



An Overview of Your Health Care Benefits

Educators Health Alliance



**EDUCATORS
HEALTH
ALLIANCE**

A Healthy Alliance - Nebraska State Education Association,
Nebraska Council of School Administrators and
Nebraska Association of School Boards



**BlueCross BlueShield
of Nebraska**

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

EHA Health Plan Option I

	In-Network	Out-of-Network
Overall contract benefit maximum	\$5 million per person	
Overall contract benefit maximum for substance abuse treatment	\$20,000 per person	
Calendar year deductible		
Individual	\$350	\$700
Family	\$700	\$1,400
Calendar year coinsurance maximum		
Individual	\$2,000	\$4,000
Family	\$4,000	\$8,000
Coinsurance you pay for most covered services after satisfaction of the calendar year deductible	20% of allowable charges	40% of allowable charges
Physician office visit exam	\$35 copay per visit	Subject to deductible and 40% coinsurance
Routine/preventive care		
Family members from birth through age 4	Deductible waived; subject to 20% coinsurance	Deductible waived; subject to 40% coinsurance
Family members age 5 and older \$500 calendar year benefit maximum per person	Subject to deductible and 20% coinsurance	Subject to deductible and 40% coinsurance
Mammograms, Pap smears, PSA tests and immunizations	Benefits for covered services paid at 100% of the allowable charge (deductible and coinsurance waived)	Subject to deductible and 40% coinsurance (deductible waived for pediatric immunizations)
Inpatient mental illness and/or substance abuse treatment <i>Benefits subject to 30-day maximum per calendar year. (Benefits for serious mental illness are not subject to this maximum.)</i>	Subject to deductible and 20% coinsurance	Subject to deductible and 50% coinsurance
Outpatient mental illness and/or substance abuse treatment		
Therapy visits <i>Subject to a 60-visit maximum per calendar year. (Benefits for serious mental illness are not subject to this maximum.)</i>	\$30 copay per visit	\$50 copay per visit
Miscellaneous charges (e.g. lab)	Subject to deductible and 25% coinsurance	Subject to deductible and 50% coinsurance

Prescription drug benefits

Tier	Classification	Member Coinsurance per 30-day supply		Out-of-Pocket Minimums and Maximums Per Prescription	
		In-Network	Out-of-Network	In-Network	Out-of-Network
1	Generic drugs	25%	25% + 25% penalty	\$5 minimum / \$25 maximum*	
2	Formulary name brand drugs	25%	25% + 25% penalty	\$30 minimum / \$60 maximum*	
3	Nonformulary name brand drugs	50%	50% + 25% penalty	\$60 minimum / \$90 maximum*	
4	Specialty drugs	25%	50%	In-Network	Out-of-Network
				\$50 minimum / \$100 maximum	\$150 minimum / \$300 maximum
Diabetic and Ostomy Supply Benefits				Calendar Year Prescription Drug Out-of-Pocket Maximums	
		Member Coinsurance Per 30-day supply		Per individual	\$2,500
		In-Network	Out-of-Network	Family maximum	\$5,000
Diabetic supplies				Once the applicable out-of-pocket maximum is reached, you pay nothing for covered prescription drugs for the remainder of the calendar year.	
Generic and formulary		20%	20% + 25% penalty		
Nonformulary		30%	30% + 25% penalty		
Ostomy supplies		20%	20% + 25% penalty		

*Does not include 25% out-of-network penalty, if applicable.

EHA Health Plan Option 2

	In-Network	Out-of-Network
Overall contract benefit maximum	\$5 million per person	
Overall contract benefit maximum for substance abuse treatment	\$20,000 per person	
Calendar year deductible		
Individual	\$600	\$1,200
Family	\$1,200	\$2,400
Calendar year coinsurance maximum		
Individual	\$2,000	\$4,000
Family	\$4,000	\$8,000
Coinsurance you pay for most covered services after satisfaction of the calendar year deductible	20% of allowable charges	40% of allowable charges
Physician office visit exam	\$35 copay per visit	Subject to deductible and 40% coinsurance
Routine/preventive care		
Family members from birth through age 4	Deductible waived; subject to 20% coinsurance	Deductible waived; subject to 40% coinsurance
Family members age 5 and older \$500 calendar year benefit maximum per person	Subject to deductible and 20% coinsurance	Subject to deductible and 40% coinsurance
Mammograms, Pap smears, PSA tests and immunizations	Benefits for covered services paid at 100% of the allowable charge (deductible and coinsurance waived)	Subject to deductible and 40% coinsurance (deductible waived for pediatric immunizations)
Inpatient mental illness and/or substance abuse treatment <i>Benefits subject to 30-day maximum per calendar year. (Benefits for serious mental illness are not subject to this maximum.)</i>	Subject to deductible and 20% coinsurance	Subject to deductible and 50% coinsurance
Outpatient mental illness and/or substance abuse treatment		
Therapy visits <i>Benefits subject to a 60-visit maximum per calendar year. (Benefits for serious mental illness are not subject to this maximum.)</i>	\$30 copay per visit	\$50 copay per visit
Miscellaneous charges (e.g. lab)	Subject to deductible and 25% coinsurance	Subject to deductible and 50% coinsurance

Prescription drug benefits

Tier	Classification	Member Coinsurance per 30-day supply		Out-of-Pocket Minimums and Maximums Per Prescription	
		In-Network	Out-of-Network	In-Network	Out-of-Network
1	Generic drugs	25%	25% + 25% penalty	\$5 minimum / \$25 maximum*	
2	Formulary name brand drugs	25%	25% + 25% penalty	\$30 minimum / \$60 maximum*	
3	Nonformulary name brand drugs	50%	50% + 25% penalty	\$60 minimum / \$90 maximum*	
4	Specialty drugs	25%	50%	In-Network	Out-of-Network
				\$50 minimum / \$100 maximum	\$150 minimum / \$300 maximum
Diabetic and Ostomy Supply Benefits				Calendar Year Prescription Drug Out-of-Pocket Maximums	
		Member Coinsurance Per 30-day supply		Per individual	\$2,500
		In-Network	Out-of-Network	Family maximum	\$5,000
Diabetic supplies				Once the applicable out-of-pocket maximum is reached, you pay nothing for covered prescription drugs for the remainder of the calendar year.	
Generic and formulary		20%	20% + 25% penalty		
Nonformulary		30%	30% + 25% penalty		
Ostomy supplies		20%	20% + 25% penalty		

*Does not include 25% out-of-network penalty, if applicable.

EHA Health Plan Option 3

	In-Network	Out-of-Network
Overall contract benefit maximum	\$5 million per person	
Overall contract benefit maximum for substance abuse treatment	\$20,000 per person	
Calendar year deductible		
Individual	\$800	\$1,600
Family	\$1,600	\$3,200
Calendar year coinsurance maximum		
Individual	\$2,250	\$4,500
Family	\$4,500	\$9,000
Coinsurance you pay for most covered services after satisfaction of the calendar year deductible	20% of allowable charges	40% of allowable charges
Physician office visit exam	\$35 copay per visit	Subject to deductible and 40% coinsurance
Routine/preventive care		
Family members from birth through age 4	Deductible waived; subject to 20% coinsurance	Deductible waived; subject to 40% coinsurance
Family members age 5 and older \$500 calendar year benefit maximum per person	Subject to deductible and 20% coinsurance	Subject to deductible and 40% coinsurance
Mammograms, Pap smears, PSA tests and immunizations	Benefits for covered services paid at 100% of the allowable charge (deductible and coinsurance waived)	Subject to deductible and 40% coinsurance (deductible waived for pediatric immunizations)
Inpatient mental illness and/or substance abuse treatment <i>Benefits subject to 30-day maximum per calendar year. (Benefits for serious mental illness are not subject to this maximum.)</i>	Subject to deductible and 20% coinsurance	Subject to deductible and 50% coinsurance
Outpatient mental illness and/or substance abuse treatment		
Therapy visits <i>Benefits subject to a 60-visit maximum per calendar year. (Benefits for serious mental illness are not subject to this maximum.)</i>	\$30 copay per visit	\$50 copay per visit
Miscellaneous charges (e.g. lab)	Subject to deductible and 25% coinsurance	Subject to deductible and 50% coinsurance

Prescription drug benefits

Tier	Classification	Member Coinsurance per 30-day supply		Out-of-Pocket Minimums and Maximums Per Prescription	
		In-Network	Out-of-Network	In-Network	Out-of-Network
1	Generic drugs	25%	25% + 25% penalty	\$5 minimum / \$25 maximum*	
2	Formulary name brand drugs	25%	25% + 25% penalty	\$30 minimum / \$60 maximum*	
3	Nonformulary name brand drugs	50%	50% + 25% penalty	\$60 minimum / \$90 maximum*	
4	Specialty drugs	25%	50%	In-Network	Out-of-Network
				\$50 minimum / \$100 maximum	\$150 minimum / \$300 maximum
Diabetic and Ostomy Supply Benefits				Calendar Year Prescription Drug Out-of-Pocket Maximums	
		Member Coinsurance Per 30-day supply		Per individual	\$2,500
		In-Network	Out-of-Network	Family maximum	\$5,000
Diabetic supplies				Once the applicable out-of-pocket maximum is reached, you pay nothing for covered prescription drugs for the remainder of the calendar year.	
Generic and formulary		20%	20% + 25% penalty		
Nonformulary		30%	30% + 25% penalty		
Ostomy supplies		20%	20% + 25% penalty		

*Does not include 25% out-of-network penalty, if applicable.

EHA Health Plan Option 4

	In-Network	Out-of-Network
Overall contract benefit maximum	\$5 million per person	
Overall contract benefit maximum for substance abuse treatment	\$20,000 per person	
Calendar year deductible		
Individual	\$1,100	\$2,200
Family	\$2,200	\$4,400
Calendar year coinsurance maximum		
Individual	\$2,250	\$4,500
Family	\$4,500	\$9,000
Coinsurance you pay for most covered services after satisfaction of the calendar year deductible	20% of allowable charges	40% of allowable charges
Physician office visit exam	\$35 copay per visit	Subject to deductible and 40% coinsurance
Routine/preventive care		
Family members from birth through age 4	Deductible waived; subject to 20% coinsurance	Deductible waived; subject to 40% coinsurance
Family members age 5 and older \$500 calendar year benefit maximum per person	Subject to deductible and 20% coinsurance	Subject to deductible and 40% coinsurance
Mammograms, Pap smears, PSA tests and immunizations	Benefits for covered services paid at 100% of the allowable charge (deductible and coinsurance waived)	Subject to deductible and 40% coinsurance (deductible waived for pediatric immunizations)
Inpatient mental illness and/or substance abuse treatment <i>Benefits subject to 30-day maximum per calendar year. (Benefits for serious mental illness are not subject to this maximum.)</i>	Subject to deductible and 20% coinsurance	Subject to deductible and 50% coinsurance
Outpatient mental illness and/or substance abuse treatment		
Therapy visits <i>Benefits subject to a 60-visit maximum per calendar year. (Benefits for serious mental illness are not subject to this maximum.)</i>	\$30 copay per visit	\$50 copay per visit
Miscellaneous charges (e.g. lab)	Subject to deductible and 25% coinsurance	Subject to deductible and 50% coinsurance

Prescription drug benefits

Tier	Classification	Member Coinsurance per 30-day supply		Out-of-Pocket Minimums and Maximums Per Prescription	
		In-Network	Out-of-Network	In-Network	Out-of-Network
1	Generic drugs	25%	25% + 25% penalty	\$5 minimum / \$25 maximum*	
2	Formulary name brand drugs	25%	25% + 25% penalty	\$30 minimum / \$60 maximum*	
3	Nonformulary name brand drugs	50%	50% + 25% penalty	\$60 minimum / \$90 maximum*	
4	Specialty drugs	25%	50%	In-Network	Out-of-Network
				\$50 minimum / \$100 maximum	\$150 minimum / \$300 maximum
Diabetic and Ostomy Supply Benefits				Calendar Year Prescription Drug Out-of-Pocket Maximums	
		Member Coinsurance Per 30-day supply		Per individual	\$2,500
		In-Network	Out-of-Network	Family maximum	\$5,000
Diabetic supplies				Once the applicable out-of-pocket maximum is reached, you pay nothing for covered prescription drugs for the remainder of the calendar year.	
Generic and formulary		20%	20% + 25% penalty		
Nonformulary		30%	30% + 25% penalty		
Ostomy supplies		20%	20% + 25% penalty		

*Does not include 25% out-of-network penalty, if applicable.

EHA Health Plan Option 5

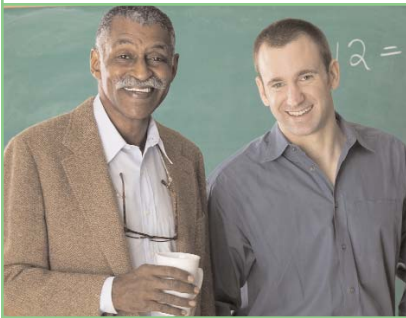
This plan is Health Savings Account (HSA)-eligible.

	In-Network	Out-of-Network
Overall contract benefit maximum	\$5 million per person	
Overall contract benefit maximum for substance abuse treatment	\$20,000 per person	
Calendar year deductible		
Individual	\$1,250	\$2,500
Family	\$2,500	\$5,000
Calendar year coinsurance maximum		
Individual	\$2,250	\$4,500
Family	\$4,500	\$9,000
Coinsurance you pay for most covered services after satisfaction of the calendar year deductible	20% of allowable charges	40% of allowable charges
Physician office visit exam	Subject to deductible and 20% coinsurance	Subject to deductible and 40% coinsurance
Routine/preventive care <i>\$500 calendar year benefit maximum per person</i>	Benefits for covered services paid at 100% of the allowable charge (deductible and coinsurance waived)	
Inpatient mental illness and/or substance abuse treatment <i>Benefits subject to 30-day maximum per calendar year. (Benefits for serious mental illness are not subject to this maximum.)</i>	Subject to deductible and 20% coinsurance	Subject to deductible and 50% coinsurance
Outpatient mental illness and/or substance abuse treatment <i>Benefits subject to a 60-visit maximum per calendar year. (Benefits for serious mental illness are not subject to this maximum.)</i>	Subject to deductible and 25% coinsurance	Subject to deductible and 50% coinsurance
Prescription drugs	Subject to in-network deductible and coinsurance	

EHA Health Plan Option 6

This plan is Health Savings Account (HSA)-eligible.

	In-Network	Out-of-Network
Overall contract benefit maximum	\$5 million per person	
Overall contract benefit maximum for substance abuse treatment	\$20,000 per person	
Calendar year deductible		
Individual	\$5,000	\$10,000
Family	\$10,000	\$20,000
Calendar year coinsurance maximum		
Individual	\$0	\$0
Family	\$0	\$0
Coinsurance you pay for most covered services after satisfaction of the calendar year deductible	0% of allowable charges	0% of allowable charges
Physician office visit exam	Subject to deductible	Subject to deductible
Routine/preventive care <i>\$500 calendar year benefit maximum per person</i>	Benefits for covered services paid at 100% of the allowable charge (deductible waived)	
Inpatient mental illness and/or substance abuse treatment <i>Benefits subject to 30-day maximum per calendar year. (Benefits for serious mental illness are not subject to this maximum.)</i>	Subject to deductible	Subject to deductible
Outpatient mental illness and/or substance abuse treatment <i>Benefits for therapy visits subject to a 60-visit maximum per calendar year. (Benefits for serious mental illness are not subject to this maximum.)</i>	Subject to deductible	Subject to deductible
Prescription drugs	Subject to in-network deductible	



A Health Care Plan Exclusively For Educators Health Alliance Members

This brochure provides you with an overview of the Blue Cross and Blue Shield **BluePreferred**[®] PPO coverage offered to members of the Educators Health Alliance. **This is not a contract. It is intended as a general overview only. It does not contain all the details of this coverage.** For more complete information about your plan, including benefits, exclusions and contract limitations, please refer to the certificate of coverage or the master group contract.

What is BluePreferred?

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

The BlueCard[®] Program: Your National PPO Network

You have access to a national Blue Cross and Blue Shield PPO network called the BlueCard Program.

How to Locate BlueCard PPO Providers Nationwide

It's easy to locate BlueCard Program PPO providers wherever you are.

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

To access your benefits wherever you are, all you have to do is use hospitals and doctors in the local Blue Cross and Blue Shield Plan's **BlueCard** PPO provider network. When you do, you also enjoy the discount and claim filing agreements Blue Cross and Blue Shield Plans across the country have negotiated with the BlueCard doctors and hospitals in their area.

Your PPO Network in Nebraska

In Nebraska, the BlueCard PPO network is called **BluePreferred**, and it's the largest in the state -- made up of 93% of the state's doctors and nearly 100% of non-governmental acute care hospitals. That makes obtaining in-network care easy and convenient.

BluePreferred providers have agreed to accept our benefit payment for covered services as payment in full, except for any deductible, copays and coinsurance amounts and charges for noncovered services, which are your responsibility. That means that **BluePreferred** providers, under the terms of their contract with us, can't bill you for amounts over our benefit allowance (noncontracting providers can bill you for amounts over our benefit allowance).

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

How to Locate BluePreferred PPO Providers in Nebraska

By phone: (402) 390-1855 or 1-800-642-6004
On the Web: www.bcbsne.com

Maximum Benefits

All options feature a \$5 million benefit maximum per covered person, including a \$20,000 contract benefit maximum for treatment of drug abuse and/or alcoholism.

Calendar Year Deductible

Please note: If a school district changes September 1 to a new **Blue Preferred** plan with a higher deductible, that new deductible will apply to all claims incurred between September 1 and December 31, and then must be satisfied again for the next calendar year starting January 1.

Options 1 through 4

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

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

The following do not apply toward the deductible: copay amounts for office visits and outpatient mental illness, substance abuse therapy sessions; coinsurance amounts for prescription drugs.

Options 5 and 6

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

Coinsurance and Your Calendar Year Coinsurance Maximum

Options 1 through 4

After you meet your calendar year deductible, you are responsible for paying a certain percentage of covered charges (called "coinsurance") until you reach your

coinsurance maximum. Once you reach your coinsurance maximum, you pay nothing for most covered services for the rest of the calendar year.

Under family membership, family members may combine their covered expenses to satisfy the required family coinsurance maximum. No one family member contributes more than the individual coinsurance maximum amount.

The following amounts do not apply toward the coinsurance maximum: copay amounts for office visits and outpatient mental illness and/or substance abuse therapy visits; coinsurance for treatment of substance abuse; prescription drug coinsurance amounts.

Options 5 and 6

After you meet your calendar year deductible, you are responsible for paying a certain percentage of covered charges (called "coinsurance") until you reach your coinsurance maximum. Once you reach your coinsurance maximum, you pay nothing for most covered services for the rest of the calendar year.

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

Routine Care Benefits

Options 1 through 4

Routine care for family members age 5 and above. Benefits are available for up to \$500 per calendar year for periodic examinations to determine physical development, routine office exams, lab and x-ray services and cardiac stress tests. The covered services are subject to your plan's applicable deductible and coinsurance amounts.

Routine well child care through 4 years of age. Covered services include periodic exams to determine physical development, office visits, radiology (x-ray) and pathology (laboratory) testing. The covered services are subject to the applicable coinsurance only. Benefits are not subject to the \$500 calendar year routine care maximum.

Mammograms, Pap smears, PSA tests and immunizations. When covered services are obtained from an in-network provider, benefits for routine mammograms, Pap smears, PSA tests and immunizations are

available at 100% of the allowable charge (no deductible or coinsurance). If out-of-network providers are used, available benefits are subject to applicable deductible and coinsurance. (The deductible is waived for pediatric immunizations.) Benefits are not subject to the \$500 calendar year routine care maximum.

Options 5 and 6

Covered routine care services are subject to a \$500 calendar year benefit maximum per covered family member. Applicable deductible and coinsurance amounts do not apply.

\$35 Office Visit Exam Copay

Available under Options 1 through 4 only

When you go to a PPO doctor, you pay a \$35 copay for a diagnostic (non-routine) office visit exam (does not apply to consultations or mental illness/substance abuse office visits). X-ray and lab charges and any tests or services the doctor may order will be subject to deductible and coinsurance.

Prescription Drug Coverage

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

Options 1 through 4

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

Refer to the charts on pages 1 through 4 for further details. To review the drug formulary online, go to www.bcbsne.com or call our Member Services Department.

To use your prescription drug benefits, take your Blue Cross and Blue Shield of Nebraska I.D. card and your prescription to an Rx Nebraska participating pharmacy* and pay the applicable coinsurance amount.

**Please note: To be considered in-network, specialty drugs must be purchased through either Triessent® or OptionCare®. For more information, please refer to these brochures.*

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

If you have to file a claim (for example, if you have the prescription filled at a non-participating pharmacy, or if you don't present your card at a participating pharmacy), you will be reimbursed for the cost of the drug less the applicable coinsurance amount and a 25% penalty. Prescription drug coinsurance amounts do not apply toward the health plan's deductible or coinsurance maximum, but do apply toward the calendar year prescription drug out-of-pocket maximum.

Options 5 and 6

Your prescription drug benefits are subject to your plan's in-network deductible and coinsurance amounts.

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

Using Your Mail Service Pharmacy Benefit

If you use the PrimeMail® Mail Service Pharmacy Program, you may order up to a 180-day supply of a covered maintenance medication at one time (if allowed by your prescription).

Please note: If you are ordering a 180-day supply, make sure the prescription is written for a 180-day supply, not including refills. You could pay more out of pocket if the prescription isn't written correctly. To review the listing of covered maintenance medications, go to the Members section of www.bcbsne.com and click on the Pharmacy link.

Under all EHA options, prescription drug benefits are subject to limitations and exclusions. Please refer to your certificate of coverage and Schedule of Benefits.

Inpatient Notification & Certification

Notification

Blue Cross and Blue Shield of Nebraska must be notified of all medical/surgical inpatient hospital admissions. This enables us to coordinate discharge planning, case management and disease management services with the patient's providers. If the patient is hospitalized in a contracting **BluePreferred** hospital in Nebraska, notification will be provided by the hospital.

If the patient is hospitalized in a non-**BluePreferred** hospital in Nebraska or is admitted to an inpatient facility in another state, Blue Cross and Blue Shield of Nebraska must be notified.

Certification

Benefits must be precertified for the following inpatient care, regardless of where the care is received, in or out of network:

- Mental illness and/or substance abuse treatment
- Physical rehabilitation
- Long term acute care
- Skilled nursing facility care

When possible, certification/notification should be completed prior to the inpatient admission. If certification/notification does not take place when required, available benefits for covered services will be reduced by 25%. Benefits for services that are not medically necessary will be denied.

Inpatient notification/certification of benefits: call (402) 390-1870 or 1-800-247-1103

Inpatient Hospital & Long Term Acute Care Benefits

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

- Semiprivate room; cardiac and intensive care units; treatment rooms and equipment.
- Anesthesia.
- Respiratory care.
- FDA-approved drugs, intravenous solutions and vaccines administered in the hospital.
- Chemotherapy.
- Radiology, pathology and radiation therapy.
- Physical, occupational and speech therapy.
- Inpatient physical rehabilitation, subject to benefit precertification and certain requirements.
- Physician-ordered skilled nursing facility services, up to 30 days per calendar year; subject to medical necessity criteria.

Outpatient Hospital Benefits

Benefits for the services listed under “Inpatient Hospital and Long Term Acute Care Benefits” are also available (subject to certain limitations) when they are received in

a hospital outpatient department, emergency room or freestanding ambulatory surgical facility. In addition, benefits for outpatient cardiac and pulmonary rehabilitation are available, subject to preauthorization requirements and medical criteria.

Physician Benefits

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

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

Maternity & Newborn Benefits

Maternity coverage is available to subscribers and covered spouses and dependent daughters. Obstetrical benefits include prenatal and postnatal care. If the member is covered under a single membership, a newborn will be covered for a period of 31 days. Application for change to family coverage must be made within 31 days of birth to continue the baby’s coverage.

Benefits for covered newborn care include hospital room and board, screening tests, physician services and other medically necessary treatment.

Oral Surgery

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

- Pre-treatment evaluation and outpatient removal of impacted teeth.
- Removal of tumors and cysts.
- TMJ services, including invasive surgical procedures and radiology and lab services.
- Bone grafts to the jaw.
- Osteotomies.
- Treatment of natural teeth due to an accident which occurs within 12 months of an injury not related to eating, biting or chewing.

Mental Illness & Substance Abuse

Please note: Under all Educators Health Alliance plans, benefits for covered substance abuse treatment are subject to a \$20,000 per person contract maximum.

Options 1 through 4: Coinsurance for inpatient treatment and copay/coinsurance for outpatient treatment of mental illness and/or substance abuse do not apply toward the calendar year coinsurance maximum. Coinsurance for treatment of a serious mental illness does apply toward the coinsurance maximum.

Options 5 and 6: All coinsurance for covered inpatient and outpatient treatment of mental illness and/or substance abuse applies toward the calendar year coinsurance maximum.

Serious mental illness is defined as any mental health condition that current medical science affirms is caused by a biological disorder of the brain and that substantially limits the life activities of the person with mental illness. Serious mental illness includes, but is not limited to: schizophrenia, schizoaffective disorder, delusional disorder, bipolar affective disorder, major depression and obsessive compulsive disorder. Serious mental illness does not include substance abuse.

Inpatient Treatment

Under all plans, inpatient benefits are subject to a 30-day maximum per calendar year.

Outpatient Treatment

Under all plans, outpatient benefits are subject to a 60-unit maximum per calendar year.

Home Health Aide, Skilled Nursing Care & Hospice Benefits

These covered services require benefit preauthorization. Limitations and exclusions apply.

Home health aide: When related to active medical treatment, benefits include personal services (e.g. bathing, feeding and performing necessary household duties).

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

Hospice care: Benefits include Medicare-certified home health aide services for a terminally ill patient, including nursing services, respite care, medical social

worker visits, crisis care and bereavement counseling. Limited benefits for inpatient hospice care are also available.

Organ & Tissue Transplant Benefits

Benefits are available for covered services associated with medically necessary organ and tissue transplants, including (but not limited to) liver, heart, lung, heart-lung, kidney, pancreas, pancreas-kidney and cornea. Limited benefits are also available for allogeneic/autologous bone marrow transplants for the specific conditions listed in the contract.

Other Covered Services

- Ambulance services.
- Outpatient occupational therapy, physical therapy, speech therapy, cognitive training, chiropractic/osteopathic physiotherapy and spinal manipulations and adjustments, up to a combined maximum of 60 sessions per calendar year.
- Rental/initial purchase (whichever costs less) of medically necessary home medical equipment ordered by a doctor. Limited benefits are available for the repair, maintenance and adjustment of purchased covered medical equipment.
- Diabetes outpatient self-management training and patient management; podiatric appliances. Diabetes education benefits are subject to a maximum of \$500 in a two-year period.
- Services in accordance with the Women's Health and Cancer Rights Act, which requires that a group health plan providing medical and surgical benefits for mastectomies also provide benefits for breast reconstruction, prostheses and treatment of physical complications.

Noncovered Services

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

No benefits are available for the following:

- Audiological exams (except newborn); hearing aids and their fitting.
- Abortions (except to save the life of the mother).

- Blood, plasma, or services by or for blood donors.
- Eye exams, refractions, eyeglasses, contact lenses, eye exercises or visual training.
- Artificial insemination; invitro fertilization; fertility treatment, and related testing.
- Massage therapy by a massage therapist.
- Treatment for weight reduction/obesity, including surgical procedures.
- Nutrition care, supplies, supplements or other nutritional substances, including Neocate, Vivonex and other over-the-counter infant formulas and supplements.
- Radial keratotomy or any other procedures/alterations of the refractive character of the cornea to correct myopia, hyperopia and/or astigmatism.
- Services we consider to be investigative, not medically necessary, experimental, cosmetic or obsolete.
- Services, drugs, medical supplies, devices or equipment that are not cost effective compared to established alternatives or that are provided for the convenience or personal use of the patient.
- Services provided before the coverage effective date or after termination.
- Services for illness or injury sustained while performing military service.
- Services for injury/illness arising out of or in the course of employment.
- Charges for services which are not within the provider's scope of practice.
- Residential treatment programs for treatment of mental illness and/or substance abuse.
- Charges in excess of our contracted amount.
- Charges made separately for services, supplies and materials we consider to be included within the total charge payable.
- Services for any autologous or allogeneic bone marrow transplants not specifically listed in the contract as covered.

THIS CONTRACT DOES NOT PROVIDE BASIC COVERAGE FOR THE TREATMENT OF ALCOHOLISM AS DEFINED BY NEBRASKA LAW. SUCH COVERAGE FOR THE TREATMENT OF ALCOHOLISM IS AVAILABLE IF THE EMPLOYER SPECIFICALLY REQUESTS IT, AND THEN ONLY UPON SUCH TERMS AND CONDITIONS AS THE EMPLOYER AND THE COMPANY AGREE.

This contract provides limited coverage for the treatment of alcoholism as described in this brochure.

New Enrollees

All new employees who enroll within 31 days of employment, and special enrollees who enroll in a timely manner, will have a 12-month waiting period for pre-existing conditions. The waiting period will be decreased by any previous creditable coverage.

Waiting Periods

For new enrollees, no benefits will be paid for a pre-existing condition for 12 months (18 months for late enrollees), after the earlier of the first day of coverage or the first day of the eligibility waiting period (if any).

A waiting period for a pre-existing condition will be reduced or waived by periods of prior creditable coverage applicable to the covered person. A period of creditable coverage will not be counted toward this reduction if there was more than a 62-day period between such prior coverage and the earlier of first day of coverage or the first day of the eligibility waiting period (if any) under this contract. The individual is responsible for providing satisfactory evidence of creditable coverage. The method of calculating creditable coverage will be based on the applicable provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

An eligible dependent who is born or adopted after the effective date of coverage of the parent is not subject to a pre-existing condition waiting period if enrolled within 31 days from the date of birth or placement for adoption.

A pre-existing condition is defined as a condition, whether physical or mental, regardless of the cause of condition, for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period ending on the first day of coverage, or if there is an eligibility waiting period, the first day of such waiting period. Pregnancy is not considered a pre-existing condition.

Late Enrollment

A "late enrollee" is defined as an employee or dependent for whom coverage is not requested within 31 days of his or her initial eligibility or during a special enrollment period. If late enrollment is allowed, coverage for a late enrollee is subject to an 18-month waiting period for pre-existing conditions.

Late enrollees in small school districts (50 or fewer employees) may enroll only during the annual enrollment period designated for the EHA health plan. No

late enrollees will be allowed in large school districts (51 or more employees).

You or your eligible dependents are not considered late enrollees if:

- you and/or your dependent were covered under other qualifying previous coverage at the time of your initial eligibility for this group coverage; and
- you and/or your dependent lost coverage under the qualifying previous coverage as a result of: termination of employment; termination of eligibility; involuntary termination of the qualifying previous coverage; death of a spouse; divorce of a spouse; and
- you and/or your eligible dependent request enrollment within 31 days after termination of qualifying previous coverage; or
- your employer offers multiple health benefit plans and you or your eligible dependent have elected a different plan during an open enrollment period.

Types of Enrollment

Single Membership: Covers the employee only.

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

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

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

Eligible Dependent Children: The employee's unmarried dependent children (excluding foster children) are covered through 18 years of age, or through 23 years of age if full-time students attending an accredited educational institution. Physically or mentally handicapped children may be eligible for continuous coverage after age 18 if application is made within 31 days of the child's 19th birthday. Students who become disabled after age 19 will be eligible for continuous coverage if the student is incapable of attending school due to a mental or physical handicap.

The Allowable Charge

Payment is based on the allowable charge for a covered service. Generally, the allowable charge for services by PPO and Participating providers will be the contracted amount. The allowable charge for services by noncontracting providers will generally be the lesser of the billed charge or the Reasonable Allowance for the service.

What is an HSA?

Options 5 and 6 are HSA-eligible health plans. HSA stands for "Health Savings Account." An HSA is a special tax-exempt account established through a qualified financial institution to pay for medical expenses.

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

Funds in an HSA may be used to pay qualified medical expenses not reimbursed by insurance. Examples include deductibles and coinsurance, charges for non-covered services, and health and long term care insurance premiums. Withdrawals for other purposes are taxable (and before age 65, subject to a 10% penalty).

Contributions may be made by the individual, his or her employer, or both.

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

This brochure contains only a partial description of the benefits, limitations, exclusions and other provisions of Educators Health Alliance health care coverage. It describes the more important parts of the master group contract in a general way, and should not be considered to be all or part of the master group contract. In the event there are discrepancies between this document and the contract, the terms and conditions of the contract will govern.



Your Online Tools and Resources

from Blue Cross and Blue Shield of Nebraska

AccessBlue

AccessBlue is our secure online member services portal, available 24 hours a day, seven days a week.

When you register with AccessBlue, you can check the status of a claim, view your Explanation of Benefits online, print or request I.D. cards, find a network hospital and use interactive tools to help manage your family's health care needs and costs -- whenever and wherever it's convenient for you.

Once your coverage becomes effective, you will be able to register to start using AccessBlue. Within 24 to 48 hours of your initial online registration, you will receive a letter from us containing the unique access code you'll need to log in and start using AccessBlue. If you have any questions about registration, just call the **AccessBlue Help Line at 1-877-704-2583.**

To register to start using AccessBlue, go to:
www.bcbsne.com.

Registered AccessBlue users have access to four interactive online tools: Healthcare Advisor, Treatment Cost Advisor, Coverage Advisor and MyRxHealth.

Healthcare AdvisorSM

Healthcare Advisor's treatment decision support tools help users better understand their options. You can learn what to expect when diagnosed with an illness, or before having surgery. You can use it to research different treatment options, and determine which hospitals have met leading standards for patient safety.

Treatment Cost AdvisorSM

The Treatment Cost Advisor tool helps you estimate medical costs before you receive care. Find cost information for many common medical conditions and health care services. Get reliable cost estimates and in- and out-of-network cost comparisons.

Coverage AdvisorSM

Coverage Advisor helps you determine which health care services you are likely to need, and then estimates the annual cost of those services. Coverage Advisor helps you make informed benefit plan decisions.

MyRxHealth

MyRxHealth, from Blue Cross and Blue Shield of Nebraska's pharmacy benefits manager, Prime Therapeutics, Inc., is loaded with valuable information and interactive tools that employees can use to manage their families' prescription drug purchases.

At MyRxHealth, you can find benefit information and personal Rx claim history, drug formulary look up, Rx Nebraska participating pharmacy locator, drug cost calculator and comparison of brand name and generic drug costs.

BlueHealth Advantage

The lifestyle decisions we make regarding diet, weight, exercise, smoking, seatbelt use and more directly impact our health care costs.

BlueHealth Advantage, our wellness and lifestyle management website, can help you make positive lifestyle changes. BlueHealth Advantage offers:

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

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





To contact the Blue Cross and Blue Shield of Nebraska Member Services Department

Phone

Omaha (402) 390-1855
Toll-free 1-800-642-6004

E-mail

www.bcbsne.com

To locate BluePreferred providers in Nebraska

Phone

Omaha (402) 390-1855
Toll-free 1-800-642-6004

Website

www.bcbsne.com

To locate BlueCard PPO providers nationwide

Phone

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

Website

www.bcbs.com

To locate participating Rx Nebraska pharmacies nationwide

Phone

1-877-800-0746

Website

www.bcbsne.com



**BlueCross BlueShield
of Nebraska**