasons;
- discharge for misconduct (other than gross misconduct), or
- a reduction in work hours,

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.

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 continuation coverage, the COBRA coverage period for the disabled individual and his or her related beneficiaries may be extended to 29 months instead of 18 months when loss of coverage is due to termination or reduction in hours of employment. You must provide written notice of the disability determination to the plan within 18 months of becoming eligible for COBRA and no later than 60 days after the date of the Social Security Administration's determination.

If the Social Security Administration determines that you or the dependent are no longer disabled, the extended continuation of coverage period (19th through 29th month) will be terminated the month that begins more than 30 days after the determination. You must notify the plan within 30 days of a determination that an individual is no longer disabled.

Change In Dependent Status, Divorce/Separation Or Medicare Entitlement — COBRA requires that continued coverage under the Group health plan be offered to your covered spouse and eligible children if they would otherwise lose coverage as a result of:

- divorce or legal separation;
- a child losing dependent status; or
- the employee becoming entitled to Medicare.

When one of these circumstances occur, you or the dependent are obligated to notify the employer or Plan Administrator within 60 days. Failure to provide timely and proper notice may result in the loss of the right to COBRA.

After receiving a timely notice of such an event, and eligibility has been determined, your employer or the Plan Administrator will send the Qualified Beneficiary an election form and the information needed to apply for coverage. Coverage may be continued at the individual's expense for up to 36 months.

Your Death — If you should die while you are covered under this Group health plan, continued coverage is available to your spouse and Eligible Dependents.

COBRA provides that subject to certain limitations, your surviving spouse and children may continue the Group health 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.

Special Provisions — If an employer files Chapter 11 bankruptcy, special provisions regarding COBRA continuation coverage may apply for the retiree or deceased retiree's surviving spouse and dependent children. Please check with your employer for details.

Electing COBRA Coverage

Within 14 days after notice of a Qualifying Event is received by the Plan Administrator, you and/or your dependents 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. Failure to provide timely and proper notice may result in the loss of the right to COBRA coverage.*

Qualified Beneficiaries must complete and return the COBRA election form in order to continue coverage. The notice will include instructions for completing and returning the form. 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 Group 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 whom 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 an insured person becomes entitled to benefits under Medicare (after 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 continuous 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 employee 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 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 employer 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 meets the plan's limiting age 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.

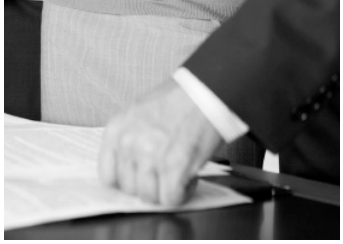
In order to elect continuation coverage, you must request an election form from Blue Cross and Blue Shield of Nebraska. The completed form must be returned no sooner than 31 days prior to or no later than 31 days after the date on which the child would otherwise lose coverage. You should also notify 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 Group through which your coverage is provided 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. We do not receive the monthly payment on a timely basis;
2. You request coverage to be terminated;
3. Your coverage with BCBSNE 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.



Benefit Plan Document

This document provides an overview of your benefits. It is not intended to be a complete description of every detail of the Plan. All coverage and benefit determinations are governed by the Benefit Plan Document which consists of the Master Group Application, any Subgroup applications, the enrollment information, the Master Group Contract, addenda, attachments or endorsements. If there is a discrepancy or conflict between this document and the Benefit Plan documents, the Benefit Plan documents will govern.

Fraud Or Misrepresentation

A Covered Person's coverage may be canceled or rescinded for fraud or intentional misrepresentation of material fact 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.

Subrogation

Subrogation is the right to recover benefits paid for Covered Services provided as the result of Injury or Illness which was caused by another person or organization. When benefits are paid under the Master Group Contract, BCBSNE shall be subrogated to all of the Covered Person's right of recovery against any person or organization to the extent of the benefits paid. The Subscriber, the Covered Person or the person who has the right to recover for a Covered Person (usually a parent or spouse), agrees to make reimbursement to BCBSNE if payment is received from the person who caused the Illness or Injury or from that person's liability carrier.

This subrogation 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 or as provided by applicable law. BCBSNE's rights shall not be defeated by allocating the proceeds to nonmedical damages.

NOTE: *When a Covered Person's individual automobile medical coverage, including medical benefits provided under an "underinsured" or "uninsured" provision, provides medical benefits, the Subrogation provisions are not applicable (Coordination of Benefits applies).*

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, BCBSNE 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, or as provided by applicable state law.

Such proceeds may include any settlement; judgment; payments made under group auto insurance; individual or group no fault auto insurance; another person's uninsured, underinsured or medical payment insurance; or proceeds otherwise paid by a third party. This contractual right to reimbursement is in addition to and separate from the subrogation right. Our rights shall not be defeated by allocating the proceeds to nonmedical damages.

When BCBSNE recovers proceeds under this contractual right to reimbursement for all or a part of the Claim, amounts previously credited to a Covered Person's Deductible or Coinsurance liability may be removed. Future Claims will be subject to the reinstated Deductible or Coinsurance.

No adult Subscriber may assign any rights to recover medical expenses from any third party to any minor or other dependent of the adult Subscriber or to any other person, without the express written consent of BCBSNE. The right to recover, whether by subrogation or reimbursement, shall apply to settlements or recoveries of deceased persons, minor dependents of a Subscriber, incompetent or disabled Subscribers, or their incompetent or disabled Eligible Dependents.

The Subscriber agrees to fully cooperate and assist in any way necessary to recover such payments, including but not limited to notifying BCBSNE of a claim or lawsuit filed on his or her behalf, or on behalf of any Eligible Dependent for an Injury or Illness. The Subscriber, Eligible Dependent or an authorized representative shall contact BCBSNE prior to settling any claim or lawsuit to obtain an updated itemization of its subrogation Claim or reimbursement 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 BCBSNE. The party holding the funds that rightfully belong to BCBSNE shall not interrupt or prejudice BCBSNE's recovery of such payments.

Costs incurred in enforcing these provisions shall also be recovered, including, but not limited to, attorneys' fees, litigation and court costs, and other expenses.

Workers' Compensation

Benefits are not available for Services provided for Injuries or Illnesses arising out of and in the course of employment, whether or not the Covered Person fails to assert or waives his or her right to Workers' Compensation or Employer Liability Law. The employer is required to furnish or pay for such Services or a settlement can be made, pursuant to Workers' Compensation laws. (See also the section of this book titled "Exclusions—What's Not Covered.")

If a Covered Person enters into a lump-sum settlement which include 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.

Benefits are not payable for services determined to be not compensable due to noncompliance with terms, rules and conditions under Workers' Compensation laws, or in a Certified or otherwise Licensed Workers' Compensation Managed Care Plan. In addition, benefits are not payable for Services that are related to the work Injury or Illness, but are determined to be not necessary or reasonable by the employer or Workers' Compensation carrier.

In certain instances, benefits for such Services are paid in error under the Group health Plan. If payment is received by the Covered Person for such Services, reimbursement must be made. This reimbursement may be refunded from any recovery made from the employer, or the employer's Workers' Compensation carrier, as permitted by law. 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.

Legal Actions

The Subscriber cannot bring a legal action to recover under the Contract for at least 60 days after written proof of loss is given to Us. The Subscriber cannot start a legal action after three years from the date written proof of loss is required.

Assistance With Your Questions

If You have any questions about your plan, you should contact the Plan Administrator. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

ACA: The Patient Protection and Affordable Care Act and implement regulations and subregulatory guidance.

Adult Designee: A person of the same or opposite gender of the Subscriber, who meets the eligibility criteria below, as determined by the University of Nebraska:

- has resided in the same residence as the Subscriber for at least the past 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 of Nebraska;
- is not currently married to or legally separated from another individual either under statutory or common law;
- is not related to the Subscriber as a parent, step-parent, a collateral descendent of a parent or step-parent (i.e. sibling, niece or nephew), a grandparent, step-grandparent, or a grandparent's or step-grandparent's descendant (i.e. aunt, uncle or cousin);
- is not a renter, boarder, tenant or employee of the Subscriber;
- has not been hired or is not directly supervised by the Subscriber in an employment settling; or may not be transferred, suspended, laid off, recalled, promoted, discharged, assigned, rewarded or disciplined as an employee by the Subscriber; or the Subscriber has no responsibility to direct the Adult Designee or to adjust the Adult Designee's grievances or effectively to recommend such action, if the exercise of such authority is not merely of a routine or clerical nature but requires the use of independent judgment;
- is not a child of the Subscriber or a descendent of a Subscriber's child.

In addition, the Subscriber and the Adult designee must possess and provide the University of Nebraska either a copy of the Internal Revenue Services (IRS) form listing the Adult Designee as a dependent, or at least three of the following documents;

- joint ownership of a residence or other significant property (home, condo, mobile home, care) or joint tenancy on a resident lease identifying both the Subscriber and the Adult Designee as tenants;
- life insurance policy or retirement benefit account of the Subscriber or the Adult Designee naming the other as primary beneficiary;
- will of the Subscriber or Adult Designee designating the other as primary beneficiary, executor or personal representative;
- durable power of attorney for purposes of health care or financial management providing that the Subscriber and Adult Designee have granted powers to one another;
- joint bank or credit account;
- joint liability of debt (for example, credit cards or car loans);
- other evidence of joint ownership of a major asset.

If there is any change in status regarding the Adult Designee of the Adult Designee's dependent children, the Subscriber is responsible for notifying the University of Nebraska within 31 days of the change. Coverage will be terminated for the Adult Designee and his/her dependent children when an Adult Designee no longer meets the eligibility criteria listed above. Unless otherwise stated, an Adult Designee and his/her dependent children will not be offered an independent right to continuation of benefits through COBRA if these individuals lose coverage under this Plan for any reason; although the Subscriber may elect to continue coverage through COBRA for the Subscriber, the Adult Designee and his/her dependent children if the Subscriber becomes eligible for COBRA continuation coverage.

Adverse Benefit Determination: A determination by BCBSNE or its Utilization Review designee, of the denial, reduction, or termination of a benefit, or a failure to provide or make payment (in whole or in part) of a benefit. This includes any such determination that is based on:

1. the application of Utilization Review;
2. a determination that the Service is Investigative;
3. a determination that the Service is not Medically Necessary or appropriate;
4. an individual's eligibility for coverage or to participate in a plan.

An adverse benefit determination also includes any rescission of coverage, which is defined as a cancellation or discontinuance of coverage that has a retroactive effect, except if for failure to timely pay required premiums or contribution for coverage.

Alcoholism or Drug Abuse (Substance Abuse) Treatment Center: A facility 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 Healthcare Organizations (JCAHO) or the Commission on the Accreditation of Rehabilitation Facilities (CARF). Such facilities are not Licensed as a Hospital, but provide 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 used by BCBSNE to calculate payment of 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 the Contract, Nebraska law or pursuant to the direction of BCBSNE.

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.

BCBSNE: Blue Cross and Blue Shield of Nebraska

BlueCard Program: This Blue Cross and Blue Shield Association (BCBSA) program is a collection of policies, provisions and guidelines that enables BCBSNE 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 BCBSNE or Our designee, that an admission, extension of stay or other health or dental 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.

Claim: A request for benefits under this Plan.

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 after application of the Deductible. The Coinsurance percentage 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.

Congenital Abnormality: A condition existing at birth which is outside the broad range of normal, such as cleft palate, birthmarks, webbed fingers or toes. Normal variations in size and shape of the organ such as protruding ears are not considered a Congenital Abnormality.

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.

Contract: The agreement between BCBSNE and the Board of Regents of the University of Nebraska, which includes the Master Group Application, Administrative Services Agreement and any addenda or attachments, the Master Group Benefit Contract, and any endorsements thereto, and the enrollment forms of Subscribers and their Eligible Dependents.

Contracted Amount: The Allowable Charge agreed to by BCBSNE or a Host Blue Plan and Contracting Providers for Covered Services received by a Covered Person.

Contracting Provider: An In-Network Provider or a Host Blue BlueCard Program Preferred or Participating Provider.

Copayment (Copay): A fixed dollar amount of the Allowable charge, payable by the Covered Person for a Covered Service, as indicated in the Master Group Application and/or Schedule of Benefits Summary. Copayments are separate from and do not accumulate to the Deductible or Coinsurance Limit.

Cosmetic: Any Services provided to improve or change the patient's physical appearance or characteristics, 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 administered by BCBSNE.

Covered Services: Hospital, medical or surgical procedures, treatments, drugs, supplies, Durable 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, or (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 includes:

1. care given to a Covered Person who:
   a. is mentally or physically disabled; and
   b. needs a protected, monitored or controlled environment or assistance to support the basics of daily living, in an institution or at home; and
   c. may be ventilator dependent or require routine catheter maintenance.
2. health-related Services that are provided for the primary purpose of meeting the personal needs of the Covered Person or maintaining a level of function (even if the specific Services are considered to be skilled Services), as opposed to improving that function to an extent that might allow for a more independent existence;
3. Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively, such as recording pulse, temperature, and respiration; supervising medications that can usually be self-administered; or administration and monitoring of feeding systems.

A Custodial Care determination may still be made if the care is ordered by a Physician, or Services are being administered by a registered or Licensed practical nurse.

Deductible: An amount of Allowable Charges which the Covered Person must pay each calendar year for Covered Services before benefits are payable by the Contract.

Durable Medical Equipment: Equipment and supplies which treat an Illness or Injury, to improve the functioning of a particular body part, or to prevent further deterioration of the Covered Person'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. Durable Medical Equipment includes such items as prosthetic devices that replace a limb or body part, orthopedic braces, crutches and wheelchairs. It does not include sporting or athletic equipment or items purchased for the convenience of the family.

Eligibility Waiting Period: Applicable to new Employees only, the period between the first day of employment and the first date of coverage under the 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, as defined, and any Adult Designee's dependent children, as described below.
3. Children to age 26.

   "Children" means:
   - natural-born and legally adopted children of the Subscriber or Adult Designee;
   - stepchildren of the Subscriber;
   - foster children placed with the Subscriber by a placement agency, decree or other order of a court;
   - grandchildren who live with and are chiefly dependent upon the Subscriber/Adult Designee for support and maintenance and for whom the Subscriber/Adult Designee has obtained legal guardianship;
   - a child for whom the Subscriber or Adult Designee has legal guardianship.

   Appropriate documentation must be provided to verify court appointed legal guardian status.

   Coverage ends when the dependent child turns age 26.

4. A covered 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 the Subscriber/Adult Designee for support and maintenance.

   Proof of the requirements stated above 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: Any 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 lay person, 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 the 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.

Final Internal Adverse Benefit Determination: An Adverse Benefit Determination that has been upheld by BCBSNE, or its Utilization Review designee, at the completion of the internal appeal process as set forth herein.

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

Habilitative Services: Health care Services that help a person keep, learn, or improve skills and functioning for daily living. These Services may include physical and occupational therapy, speech-language pathology and other Services for people with disabilities in a variety of Inpatient and/or Outpatient settings.

Not all Services are habilitative. Examples of Services that are not habilitative, and not covered under this paragraph, include but are not limited to: Custodial Care; day care; recreational care; Residential treatment; respite care; social services; vocational training; applied behavioral analysis; or Services provided under any state or federal special education program, including Services provided through a school system, for which there is no charge to the person.

Hospital: A Hospital is an institution or facility duly Licensed by the State of Nebraska or the state in which it is located, which provides medical, 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.

Host Blue: 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.

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 Us to provide Services as a part of a Preferred Provider network in Nebraska.

Inpatient: A Covered Person 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. BCBSNE 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 that 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.

Medicaid: Grants to states for Medical Assistance Programs, Title XIX of the Social Security Act, as amended.

Medically Necessary (or used as "Medical Necessity"): 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 Illness, 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.

BCBSNE 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.

Medicare: Health Insurance for the Aged and Disabled, Title XVIII of the Social Security Act, as amended.

Mental Health Services Provider: A qualified Physician, Licensed Psychologist, Licensed Special Psychologist, and Licensed Mental Health Practitioners. 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 the 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: 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 or any subsequent version).

Noncovered Person: A person for whom benefits are not available under the Contract.

Noncovered Services: Services that are not payable under the Contract.

Out-of-network Allowance: An amount BCBSNE uses to calculate 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 Host Blue Plan for out-of-area Providers.

Out-of-network Provider: A provider of health care Services who has not contracted with BCBSNE to provide Services as a part of a Preferred Provider 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, in an observation room, in an Ambulatory Surgical Facility, Urgent Care Facility, 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, (or equivalent state agency) or accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the Commission on the Accreditation of Rehabilitation Facilities (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 Treatment Programs or day rehabilitation programs for Mental Illness, or Residential Treatment Programs, halfway house or methadone maintenance programs for Substance Abuse. Benefits will not be provided for programs or services ordered by the Court that are not Medically Necessary as determined by BCBSNE.

Physical Rehabilitation: The restoration of a person who was 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 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.

Postservice Claim: Any Claim which is not a Preservice Claim.

Preauthorization: Preauthorization of benefits is prior written approval of benefits for certain, Services such as organ transplants, cardiac and pulmonary rehabilitation, subsequent purchased of Durable Medical Equipment, and Home Health Care and Hospice Services. This Preauthorization is based on the terms of the Contract and is based on the information submitted to BCBSNE and 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, abortions, threatened abortions, miscarriages, premature deliveries, ectopic pregnancies, cesarean sections 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.

Preservice Claim(s): Any Claim for a benefit under the Contract with respect to which the terms of the Contract require approval of the benefit in advance of obtaining medical care and failure to do so will cause benefits to be denied or reduced.

Primary Care Physician: A Physician who has a majority of his or her practice in the fields of internal or general medicine, obstetrics/gynecology, general pediatrics or family practice.

Residential Treatment Program: Services or a program for persons with behavioral health disorders organized and staffed to provide both general and specialized nonhospital-based interdisciplinary Inpatient services 24 hours a day, seven days a week with oversight by a Physician. 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 addiction treatment centers, intermediate care facilities, psychiatric treatment centers, or other nonmedical settings.

Schedule of Benefits: A summarized personal document which provides information such as Copayments, Deductibles, percentages payable, special benefits, maximums and limitations of coverage, and the type of Membership Unit selected. This term also includes the Schedule of Benefits Summary.

Schedule of Benefits Summary: See Schedule of Benefits.

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:

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 the 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.
2. 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 affects 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 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.

BCBSNE will determine whether a technology is Scientifically Validated.

Services: Hospital, medical or surgical procedures, treatments, drugs, supplies, Durable Medical Equipment, or other health, mental health or dental care, including any single service or combination of such services.

Service Area: The geographic area in which a Blue Cross and Blue Shield plan is authorized to use the Blue Cross and Blue Shield brands pursuant to its license agreement with Blue Cross and Blue Shield Association.

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 or Adult Designee.

Skilled Nursing Care: A level of care that includes services that can only be performed safely and correctly by a licensed nurse (either a registered nurse or a Licensed practical nurse). 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 individual who enrolls for health coverage and is named on an identification card issued pursuant to the Contract, and who is an Employee hired by the 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 or Adult Designee.

Substance Dependence and Abuse: Alcoholism, drug abuse and nicotine dependence or addiction. This term does not include tobacco dependence or addiction, unless otherwise included by Endorsement to the Contract.

Treating Physician: A Physician who has personally evaluated the Covered Person. 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.

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 a Covered Person's health, and that are required as a result of an unforeseen sickness, Injury or the onset of acute or severe symptoms.

Utilization Review: The evaluation by BCBSNE or its designee, of the use of Services, including medical, diagnostic or surgical procedures or treatments, the utilization of medical supplies, drugs, or Durable 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.

Value-Based Program: Also known as patient-focused care, a Value-Based Program is an outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local providers that is evaluated against cost and quality metrics/factors and is reflected in provider payment. Value-Based (patient-focused) Programs may include, but are not limited to, Accountable Care Organizations, Global Payment Costs of Care arrangements, Patient Centered Medial Homes and Shared Savings arrangements.

Work-hardening: Physical therapy or similar Services provided primarily for strengthening an individual for purposes of his or her employment.

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