Health Care Benefits for

FAMC Employees

(Fremont Area Medical Center)

effective as of 1/2007

BlueCross BlueShield of Nebraska

About Your Benefit Plan Description

This document is your Benefit Plan Description. It has been written to help you understand your group health care plan administered in accordance with the provisions set forth in the Master Group Contract and Administrative Service Agreement between Fremont Area Medical Center (FAMC) and your Contract Administrator, Blue Cross and Blue Shield of Nebraska,* an independent licensee of the Blue Cross and Blue Shield Association.

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

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

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

Fremont Area Medical Center (FAMC)

Summary of Health Benefits for Options 1 and 2

Effective January 1, 2007

	Option 1	Option 2
Total Benefits (Overall):	$2,000,000	$2,000,000
Total Benefit for Treatment of Drug Abuse and/or Alcoholism:	$20,000	$20,000

	Option 1		Option 2	
	BluePreferred (PPO) Provider	**Non-Preferred (Non-PPO) Provider**	**BluePreferred (PPO) Provider**	**Non-Preferred (Non-PPO) Provider**
Calendar Year Deductible				
Individual:	$300	$600	$800	$1,600
Family Maximum:	$600	$1,200	$1,600	$3,200
Coinsurance* for Covered Services				
Most Hospital/Medical/Surgical:	20%	30%	20%	30%
Inpatient MIDA** Treatment:	20%	60%	20%	60%
Outpatient MIDA** Treatment:	30%	60%	30%	60%
Coinsurance* Liability Limit				
Individual:	$2,000	$2,750	$3,500	$6,125
Family Maximum:	$3,250	$4,375	$5,500	$9,438
Annual Out-of-Pocket				
Individual:	$2,300	$3,350	$4,300	$7,725
Family Maximum:	$3,850	$5,575	$7,100	$12,638
Preventive (Routine) Benefit:	The first $500 per calendar year will not be subject to any deductible or coinsurance. Benefits for covered services in excess of $500 will be subject to the applicable coinsurance.			

Summary of Rx Benefits for Options 1 and 2

	Retail (Copay per 30-day supply)	**Mail Order** (Copay per 90-day supply)
Rx Nebraska Drug Card Program		
Generic Prescription:	$15	$30
Formulary Brand Prescription:	$35	$88
Non-Formulary Brand Prescription:	$50	$150

***** Coinsurance is the percentage of each allowable charge which you must pay.

****** Mental Illness, Drug Abuse and/or Alcoholism (MIDA) Treatment.

Important Telephone Numbers

Customer Service:

Omaha 402-390-1820
Toll-free 1-800-642-8980
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

Inpatient Notification / Certification:

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

BlueCard Provider Information:

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

Pharmacy Locator:

Toll-free 1-877-800-0746

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Some Important Facts About Your Coverage

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

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

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

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

By using Preferred Providers, you benefit from these important advantages:

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

When this plan pays benefits for services provided to you, it pays directly to the Preferred Provider. This way you do not have to pay a Preferred Provider more than a deductible and/or coinsurance amount at the time covered services are provided. **Preferred Providers will also file claims for you.**

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

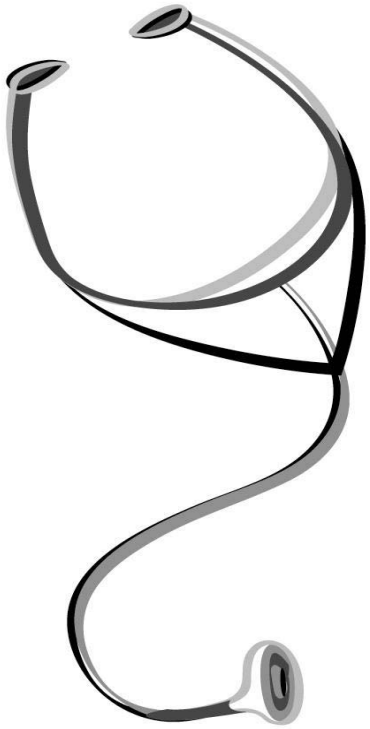
USING YOUR BENEFITS WISELY

Blue Cross and Blue Shield of Nebraska 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.

Selecting A Provider

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



In the Blue*Preferred* Service Area (Nebraska)

Selection of a provider of care always remains your choice. If you choose a Blue*Preferred* Provider, you are eligible to receive the highest benefit level (preferred) possible under your group health plan. However, if you choose a non-Preferred Provider, the benefit level (non-preferred) will generally be less. For help in locating a Blue*Preferred* Provider, contact Blue Cross and Blue Shield of Nebraska's Customer Service Center at their toll-free number (1-800-642-8980). A directory of *BluePreferred* Providers is available upon request or at the Blue Cross and Blue Shield of Nebraska website: **www.bcbsne.com**.

Outside the Blue*Preferred* Service Area

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

Also, for help in locating a provider, you can visit the "BlueCard PPO Provider Finder" at the Blue Cross and Blue Shield Association website: **www.bcbs.com.**

BlueCard Program

Blue Cross and Blue Shield plans across the country participate in the BlueCard Program. This program enables the Blue Cross and Blue Shield plan servicing the geographic area where health care services are provided (on-site plan) to receive and process claims for covered services.

When you obtain health care services through the BlueCard Program outside the geographic area Blue Cross and Blue Shield of Nebraska serves, the amount you pay for covered services is calculated on the lower of:

- The billed charges for your covered services, or
- The contracted amount that the on-site Blue Cross and Blue Shield Plan (Host Blue) passes on to Blue Cross and Blue Shield of Nebraska.

Often, this contracted amount will consist of a simple discount which reflects the actual price paid by the Host Blue. But sometimes it is an estimated price that factors into the actual price expected settlements with your health care provider or with a specified group of providers. The contracted amount may also be billed charges reduced to reflect an **average** expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The contracted amount may also be adjusted in the future to correct for over or underestimation of past prices. However, the amount you pay is considered the final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating subscriber liability for covered services that does not reflect the entire savings realized or expected to be realized on a particular claim or to add a surcharge. Should any state statutes mandate subscriber liability calculation methods that differ from the usual BlueCard method noted above, or require a surcharge, Blue Cross and Blue Shield of Nebraska would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

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

Blue Cross and Blue Shield of Nebraska will issue you an identification card. Your I.D. number is a unique alpha numeric combination including an alpha prefix and a numeric suffix. If other members of your family are covered by your membership, their names and dates of birth will also appear on your I.D. card. Each family member will be assigned a different numeric suffix. Only five names can appear on one I.D. card; therefore, you will receive more than one card if there are more than five eligible family members.

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

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

Schedule of Benefits

Your Schedule of Benefits is a personalized document that provides information concerning: Preferred and non-Preferred Provider deductibles, coinsurance, special benefits, and maximums and limitations of your coverage. It also identifies the type of membership option you have and indicates if any waiting periods are in effect.

Eligibility & Enrollment

Eligibility for Coverage

All full-time, regular employees who are regularly scheduled to work 40 hours per two week pay period are eligible to enroll for coverage after the employee has served a probationary period of 30 consecutive days from the date of hire. Subscribers and dependents must enroll within 31 days of their initial eligibility, or late enrollment provisions may apply. If you acquire dependents through marriage, birth or adoption, a 31-day special enrollment period is allowed to request coverage for them under this group health plan.

Please see the sections titled “Special Enrollment” and “Late Enrollment” for additional information. You may also contact Blue Cross and Blue Shield of Nebraska’s Customer Service Center for information.

Types of Membership

There are three types of enrollment options offered by Fremont Area Medical Center (FAMC) for your health plan. The enrollment option you have elected is shown on your Schedule of Benefits.

Please Note: A “Single Plus One” membership will be identified on your Schedule of Benefits as either a Subscriber-Spouse Membership or a Single Parent Membership (you plus one child).

Single Membership: Provides coverage for you only.

Single Plus One Membership: Provides coverage for you and your spouse, or for you and one dependent child.

Family Membership: Provides coverage for you, your spouse and your eligible dependent children.

Eligible Dependent is defined in the Definitions section of this book.

Note: *If two eligible persons are both employees of Fremont Area Medical Center (FAMC) and are married to each other, each person and/or their eligible dependents may not enroll under more than one membership option.*

Special Enrollment

A special enrollment period of 31 days is allowed for:

- enrollment of eligible persons due to marriage, birth, adoption or placement for adoption;
- enrollment of eligible persons not previously covered under this plan due to having had other 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, 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, 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 lifetime limit on all benefits is exhausted, or

  the employer ceasing to make contribution for the other coverage.

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. A special enrollee, other than a newborn, adopted child or a child placed for adoption, will be subject to the 12-month waiting period for pre-existing conditions with credit given for prior creditable coverage. 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. An eligible person who enrolls for coverage during a "special enrollment period" is not considered a late enrollee. A late enrollee will be subject to an 18-month waiting period for pre-existing conditions.

Late enrollment is only allowed during the open enrollment month of November, prior to the annual renewal date. Enrollment Forms must be signed by the last day of open enrollment and must be received by Blue Cross and Blue Shield of Nebraska in a timely manner. Coverage requested during November will be effective on the first of January. Please contact your Human Resource Department for additional information.

Please note that in order to avoid late enrollment restrictions, you must request enrollment within 31 days of your (or your dependent’s) initial eligibility, or during a special enrollment period, if applicable.

Waiting Period for Pre-existing Conditions

Your Schedule of Benefits shows whether or not a waiting period for pre-existing conditions applies to your (or your dependent’s) coverage. If a waiting period applies, no benefits will be paid for a pre-existing condition for a period of 12 months (18 months for a late enrollee) from the earlier of the effective date of coverage or the first day of the eligibility waiting period (if any).

The waiting period for pre-existing conditions does not apply to a child who is born, adopted or placed for adoption after your effective date of coverage, who is otherwise eligible for coverage, and enrolled within 31 days of the birth, adoption or placement for adoption. Nor does it apply to such a child who, as of the last day of a 31-day period beginning on the date of birth, adoption or placement for adoption was covered under other creditable coverage which ended not more than 63 days prior to the enrollment in this plan.

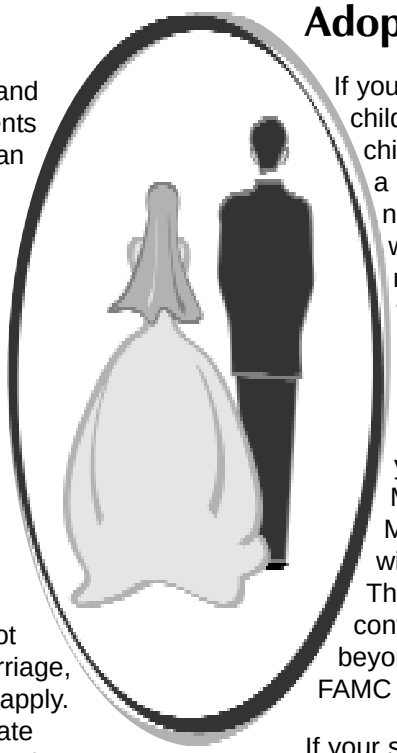
A **pre-existing condition** is defined as a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the six month period ending on the first day of coverage, or if there is an eligibility waiting period, the first day of such waiting period. A pre-existing condition does not include a pregnancy. Genetic information shall not be treated as a pre-existing condition unless there is a diagnosis of the condition related to such information.

Reduction of waiting period - The waiting period for pre-existing conditions may be reduced or waived by periods of prior creditable coverage if there is not a significant break in coverage. A significant break in coverage is a period of 63 days during which the individual does not have any creditable coverage. Days of creditable coverage that occur before a significant break in coverage will not be counted toward the reduction of a waiting period. Neither an Eligibility Waiting Period nor an HMO affiliation period is taken into account in determining a significant break in coverage.

The individual is responsible for providing satisfactory evidence of creditable coverage in order to reduce the waiting period. The method of calculating creditable coverage will be based on the applicable provisions of the Health Insurance Portability and Accountability Act of 1996. You may request a “certificate of creditable coverage” from your prior plan(s) or health insurer(s). If necessary, we will help you obtain it from them. Please contact your plan administrator for assistance, or you may contact the Blue Cross and Blue Shield of Nebraska Customer Service Center.

“Creditable Coverage” is defined in the “Definitions” section of this document.

Marriage



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

If the request for coverage is not made within 31 days of the marriage, late enrollment provisions may apply. Please see the section titled "Late Enrollment" for additional information.

Newborn Children

If you have a Family Membership in effect on the date of birth, coverage shall begin at birth for your newborn child. Please notify Blue Cross and Blue Shield of Nebraska of the birth within 31 days, so that they may update your records.

If you have a Single Membership in effect at the time of birth, or a Single Plus One Membership that includes only your spouse or another dependent child, you must request a change to a Family Membership (or a Single Plus One Membership if appropriate) within 31-days of the birth in order to cover the child. The applicable premium must be paid. Please contact FAMC for premium information.

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

If you request enrollment of the child (and spouse, if applicable) after the 31-day period, late enrollment provisions may apply.

Adopted Children

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

If you have a Single Membership in effect, or a Single Plus One Membership that includes only your spouse or another dependent child, you must request a change to a Family Membership (or to a Single Plus One Membership, if appropriate) and enroll the child within 31 days of the placement for adoption. The applicable premium must be paid in order to continue the newly adopted child's coverage beyond the initial 31-day period. Please contact FAMC for premium information.

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

If you request enrollment of the child (and spouse, if applicable) after the 31-day period, late enrollment provisions may apply.

Disabled Dependent Children

A physically or mentally disabled child may remain an eligible dependent child upon reaching age 19 if incapable of self-sustaining employment, or of returning to school as a full-time student, by reason of mental or physical handicap, and dependent upon you for support and maintenance. The application for such coverage must be received within 31 days of the dependent's 19th birthday and the dependent must meet all other group coverage eligibility requirements.

A child who becomes physically or mentally disabled while a covered student over 18 years of age may continue under your health care coverage while remaining incapable of returning to school as a full-time student, unmarried and dependent upon you for support and maintenance. You must furnish proof of disability within 31 days of its onset. (This extended coverage is subject to all other group coverage requirements.)

An application for extension of dependent coverage is available through Blue Cross and Blue Shield of Nebraska's Customer Service Center.

Qualified Medical Child Support Orders

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

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

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

Active Employees Ages 65 and Over

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

Family Medical Leave Act (FMLA)

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

Termination Of Coverage

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

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

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

Continuation Of Coverage (COBRA)

The consolidated Omnibus Budget Reconciliation Act, known as COBRA, is a federal law which provides that covered employees and their dependents may elect to continue coverage under the group health plan if coverage is lost due to the occurrence of certain "qualifying events." Persons who are eligible to continue coverage are called "qualified beneficiaries." A qualified beneficiary also includes a child born to, or placed for adoption with you during a period of COBRA coverage. The COBRA qualifying events are described below, as well as the procedures for electing COBRA continuation coverage. **Payment for continuation coverage is at the employee's or dependent's own expense.**

NOTE: *To protect your rights under COBRA, please keep your employer informed of your current address.*

Please share the COBRA 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:

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

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

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

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

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

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

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

Change in Dependent Status, Divorce or Separation or Medicare Entitlement

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

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

When one of these circumstances occurs, you or the dependent are obligated to notify your employer or plan administrator within 60 days. The failure to provide timely and proper notice may result in the loss of the right to COBRA coverage.

After receiving a timely notice of such an event, your employer or plan administrator will send the qualified

beneficiaries an election form and information needed to apply for coverage, if eligible. The coverage may be continued at his/her expense **for up to 36 months.**

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

Your Death

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

COBRA provides that subject to certain limitations, your surviving spouse and children may continue the group coverage at their own expense for up to 36 months. **Federal law requires your employer to send the surviving family members instructions as to how to apply for continued coverage, if they are eligible.**

Electing COBRA Coverage

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

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

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

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

The election form must be received by the later of:

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

COBRA continuation coverage may only begin on the day after coverage under the plan would otherwise end. The required premium, including any retroactive premium, must be paid from the day coverage would have otherwise ended. The premium must be paid within 45 days after the day continued coverage is elected. Succeeding premiums must be paid monthly within 30 days of the premium due date. The COBRA notice and election form will inform you or your dependents of the monthly premium amount, and to 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 the continued health insurance is converted to conversion coverage,
- the day the individual becomes entitled to benefits under Medicare (after the COBRA election), or

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

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

Trade Adjustment Assistance (TAA) Reform Act of 2002

The Trade Adjustment Assistance (TAA) Reform Act provides benefits to individuals eligible for trade adjustment assistance because international trade has adversely affected their employment. The Act provides that a TAA eligible individual who did not elect continuation coverage during the initial COBRA election period is entitled to a second 60-day election period. This election must take place no later than six months after the date of the TAA related loss of coverage. It also includes a federal tax credit of 65% of premiums paid for qualified private health insurance coverage, including COBRA coverage.

Additional information regarding requirements and benefits under the TAA Reform Act may be obtained from the U.S. Department of Labor or the Nebraska Workforce Development, Department of Labor.

Uniformed Services Employment And Reemployment Rights (Military Leave)

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

Continuation of Group Health Coverage:

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

- 24 consecutive months from the date active duty began; or
- the day after the date on which you fail to apply for, or return to employment, in accordance with USERRA.

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

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

- the day the employer ceases to provide any group health plan for its employees;
- the day premium is due and unpaid;
- the day a covered person again becomes covered under the plan;
- the day coverage has been continued for the period of time stated in the previous paragraph, above.

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

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

Conversion Privilege

A covered person may elect to apply for conversion coverage at his/her own expense, whenever his/her coverage under this group plan is terminated, subject to the following requirements:

- The covered person is no longer eligible for this group coverage.
- The covered person becomes eligible for conversion coverage while the group plan's contract with Blue Cross and Blue Shield of Nebraska is still in effect.
- The application for conversion coverage is received by Blue Cross and Blue Shield of Nebraska (or other appropriate Blue Cross and Blue Shield plan) within 31 days of the termination of the covered person's group coverage or within 31 days of the eligible dependent's ineligibility for group coverage, or within 31 days of the expiration date of the covered person's maximum COBRA coverage period.
- The premium payment for the first month's dues must be submitted with the application for conversion coverage. The covered person is responsible for this premium amount, as well as any succeeding premium amounts for conversion coverage.
- The conversion coverage will be issued without medical underwriting under the same type of membership unit as is held by the covered person. If appropriate, any covered person may apply for a Single Membership conversion if his/her prior coverage was under a Family Membership unit.

Benefits provided by the conversion coverage and all other terms and conditions thereof, including rates shall be determined by Blue Cross and Blue Shield of Nebraska (or other appropriate Blue Cross and Blue Shield plan). **Note: Such benefits may be different from benefits provided under this group plan.** Please refer to your employer's Master Group Contract for more complete information, or you may contact Blue Cross and Blue Shield of Nebraska's Customer Service Center for assistance.

Note: *If a covered person is an inpatient on the date of change to a nongroup conversion plan, hospital benefits for that admission will be provided under this group plan.*

In the event you reside in a state other than Nebraska, please contact the Blue Cross and Blue Shield plan servicing your area. If you need assistance in locating that plan, please contact Blue Cross and Blue Shield of Nebraska's Customer Service Center for the plan's address and/or telephone number.

Understanding Your Health Coverage

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

Hospital and Skilled Nursing Facility Benefits

Physician Medical-Surgical Benefits

Mental Illness, Drug Abuse, and Alcoholism Benefits

Organ/Tissue Transplant Benefits

Oral Surgery and Dentistry Benefits

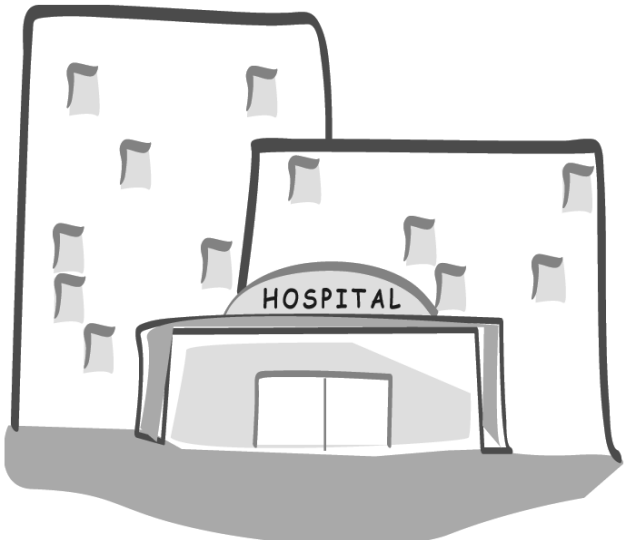
Home Health Aide, Skilled Nursing Care and Hospice Benefits

Other Benefits — Including such services as ambulance service, physical therapy, speech therapy, home medical equipment and certain other services.

Prescription Drug Card Benefits — Benefits are available for covered prescription medications, insulin, injectables (including needles and syringes), and diabetic and ostomy supplies under the Rx Nebraska Prescription Drug program. Please note that Rx Nebraska is not a part of the BluePreferred network.

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

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



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

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

Important Health Coverage Terms

Allowable Charge — Payment is based on the allowable charge for a covered service. Generally, the allowable charge for services by Preferred or Contracting Providers will be a contracted amount for the service. The allowable charge for services by non-Contracting Providers will generally be the lesser of the billed charge or reasonable allowance for the service. Please refer to the Definitions found in the back of this document for details.

Reasonable Allowance — The amount determined by Blue Cross and Blue Shield of Nebraska to be payable to non-contracting providers for a covered service.

Coinsurance — This is the percentage you must pay, after the deductible is applied. (Your coinsurance payment is generally lower if you receive services from a Preferred Provider.)

Copayment — This is a fixed dollar amount you must pay for certain services.

Deductible — There is a calendar year deductible applicable to each covered person before benefits begin. For a family, the maximum deductible amount is limited to twice the individual deductible amount per calendar year. After the deductible is met, benefits for the rest of that calendar year will not be subject to any further deductible. If you or your covered dependents do not meet your deductible(s), any covered charges incurred in October, November and December may be carried over and applied against the next year's deductible.

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

Coinsurance Limit — The coinsurance limit is the total amount of coinsurance each covered person must pay in a calendar year, except as noted below. When the amount of your eligible coinsurance payments equals the dollar amount specified on your Schedule of Benefits and on the chart in the front of this book, the coinsurance percentage no longer applies for the rest of the calendar year. For a family, the maximum coinsurance amount is limited per calendar year. This dollar amount is specified on your Schedule of Benefits. After the limit is met, benefits for the rest of that calendar year will not be subject to any further coinsurance amounts.

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

- Charges in excess of the allowable charge.
- Charges for services that are not covered by this group plan.
- The coinsurance for treatment of mental illness, drug abuse and alcoholism (unless otherwise noted) under any part of this group plan.
- The calendar year deductible.
- The reduction amount as a result of a failure to comply with inpatient notification and certification provisions.
- The coinsurance or copayment for a prescription drug charge processed under the Rx Nebraska Prescription Drug Program.

Your deductible, copayment, coinsurance and coinsurance limit amounts are chosen by your employer and are shown on your Schedule of Benefits and on the chart in the front of this book.

Total Benefits — Your Schedule of Benefits shows a specific dollar maximum per insured for benefits under this group plan. Separate maximums applicable to specific benefits under your group health plan will also be indicated on your Schedule of Benefits.

NOTICE

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

Utilization Review

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

Fraud or Misrepresentation

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

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

Medical Records

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

Inpatient Notification, Certification And Concurrent Review

Notification Requirements

Blue Cross and Blue Shield of Nebraska must be notified of all medical/surgical inpatient hospitalizations prior to admission. When you are treated at a BluePreferred hospital notification will be provided by the hospital.

When you are hospitalized in a Non-BluePreferred hospital or in a hospital outside of Nebraska, it is your responsibility to see that Blue Cross and Blue Shield of Nebraska is notified of the admission. Notification may be made by you, your physician, the hospital, or someone acting on your behalf. If the anticipated admission date changes, notification of the change must be made. Make sure you advise the members of your family about these requirements since they apply to you and your covered family members.

If you fail to provide notification of the admission, allowable charges for all covered services associated with that stay will be reduced by $500. Benefits for all services which are determined to be not medically necessary will be denied.

Emergency admission: Blue Cross and Blue Shield of Nebraska must be notified of an admission for an emergency medical condition within 24 hours of the admission (or the next business day). If notification is not received, the 24-hour period prior to the admission and the 24 hour period after such admission will be reviewed to determine if the patient'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.

Maternity admission: 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 patient and her physician. Notification or Certification is not required for an initial maternity admission. However, certification is required if the hospitalization extends beyond these times.

Certification Requirements

All inpatient admissions related to the treatment of mental illness and/or substance abuse; physical rehabilitation; long term acute care and skilled nursing facility care must be precertified for benefit payment. Precertification is required regardless of the PPO/Preferred status of the hospital or facility and whether it is in or out-of the state of Nebraska.

When Blue Cross and Blue Shield of Nebraska 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 Blue Cross and Blue Shield of Nebraska (or by persons designated by Blue Cross and Blue Shield of Nebraska).

The physician, hospital, covered person or someone acting on the covered person's behalf may request the certification. Blue Cross and Blue Shield of Nebraska will notify such provider, the covered person or someone acting on the covered person's behalf whether or not benefits will be certified for an inpatient admission and the number of days considered medically necessary.

When possible, admission certification by the facility or physician should be arranged prior to the inpatient admission. Claims may be denied if the covered person's condition or the facility does not meet the criteria for the admission.

If certification of an admission by the covered person was possible, and not made, the allowable charge for all related services will be reduced by $500. In addition, benefits for services determined to be not medically necessary will be denied.

The Concurrent Review Process

Concurrent Review is a review of an ongoing inpatient admission to analyze the medical necessity and appropriateness of your continued inpatient stay.

If additional days are needed beyond the number of days originally certified, benefits for those days must also be certified. The hospital or other facility will be advised to call Blue Cross and Blue Shield of Nebraska to determine if additional days are medically necessary.

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

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

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

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

AVOID WEEKEND ADMISSIONS

Ask your physician to avoid nonemergency weekend admission 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.

Hospital And Facility Services

Inpatient Hospital Care

A deductible amount equal to one days' semi-private room rate will be applied to each inpatient hospital/ facility admission unless the admission is related to a medical emergency, an accident or to childbirth.

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

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

Cardiac care or intensive care unit.

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

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

Anesthesia.

Respiratory care.

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

Administration and processing of blood, blood plasma, blood derivatives or fractionates.

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

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

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

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

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

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

Reminder: Blue Cross and Blue Shield of Nebraska must be notified of all medical/surgical inpatient hospital admissions. Failure to provide notification of the admission will result in the allowable charges being reduced by $500.

Long Term Acute Care

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

Benefits must be <u>precertified</u> for <u>all</u> Long Term Acute Care admissions regardless of the facility's Preferred or non-Preferred status. If certification of an admission was possible, and not made, the allowable charge for all related covered services will be reduced by $500.

Physical Rehabilitation Program

Benefits for inpatient physical rehabilitation services must be precertified by Blue Cross and Blue Shield of Nebraska prior to admission. If certification of an admission was possible and not made, allowable charges for all related covered services will be reduced by $500. The covered person must be disabled and meet specifications for coverage as determined by Blue Cross and Blue Shield of Nebraska. The inpatient rehabilitation must follow within 90 days of the acute hospitalization for the injury, illness or condition causing the disability. Benefits are not available for Custodial Care.

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

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

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

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

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

Benefits for physical rehabilitation will stop when:

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

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

Reminder: All inpatient admissions related to an inpatient physical rehabilitation admission must be precertified for benefit payment by Blue Cross and Blue Shield of Nebraska prior to admission. Precertification may take place at any time prior to admission, or within 24 hours after admission.

Skilled Nursing Facility

Benefits are available for up to 30 days per calendar year for medically necessary skilled nursing care services provided in a semi-private room of a skilled nursing facility. Benefits for all skilled nursing facility admissions must be precertified by Blue Cross and Blue Shield of Nebraska. If certification was possible and not made, the allowable charge will be reduced by $500.

The covered person must be confined in a free-standing facility licensed by the state as a Nursing Facility (NF) or licensed by the state and/or certified by Medicare as a Skilled Nursing Facility (SNF) or, part of a hospital with designated beds licensed by state law and/or certified by Medicare as Skilled Nursing or Swing Beds. The facility or such part of the facility must provide medically necessary room, board, and 24-hour-a-day skilled nursing care, as well as other related services for the care and rehabilitation of injured, disabled or sick persons.

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

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

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

A skilled nursing facility does not include:

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

Skilled nursing facility care does not include:

- supportive services of a stabilized condition;
- care which can be learned and given by unlicensed or uncertified medical personnel;
- routine health care services;
- general maintenance or supervision of routine daily activities, or
- routine administration of oral or non-prescription drugs.

Inpatient Mental Illness and Substance Abuse

Benefits will be provided for medically necessary, scientifically validated covered services provided for the treatment of mental illness and/or substance abuse as described in the part of this book titled "Mental Illness And Substance Abuse".

All inpatient admissions to any hospital or treatment center for treatment of Mental Illness and/or Substance Abuse must be precertified regardless of whether care is received at a BluePreferred, Preferred or non-Preferred facility in Nebraska or in another state.

When You Use Outpatient Facilities

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

EMERGENCY ROOMS ARE EXPENSIVE

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

Outpatient Cardiac Or Pulmonary Rehabilitation

Benefits will be provided for medically necessary outpatient cardiac or pulmonary rehabilitation services. Benefits must be preauthorized by Blue Cross and Blue Shield of Nebraska.

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

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

Benefits are not available for:

- diet or dietetic instructions,
- smoking cessation classes,
- medication instruction,
- weight control and/or instruction,
- recreational or educational therapy, or forms of nonmedical self-help or self-care therapy, or
- environmental control items such as air conditioners and dehumidifiers.

The cardiac or pulmonary rehabilitation program must be accredited by the Joint Commission on the Accreditation of Healthcare Organizations, or as otherwise approved by Blue Cross and Blue Shield of Nebraska.

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.

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

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

Pulmonary Rehabilitation — Benefits will be provided prior to and following:

- lung transplant,
- heart-lung transplant,
- lung volume reduction surgery, and
- for severe chronic lung disease patients as reviewed and determined by Blue Cross and Blue Shield of Nebraska.

Pulmonary rehabilitation services will be limited to the following:

- Chronic lung disease patients are limited to 18 sessions (including follow-up home sessions) initially and after significant changes in clinical status. However, no more than 18 sessions will be covered in a single calendar year.
- Lung transplant, heart-lung transplant and lung volume reduction surgery patients are limited to 18 sessions following referral and prior to surgery plus 18 sessions within six months of discharge from the hospital following surgery.

- Pulmonary rehabilitation services will be covered only when under continuing supervision of a physician and in a hospital environment.

Preauthorization Request Procedure: Benefits must be preauthorized by Blue Cross and Blue Shield of Nebraska for a cardiac or pulmonary rehabilitation program, prior to starting the program. A written request for preauthorization should be directed to Blue Cross and Blue Shield of Nebraska, Attention: Medical Support Department, P.O. Box 3248, Omaha, Nebraska 68180-0001.

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

Physician's Services

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

Covered services include:

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

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

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

OUTPATIENT SURGERY

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

Anesthesia Services by a physician or certified registered nurse anesthetist. Benefits are also available for an oral surgeon or dentist with a permit issued by the state, to administer general anesthesia. The amount payable for anesthesia services will include the usual preoperative and postoperative visits and the necessary management of the patient, during and after the administration of the anesthesia. Payment will not be made for supervision of the administration of anesthesia. Benefits will not be provided for local infiltration or the administration of anesthesia by the attending or assisting surgeon (except spinal, saddle or caudal blocks related to pregnancy or general anesthesia for covered oral surgery and dentistry procedures under this contract).

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

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

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

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

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

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

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

Tissue exams related to covered surgical procedures.

Interpretation of Pap Smears.

Screening mammograms and corresponding fees for technical and professional interpretation of mammograms. No waiting periods shall apply to mammograms or resulting biopsies or other tests used to clarify a diagnosis. Diagnoses other than benign mammary dysplasias will be subject to waiting periods.

Fertility testing and related services up to an overall dollar maximum benefit of $5,000 for each covered person. Covered services include medically necessary office visits, consultations, ultrasounds, radiology and laboratory tests, surgery and hormone therapy (This dollar limitation also includes covered fertility drugs which are not covered under the section titled "Prescription Drug Benefits-Rx Nebraska.")

Routine/Preventive care. Benefits are available for routine care for a covered person, up to $500 per calendar year, not subject to any deductible or coinsurance amounts.

Benefits for routine/preventive care covered services in excess of the $500 calendar year maximum will be subject to the applicable coinsurance amount.

Routine care services include inpatient newborn well infant examinations, periodic office examinations to determine physical development, routine office visits, radiology and laboratory testing, mammography, pap smears and immunizations.

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

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

Allergy tests, allergy extracts and injections of allergy extracts.

PREADMISSION TESTING SAVES TIME AND TROUBLE

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

Pregnancy And Maternity Care

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

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

Benefits may not, under Federal law, be restricted for any hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, benefits may be paid for a shorter stay if the mother's or newborn's attending provider, after consulting with the mother, discharges the mother or newborn earlier. 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 to the patient 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).

Postpartum depression, psychosis or any other mental illness are not considered complications of pregnancy under this part. Limited benefits for this type of condition are provided under your mental illness benefits.

Benefits are not available for voluntary abortions unless the attending physician certifies that the abortion is necessary to safeguard the life of the covered person, or that the child's viability was threatened by continuation of the pregnancy.

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

Newborn Care

Benefits will be available at birth for covered services for an eligible newborn infant. Covered services include: room and board, screening tests including the infant hearing exam, physician's services for a newborn well infant while hospitalized including circumcision, newborn screening services for an infant born at home, and medically necessary definitive medical or surgical treatment.

If you have a Family Membership in effect at the time of the birth, the newborn is eligible and benefits shall be available from birth. If you have a Single Membership in effect at the time of birth, or a Single Plus One Membership that includes only your spouse or another dependent child, coverage will be available to the newborn only if you request a change to an appropriate membership option and enroll the child within 31 days of birth and pay the additional premium.

Mental Illness, Alcoholism And Drug Abuse (Substance Abuse) Benefits

Benefits are available for medically necessary covered services provided as treatment for mental illness, drug abuse or alcoholism (substance abuse). The benefits for treatment of substance abuse are limited to a maximum of $20,000. Benefits for covered services are subject to satisfaction of the applicable deductible and coinsurance amounts as indicated on your Schedule of Benefits and on the chart in the front of this book. Remember, the applicable amounts depend on whether the services are provided by a Preferred Provider or a non-Preferred Provider.

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

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

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

Inpatient Care

Benefits are available for acute inpatient treatment of mental illness and/or substance abuse for up to 30 days per calendar year. A person shall be considered to be receiving inpatient treatment if he or she is confined to a hospital or a substance abuse treatment center that provides medical management including 24-hour nursing care. Services provided by a facility that does not meet these criteria are considered part of a residential treatment program, and are not covered under the group health plan.

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

Note: Benefits for ALL inpatient admissions must be precertified by Blue Cross and Blue Shield of Nebraska. (Please refer to the Inpatient Notification, Certification section of this book for details.)

Outpatient Care

Benefits are also available, subject to the applicable deductible and coinsurance amount indicated on your Schedule of Benefits and on the chart in the front of this book, for up to 60 units of outpatient treatment of mental illness or substance abuse. One “unit” consists of covered services received on one day.

Outpatient Covered Services Include:

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

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

Benefits are also available for covered hospital and physician outpatient services not listed above. Such covered services include laboratory and diagnostic services, psychiatric/psychological testing and other covered psychiatric services. Benefits for these services are subject to the applicable deductible and coinsurance, as indicated on your Schedule of Benefits and on the chart in the front of this book.

Serious Mental Illness

Benefits for treatment of serious mental illness will not be subject to the inpatient limit of 30 days per calendar year or the outpatient limit of 60 units per calendar year. 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 the serious mental illness. Serious mental illness includes, but is not limited to:

- schizophrenia
- schizoaffective disorder
- delusional disorder
- bipolar affective disorder
- major depression
- obsessive compulsive disorder

Serious mental illness does not include substance abuse.

Coinsurance paid by the covered person for inpatient or outpatient services for treatment of a serious mental illness stated above will be included in the maximum coinsurance liability limit.

Remember, the applicable deductible and coinsurance amounts depend on whether or not the services are provided by a Preferred provider (BluePreferred).

Oral Surgery And Dentistry

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

Evaluation and treatment of impacted teeth.

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

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

Invasive surgical procedures of the jaw or the temporomandibular (jaw) joint, except as limited below for covered implants.

Medically necessary x-ray or diagnostic services for the temporomandibular joint of the jaw.

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

Reduction of a complete dislocation or fracture of the temporomandibular (jaw) joint required as a direct result of an accidental injury. Benefits are limited to covered treatment provided within 12 months of the injury. Dislocations or fractures resulting from eating, chewing or biting are not covered.

Services, supplies or appliances for dental treatment of natural healthy teeth required as the direct result of an accidental injury. Benefits are limited to covered treatment provided within 12 months of the date of injury. Injuries resulting from eating, chewing or biting are not covered.

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

Dental implants when related to trauma (within one year of injury), cancer and other tumors, benign cysts; also available for persons from puberty through age 23 with two or more adjacent congenitally missing teeth.

Evaluation and treatment of myofascial pain.

Diagnosis and treatment of the temporomandibular joint (TMJ) of the jaw up to an overall maximum benefit payment of $1,000 for each covered person. This benefit is in addition to the services indicated previously in this section.

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

Exclusions

Benefits are not available for care in connection with the following, except as specifically described above:

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

Organ And Tissue Transplant Services

Covered Transplants

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

- liver,
- heart,
- single and double lung,
- lobar lung,
- combination heart-lung,
- heart valve (heterograft),
- kidney,
- combination kidney-pancreas,
- pancreas,
- bone graft,
- cornea,
- parathyroid,
- small intestine,
- small intestine and liver, or
- small intestine and multiple viscera.

Benefits are also available for medically necessary autologous and allogeneic bone marrow transplants for certain specified conditions listed in this section.

Preauthorization Procedure

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

Blue Cross and Blue Shield of Nebraska
Attention: Medical Support Department
P.O. Box 3248
Omaha, Nebraska 68180-0001

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

Autologous and Allogeneic Bone Marrow Transplants

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

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

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

Benefits will be provided for medically necessary initial myeloablative (high dose) chemotherapy with allogeneic stem cell support only when prescribed for:

- advanced non-Hodgkin's lymphoma.
- advanced Hodgkin's disease (lymphoma).
- advanced neuroblastoma.
- acute lymphocytic and myelogenous (nonlymphocytic) leukemia (acute leukemia).
- germ cell tumor of testicular, ovarian, retroperitoneal or mediastinal origin.
- chronic myelogenous leukemia.

Benefits will be provided for medically necessary initial myeloablative (high dose) chemotherapy with autologous stem cell support only when prescribed for:

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

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

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

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

Additional Benefits For Donation

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

- Hospital, medical, surgical or other covered services provided to a donor are included as part of the recipient's coverage.
- Services provided for the evaluation of organs or tissue including, but not limited to, the determination of tissue matches.
- Services provided for the removal of organs or tissue from nonliving donors.
- Services provided for the transportation and storage of donated organs or tissues.

Limitations

Benefits will NOT be provided for:

- the purchase of human organs or tissues which are sold rather than donated to the recipient;
- the transplant of a nonhuman organ or tissue, or the implantation of an artificial/mechanical organ. (This provision does not apply to the implantation of pacemakers);

- high dose chemotherapy or radiation therapy when supported by bone marrow or stem cell transplant procedures for breast cancer, ovarian cancer or diagnoses other than those identified in the previous paragraphs, or
- services for or related to organ or tissue transplants not listed as covered in this section. Related services include administration of high dose chemotherapy or radiation therapy when supported by transplant procedures.
- donor charges other than those payable under the recipient's coverage.

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

Definitions for Allogeneic and Autologous Bone Marrow Transplants

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

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

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

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

Home Health Aide, Skilled Nursing Care And Hospice Services

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

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

Preauthorization

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

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

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

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

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

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

Home Health Aide Services

Benefits are available for home health aide services provided to a homebound covered person by a licensed or Medicare-certified home health agency.

Home health aide services must be related to active and specific medical, surgical or psychiatric treatment of the covered person. Such services include, but are not limited to bathing, feeding and performing household cleaning duties directly related to the covered person. These services must be ordered by a physician, and part of treatment plan developed by the home health agency and approved by Blue Cross and Blue Shield of Nebraska.

Skilled Nursing Services

Benefits are available for preauthorized physician-ordered nursing care in the covered person's home, which requires the skill, proficiency and training of a registered nurse (R.N.) or a licensed practical nurse (L.P.N.), for up to eight hours per day.

Benefits will not be provided for:

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

Hospice Services

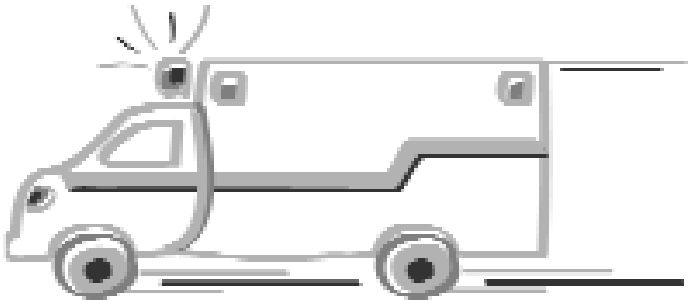
Benefits are available for preauthorized hospice services provided primarily in the patient's home by a Medicare-certified hospice.

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

Hospice benefits include:

- Home health aide services.
- Hospice nursing services provided in the home.
- Up to 30 days of Inpatient Hospice Care.
- Respite care, which is short-term inpatient care of a covered hospice patient to give temporary relief to the person who regularly assists with the care at home. This respite care may be provided in the hospice program's designated inpatient unit that is affiliated with the hospice that is providing services to the patient, which may be a skilled nursing facility, or in a hospital. (Benefits for covered hospice respite services may not exceed a maximum of 20 days).
- Medical social services provided by the hospice's medical social worker, which are directly related to the covered hospice patient's medical condition. (Benefits for hospice medical social services may not exceed a maximum of eight sessions.)
- Crisis care, which is extended skilled nursing care provided in the home or inpatient setting for up to 24 hours per day in lieu of a medically necessary inpatient hospitalization. (Benefits for hospice crisis care services may not exceed a maximum of 15 days.)
- Bereavement counseling, which consists of up to five counseling sessions provided to a covered family member, within six months of the patient's death.

Other Covered Services



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

Ambulance service provided to a covered person for:

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

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

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

Routine immunizations are subject to the deductible except for pediatric immunizations which shall be payable without application of the deductible as required by state law. Pediatric immunizations include a complete set of vaccinations for children from birth to six years of age for measles, mumps, rubella, poliomyelitis, diphtheria, pertussis, tetanus, haemophilus influenza type B and chicken pox, and as otherwise provided by state law. **Note:** This benefit is available after the “Preventive (Routine) Benefit” indicated in the chart in the front of this book and on page 24 (Routine Care) has been exhausted.

Eyeglasses or contact lenses (or replacement) when ordered by a physician because of a change in prescription as a direct result of covered intraocular surgery or ocular injury. (Purchase must be within 12 months of the surgery or injury.)

Services for renal dialysis, including all charges for covered home dialysis equipment and covered disposable supplies. Benefits will also be provided for up to six sessions of dialysis training or counseling. Such benefits will be paid pursuant to Medicare requirements for group health plans.

Diabetes Education provided by an approved program or a certified diabetes educator, up to a maximum of $500 in a two-year period for each covered person. Benefits are available for self-management training and patient management, including nutrition therapy.

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

Sleep Studies, when medically necessary.

Home Infusion.

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

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

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

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

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

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

Women's Health Act

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

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

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

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

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

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

Prescription Drug Benefits — Rx Nebraska

Benefits are available for FDA-approved drugs, injectables and insulin dispensed by a registered pharmacist requiring a physician's or dentist's prescription and bearing the label, "Caution — Federal law prohibits dispensing without a prescription." All FDA approved prescriptions must have a valid National Drug Code (NDC) number. Compounded prescriptions must contain at least one FDA approved ingredient and may be subject to review by Blue Cross and Blue Shield of Nebraska.

Benefits are also available, subject to the applicable copayment amount, for covered ostomy supplies and diabetic supplies including acetone testing agents, alcohol swabs, antiseptic pads, glucose monitor, insulin pump supplies, lancets, lancet device, needles, sugar test tablets, syringes and test strips.

Whenever appropriate, generic drugs will be used to fill prescriptions. However, when a brand name drug is used to fill a prescription, regardless of the reason, you will be responsible for payment of the applicable formulary or non-formulary brand name copayment amount. In addition, when a generic version is available, but the covered person requests a brand name drug, he or she will be responsible for the difference in cost between the brand name drug and the generic drug.

Your prescription drug benefit is based on a 3-tier design, with three copayment levels, based on the drug purchased. The copayment amounts are different based on whether you make the purchase at a retail or mail order pharmacy. In addition, a formulary list of drugs is used, which classifies drugs as generic or formulary brand-name drugs. Your copayment is less for drugs that are on the formulary list. A brand-name drug that does not appear on the list is classified as a non-formulary brand name drug. The formulary list is available at www.bcbsne.com, or you may contact the Blue Cross and Blue Shield of Nebraska Customer Service Center. This benefit design encourages the use of generic medications.

If the prescription or supply is purchased at a Rx Nebraska participating pharmacy, you are only required to pay a copayment at the time the prescription is filled. **The copayment amounts per purchase for each category is shown on your Schedule of Benefits and on the chart in the front of this book.**

The maximum dispensing amount for covered prescriptions filled at a retail pharmacy is a 30-day supply with the copayment applicable per each 30-day supply. Prescriptions for maintenance drugs may also be filled at a participating mail order pharmacy. The maximum dispensing amount at a mail order pharmacy is a 90-day supply with the copayment applicable per each 90-day supply.

You must present your Blue Cross and Blue Shield of Nebraska identification card to the pharmacist when obtaining a prescription at a participating Rx Nebraska pharmacy. If the prescription is purchased at a pharmacy not participating with Rx Nebraska, or if you do not present your Rx Nebraska I.D. card when you make your purchase at a participating Rx Nebraska pharmacy, it is your responsibility to file a claim with Blue Cross and Blue Shield of Nebraska. **If you do not use your drug card, you may submit a claim form to Blue Cross and Blue Shield of Nebraska. Eligible claims will be reimbursed for the cost of the drug less the applicable copayment amount and a 25% penalty.**

In the event that a covered person's usage of prescription drugs during a six month period indicates an excessive pattern of drug usage that is not medically necessary (as determined by Blue Cross and Blue Shield of Nebraska's Drug Utilization Review Program), the covered person will be limited to one participating pharmacy of his/her choice for obtaining covered prescription drugs. If such a limitation applies to the covered person, benefits will not be available for prescription drugs obtained from any other pharmacy.

Benefits will be available for prescription and non-prescription medications used to treat nicotine addiction. Benefits for items requiring a Physician's prescription will be subject to the applicable copayment amount. Non-prescription items must be purchased through an Rx Nebraska participating pharmacy and will subject to the generic copayment amount.

Benefits are NOT available under the Rx Nebraska Drug Coverage Program for the following items:

- Over-the-counter medications, including non-prescription medications, except for non-prescription nicotine items.
- Investigative drugs or drugs classified by the FDA as experimental.
- Drugs or medicinals for treatment of fertility/infertility.
- Diet or appetite suppressant drugs, dietary or nutritional supplements.
- Health or beauty aids.
- Topical Minoxidil (Rogaine).
- Cosmetic alteration drugs, including but not limited to Renova.
- Prescription medications determined to be "less than effective" by the Drug Efficacy Study Implementation Program (DESI).
- Home medical equipment or devices of any type including, but not limited to: contraceptive devices; therapeutic devices; or artificial appliances.

DRUG MAXIMUMS: Your prescription drug coverage is subject to utilization review by Blue Cross and Blue Shield of Nebraska, or its designee. Quantity maximums may be established for certain drugs, based on medical research. Benefits will be available for these drugs up to the specified quantity, per the day's supply indicated for your group plan. If your physician feels that you require more than the established maximum for the drug, he or she may submit a preauthorization request for review. These drugs include, but are not limited to: Ergotamine, DHE, Imitrex (tablets, injectable, and nasal spray), Zomig, Amerge, Maxalt, Axert, Midrin (including all generics), Migranal, Stadol and Viagra.

PRE-EXISTING CONDITIONS: Benefits under the Rx Nebraska Drug Prescription Drug Program are not subject to any exclusion or limitation for pre-existing conditions. Payment of benefits under this program will not, however, waive such exclusions and limitations as they apply to other benefits.

LIMITATIONS (under the Rx Nebraska Drug Coverage Program):

- Dexedrine. This drug is covered only through age 21. After age 21, preauthorization is required to determine if benefits will be available.
- Growth hormones require preauthorization to determine if benefits will be available.
- Retin-A, Differin and Azelex. These drugs are covered only through age 40. After age 40, preauthorization is required to determine if benefits will be available.
- IVIG requires preauthorization to determine if benefits will be available.
- Regranex requires preauthorization to determine if benefits will be available.
- Respigam requires preauthorization to determine if benefits will be available.
- Synagis requires preauthorization to determine if benefits will be available.
- Other prescription drugs that require preauthorization, as determined by Blue Cross and Blue Shield of Nebraska.
- Viagra. This drug is limited to 8 pills per 30 days, and is non-covered for males through age 18 and for all females.

Prescription Drug Preauthorization Request Procedure: A written request to Blue Cross and Blue Shield of Nebraska must be made prior to the initial purchase of the prescription. This request must be accompanied by appropriate documentation from the covered person's physician, dentist or other medical provider demonstrating the medical necessity of the drug. This written request should be directed to the Medical Support Department, Blue Cross and Blue Shield of Nebraska, P.O. Box 3248, Omaha, Nebraska 68180-0001. Upon receipt of the necessary information, Blue Cross and Blue Shield of Nebraska will respond in writing advising the provider and the covered person whether or not benefits are available.

Noncovered Services And Supplies

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

Noncovered services include:

- Services not described as covered services in this plan's Master Group Contract.
- Services determined by Blue Cross and Blue Shield of Nebraska to be not medically necessary.
- Services which are considered by Blue Cross and Blue Shield of Nebraska to be investigative, or for any directly related services.
- Screening audiological examinations and testing (except infant hearing exams); external and surgically implantable devices and combination external/implantable devices to improve hearing, including audiant bone conductors or hearing aids and their fitting.
- Blood, blood plasma or blood derivatives or fractionates, or services by or for blood donors, except administrative charges for blood furnished to a hospital by the American Red Cross, county blood bank, or other organization that does not charge for blood, and used for a covered person.
- Over-the-counter medications, including non-prescription vitamins, except for non-prescription nicotine items.
- Screening eye examinations, eye refractions, eyeglasses or contact lenses, eye exercises or visual training (orthoptics); except as specifically provided for under the plan.
- Services for or related to any surgical, laser or non-surgical procedures or alterations of the refractive character of the cornea for correction of myopia, hyperopia or astigmatism, including radial keratotomies. (Benefits are not available for eyeglasses or contact lenses following these procedures.)
- Hospital or physician charges for standby availability.
- Personal expenses while hospitalized, such as guest meals, TV rental and barber services.
- Services, drugs, medical supplies, devices or equipment which are not cost effective compared to established alternatives or which are provided for the convenience or personal use of a covered person.
- Custodial care.
- Dietary counseling, except covered diabetic nutrition management.
- Treatment and monitoring for obesity or for weight reduction, regardless of diagnosis, including surgical operations.
- Services, including related diagnostic testing, which are primarily of a recreational or educational nature, including music or art therapy, work-hardening therapy; vocational training; medical or nonmedical self-care or self-help training.
- Treatment or removal of corns, callosities, or the cutting or trimming of nails.
- Massage therapy provided by a massage therapist.
- Automated external defibrillator.
- Infertility treatment and related services, which includes: Assisted Reproductive Technology (ART), such as artificial insemination, sperm washing, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), and in vitro fertilization; embryo transfer procedures; drug and/or hormonal therapy for fertility enhancement; ultrasounds, lab work and other testing in conjunction with infertility treatment; except as specifically provided for under the plan, and reversal of voluntary sterilization.
- Services provided for, or related to, sex transformation surgery.

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

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

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

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

- Lodging or travel, even though prescribed by a physician, for the purpose of obtaining medical treatment.

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

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

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

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

- Exercise equipment.

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

- Food antigens and/or sublingual therapy.

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

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

  qualified physician or licensed psychologist,

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

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

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

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

- Services which are considered by Blue Cross and Blue Shield of Nebraska to be for cosmetic purpose, or any routine complications thereof, except covered services required as a result of a traumatic injury, to correct a congenital abnormality when it severely impairs or impedes normal essential function, or to correct a scar or deformity resulting from cancer or from non-cosmetic surgery.

  Reconstructive surgery is covered only when required to restore, reconstruct or correct any bodily function that was lost, impaired or damaged as a result of injury or illness.

  Except as stated above, this exclusion applies regardless of the underlying cause of the condition or any expectation that the cosmetic

procedure may be psychologically or developmentally beneficial to the patient. Procedures for liposuction, telangiectasias, dermabrasion, protruding ears and spider veins are examples of noncovered services.

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

- Services provided to or for:

  any dependent of a subscriber who has a Single Membership;

  anyone who does not qualify as an eligible dependent;

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

  conditions for which coverage has not yet become effective because of waiting periods.

- Services for illness or injury related to military service.

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

- Services available at governmental expense, except:

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

  for persons entitled to Medicare Part A and eligible for Part B benefits, the obligation to provide benefits will be reduced by the amount of payment or benefits such person receives from Medicare. This provision will not apply if the Covered Person is still actively at work or is an Eligible Dependent of a Subscriber who is actively at work and has elected this Contract as primary, unless otherwise provided by federal law. Services provided for renal dialysis and kidney transplant services will be provided pursuant to federal law.

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

- Services arising out of or in the course of employment, whether or not the covered person fails to assert or waives rights to Workers' Compensation or Employers' Liability Law. This includes services determined to be 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.

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

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

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

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

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

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

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

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

- Services by a health care facility that does not meet the licensing or accreditation standards required by Blue Cross and Blue Shield of Nebraska (non-approved facility).

- Charges for which there is inadequate documentation that a service was provided.

- Electron beam computed tomography for vascular screening, including screening for cardiovascular, cerebrovascular and peripheral vascular disease.

- Acupuncture.

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

- Voluntary abortions, except when necessary to safeguard the life of the mother or when the unborn child’s viability was threatened by continuation of the pregnancy.

Coordination Of Benefits

This contract includes a Coordination of Benefits provision. This provision limits duplication of benefits when a covered person has coverage under more than one health plan. These provisions also help establish a uniform order in which the plans pay their claims, and for the transfer of information between the plans, to help avoid claim payment delays. This provision is intended to comply with the most recent NAIC Model Group COB regulations.

Definitions for Coordination of Benefits

Allowable Expense: A health care service or expense, including deductibles, coinsurance or copayments, that is covered in whole or in part by any of the plans covering the person, during a claim determination period. When benefits are reduced under a primary plan because the person did not comply with requirements for preadmission certification or second surgical opinions, the amount of such reduction will not be considered an allowable expense. A reduction due to the use of a noncontracting provider will not be considered an allowable expense unless the services are received from a closed panel provider. Items of expense under coverages such as dental or prescription drug programs may be excluded from the definition of Allowable Expense.

Claim Determination Period: The period of a calendar year during which the covered person is covered under this contract. It does not include any part of a year before the date this coordination of benefits provision or a similar provision took effect.

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

- group, blanket or franchise insurance coverage (except student accident-type coverage).
- uninsured arrangements of group or group-type coverage.
- any coverage under labor management trustee plans, union welfare plans, employer organization plans, or employee benefit organization plans.
- hospital indemnity type coverages written on a non-expense incurred basis to the extent the benefits available are more than $200 per day.
- group or group type coverage through HMOs and other prepayment, group practice and individual practice plans.
- individual or family coverage including HMO coverage or subscriber contracts.

The term "plan" as defined for the purpose of coordination of benefits does not include non-group hospital or surgical indemnity plans. Plan also does not include plans whose benefits, by law, are in excess to those of any private insurance program or other nongovernmental program.

Primary Plan: The plan which will determine allowable benefits without regard to other covered allowable expenses.

Secondary Plan: The plan which will determine allowable benefits for the balance of the remaining charges in the claim determination period.

Primary Plan/Secondary Plan: The order of benefit determination rules state whether this plan is a primary plan or secondary plan as to the covered person. When this plan is a primary plan, its benefits are determined before those of the other plan and without considering the other plan's benefits. When this plan is a secondary plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits. When there are more than two plans covering the person, this plan may be a primary plan as to one or more other plans, and may be a secondary plan as to a different plan or plans.

Order of Benefits

If benefits are payable under any other plan or coverage which does not provide for coordination of benefits, the insurer or plan providing that coverage shall be the primary carrier.

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

If benefits are payable under any other plan which does include a coordination of benefits provision, this plan determines its order of benefits using the first of the following rules which applies to the covered person:

- The plan which covers the person as an employee/subscriber is primary to the plan covering the person as a dependent.

- For a child of parents not separated or divorced, the primary plan is the plan of the parent whose birthday falls earlier in the year. Where both parents have the same birthday, the primary carrier shall be the one which has covered the parent for the longer period of time.

- For a child of parents who are divorced or separated, first shall be the plan of the custodial parent, then the plan of the spouse of the custodial parent, and then the plan of the non-custodial parent. However, if there is actual knowledge that the court decree or qualified court order requires one parent to be responsible for health care expenses, the primary carrier shall be the plan provided by that parent.

- The plan of an employee who is neither laid off nor retired (or as that employee's dependent) is primary to the plan which covers that person as a laid off or retired employee (or that employee's dependent). If the other health benefit plan coverage does not have this provision and, if as a result, the carriers do not agree on the order of benefits, this section is ignored.

- A plan providing coverage to a person under federal (COBRA) or state continuation law is secondary to a plan providing coverage to that person as an employee, subscriber, retiree (or that person's dependent).

- If none of the above rules determines the order of benefits, the benefits of the plan which covered a subscriber longer are determined before those of the plan which covered that person for the shorter time.

Administration of Coordination of Benefits

If this plan is the primary plan, there shall be no reduction of benefits paid under this plan--benefits will be paid as if the other plan did not provide benefits.

If this plan is the secondary plan, its benefits will be determined after those of the other plan, and may be reduced because of the other plan's benefits. Payment will not be made for any amount for which the covered person is contractually held harmless by either plan. Payment between the plans shall not exceed the amount paid under this contract, had it been primary.

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

If another plan pays benefits which should have been paid under this contract, then this plan will reimburse such other plan any amounts determined to be necessary. Amounts paid to other plans in this manner will be considered benefits paid under this plan. This plan is also released from liability of any such amount paid in this manner.

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

This plan's duty regarding coordination of benefits, is limited to making a reasonable effort to avoid liability as the primary plan in appropriate cases brought to its attention; to making reasonable efforts to compute the amount payable under any other plan; and to making reasonable efforts to recover any excess payments made by it.

Subrogation And Contractual Right To Reimbursement

Subrogation

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

Contractual Right to Reimbursement

If a covered person receives full or partial proceeds from any other source for covered services for an illness or injury, the group health plan has a contractual right of reimbursement to the extent benefits were paid under the Contract for the same illness or injury. This contractual right to reimbursement shall be a first priority lien against any proceeds recovered by the covered person, whether or not the covered person has been fully compensated for all his or her losses.

Such proceeds may include any settlement, judgment, payments made under auto insurance, including no-fault, or medical payments insurance; or proceeds otherwise paid by a third party. This contractual right to reimbursement is in addition to, and separate from, the subrogation right.

The group health plan's rights shall not be defeated by allocating the proceeds in whole or in part to nonmedical damages.

No adult subscriber may assign any rights to recover medical expenses from any third party to any minor or other dependent of such covered person or to any other person, without the express written consent of the group health plan. 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 dependents.

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

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

Workers' Compensation

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

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

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

Claim Procedures

Filing a Claim

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

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

All submitted claims must include:

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

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

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

In Nebraska, claim forms should be mailed to:

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

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

Claim Determinations

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

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

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

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

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

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

When You Have Medicare

When Medicare is the primary insurance for you or a covered dependent, you must normally submit all claims for Medicare-eligible services to Medicare first. After Medicare pays their portion of covered expenses, send your claim for the balance to Blue Cross and Blue Shield of Nebraska. Your claim should include the following:

- The itemized bill from the hospital, physician or health care professional who provided the service.
- Medicare's Explanation of Medicare Benefits form.
- Your Blue Cross and Blue Shield of Nebraska I.D. number (including the alpha prefix).

Who Receives The Benefit Payment

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

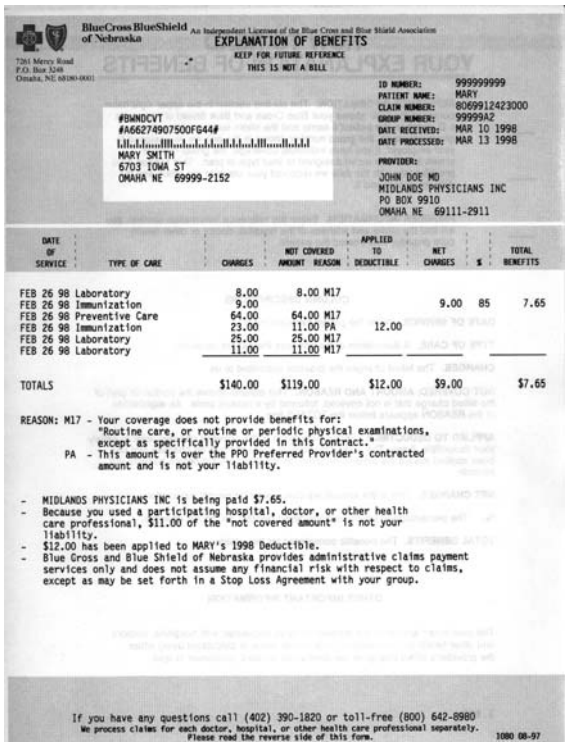
Explanation Of Benefits

Every time a claim is processed for you, an Explanation of Benefits (EOB) form will be sent. This summary tells you:

- Type of service.
- Date of service.
- Name of provider of care.
- Charges.
- Charges applied toward the deductible or coinsurance.
- Noncovered charges with explanation.
- Benefits paid by other insurance.
- Other explanatory notes.

Also included on the Explanation of Benefits is information regarding the right to appeal a benefit determination.

Save the Explanation of Benefits forms in the event that they are needed for other insurance or for tax purposes.



BlueCross BlueShield of Nebraska — An Independent Licensee of the Blue Cross and Blue Shield Association

EXPLANATION OF BENEFITS

KEEP FOR FUTURE REFERENCE

THIS IS NOT A BILL

7261 Mercy Road
P.O. Box 3248
Omaha, NE 68180-0001

#BWNDCVT
#A66274907500FG44#
MARY SMITH
6703 IOWA ST
OMAHA NE 69999-2152

ID NUMBER: 999999999
PATIENT NAME: MARY
CLAIM NUMBER: 8069912423000
GROUP NUMBER: 99999A2
DATE RECEIVED: MAR 10 1998
DATE PROCESSED: MAR 13 1998

PROVIDER:
JOHN DOE MD
MIDLANDS PHYSICIANS INC
PO BOX 9910
OMAHA NE 69111-2911

DATE OF SERVICE	TYPE OF CARE	CHARGES	NOT COVERED AMOUNT	REASON	APPLIED TO DEDUCTIBLE	NET CHARGES	%	TOTAL BENEFITS
FEB 26 98	Laboratory	8.00	8.00	M17				
FEB 26 98	Immunization	9.00				9.00	85	7.65
FEB 26 98	Preventive Care	64.00	64.00	M17				
FEB 26 98	Immunization	23.00	11.00	PA	12.00			
FEB 26 98	Laboratory	25.00	25.00	M17				
FEB 26 98	Laboratory	11.00	11.00	M17				
TOTALS		$140.00	$119.00		$12.00	$9.00		$7.65

REASON: M17 - Your coverage does not provide benefits for:
"Routine care, or routine or periodic physical examinations, except as specifically provided in this Contract."
PA - This amount is over the PPO Preferred Provider's contracted amount and is not your liability.

- MIDLANDS PHYSICIANS INC is being paid $7.65.
- Because you used a participating hospital, doctor, or other health care professional, $11.00 of the "not covered amount" is not your liability.
- $12.00 has been applied to MARY's 1998 Deductible.
- Blue Cross and Blue Shield of Nebraska provides administrative claims payment services only and does not assume any financial risk with respect to claims, except as may be set forth in a Stop Loss Agreement with your group.

If you have any questions call (402) 390-1820 or toll-free (800) 642-8980
We process claims for each doctor, hospital, or other health care professional separately.
Please read the reverse side of this form.

1080 08-97

Appeal Procedures

Blue Cross and Blue Shield of Nebraska 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 any determination made regarding claims, benefit availability, or other complaint arising under this health plan. This includes decisions made by Utilization Review, and those concerning preadmission certification and concurrent review.

First Level Appeal

If you disagree with the determination made on a claim, you may submit an appeal. A request for a first-level appeal must be submitted in writing within one year of the date the claim was processed. The letter must state that it is a request for an appeal, and if possible, include a copy of the Explanation of Benefits (EOB). The appeal should include:

- a general description of the appeal;
- the name of the covered person;
- Blue Cross and Blue Shield of Nebraska I.D. number;
- the date of service and claim number, if any; and
- any additional information that might help resolve the matter.

The written appeal should be sent to

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

Written decisions will be provided within 30 days.

An expedited review may be requested for an appeal of an urgent care claim denial, or if the time frame for a standard review would seriously jeopardize the life or health of the covered person. An expedited review decision will be made within 72 hours of receipt of the request, and written confirmation will be sent not later than three days after the oral notification. A request for an expedited review of a concurrent care denial must be made within 24 hours of the initial denial.

Notification of the Appeal Decision - A written notice of the appeal determination will be provided to you (the claimant). If the appeal determination is adverse, this written notice shall include the reasons for the decision, a reference to the contract provisions upon which the decision is based, a description of the second level review process and your rights to further action or appeal. An explanation of the clinical rationale used in making the decision will be provided to the claimant, free of charge, upon written request.

If the appeal involves medical judgment, Blue Cross and Blue Shield of Nebraska will consult with appropriate medical personnel in order to make the appeal determination. Identification of the medical personnel consulted during the appeal process, if any, will be provided upon written request. The appeal determination shall be made by individuals who were not involved in the original decision.

Second Level Appeal

If you are not satisfied with the first level appeal decision, a second level appeal may be submitted. It must be submitted within six months of receipt of the notice of the first level appeal decision. The letter must be mailed to:

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

A second level appeal decision will be made within 30 days of the request. A second level urgent care appeal will be completed in a time frame that is reasonable under the circumstances.

No deference will be given to either the initial determination or the first level appeal. The claimant will be provided with a written notification of the appeal decision, as described above.

Legal Actions

You must exhaust the first and second levels of appeal stated above prior to filing a lawsuit.

A lawsuit may not be filed less than 60 days after the claim is filed; nor more than three years from the time the claim is required to be filed.

Definitions

ALCOHOLISM OR DRUG (SUBSTANCE ABUSE)TREATMENT CENTER: A facility Licensed by the Department of Health and Human Services Regulation and Licensure, (or equivalent state agency), accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the Commission on the Accreditation of Rehabilitation Facilities (CARF). Such facility is not Licensed as a Hospital, but provides Inpatient or Outpatient care, treatment, Services, maintenance, accommodation or board in a group setting primarily and exclusively for individuals having any type of dependency or addiction to the use of alcohol or drugs.

ALLOWABLE CHARGE: Payment is based on the allowable charge for covered services.

Inpatient Contracting Hospital or other Institutional Facility: The allowable charge for covered services provided by an inpatient contracting institutional facility is the contracted amount for such services.

Outpatient Contracting Hospital or other Institutional Facility: The allowable charge for covered services provided by an outpatient contracting institutional facility is the lesser of the contracted amount or the billed charge.

Noncontracting Hospitals and other Institutional Providers: The allowable charge for covered services provided by either an inpatient or outpatient noncontracting institutional provider will be the reasonable allowance for such services.

Contracting Professional and other Noninstitutional Preferred Providers: The allowable charge for a covered service provided by a professional or other noninstitutional Preferred provider is the lesser of the Preferred Fee Schedule Amount or the billed charge. The allowable charge for covered services in another service area is the amount agreed upon by the on-site plan and its contracting providers.

Contracting Professional and other Noninstitutional Participating Providers: The allowable charge for a covered service provided by a non-BluePreferred, but participating provider in Nebraska is the lesser of the maximum benefit amount or the billed charge. The allowable charge for covered services in another service area is the amount agreed upon by the on-site plan and its participating providers.

Noncontracting Professional and other Noninstitutional Providers: The allowable charge for a covered service provided by providers in Nebraska will be the lesser of the maximum benefit amount or the billed charge. In another service area, the allowable charge will be the reasonable allowance.

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 Blue Cross and Blue Shield of Nebraska.

AUXILIARY PROVIDER: A Certified social worker, psychiatric registered nurse, Certified alcohol and drug abuse counselor or other Approved Provider who is performing Services within his or her scope of practice and who is supervised, and billed for, by a qualified Physician or Licensed Psychologist, or as otherwise permitted by state law. Certified Master Social Workers or Certified Professional Counselors performing mental health Services who are not Licensed Mental Health Practitioners are included in this definition.

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

BLUEPREFERRED 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

to provide Services as a part of the *BluePreferred* Provider network in Nebraska.

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

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

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

COINSURANCE: The percentage amount the Covered Person must pay for Covered Services, 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.

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

CONTRACT: The agreement between Blue Cross and Blue Shield of Nebraska and the Group Applicant which includes the BluePreferred Master Group Benefit Contract and any endorsements; the Master Group Application, any Subgroup Application, addenda and the individual enrollment information of Subscribers and any financial agreements.

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

CONTRACTING PROVIDER: A BluePreferred Provider, a Blue Cross and Blue Shield of Nebraska Participating Provider, or an On-site BlueCard Program Preferred or Participating Provider.

COPAYMENT: A fixed dollar amount of the Allowable Charge, payable by the Covered Person for a Covered Service, as indicated in the Master Group Application. Copayments are separate from and do not accumulate to either the Deductible or the Coinsurance Limit.

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

COVERED PERSON: Any person entitled to benefits for Covered Services pursuant to the Contract underwritten or administered by Blue Cross and Blue Shield of Nebraska.

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

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

a) a group health plan, as defined by HIPAA
b) health insurance coverage consisting of medical care offered by a health insurance issuer in the group or individual market
c) Part A or Part B of Medicare
d) Medicaid, other than coverage consisting solely of benefits under section 1928 (for pediatric immunizations)

e) Title 10 U.S.C. Chapter 55 (medical and dental care of the uniformed services)
f) a medical care program of the Indian Health Service or a tribal organization
g) a State health benefits risk pool
h) the Federal Employees Health Benefits Program
i) a public health plan, which means a plan providing health coverage that is established by a State, the U.S. government, or a foreign country, or a political subdivision thereof
j) a health plan of the Peace Corps
k) a State Children's Health Insurance Program (SCHIP).

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

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

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

Custodial Care is care given to a patient who:

1. is mentally or physically disabled; and
2. needs a protected, monitored or controlled environment or assistance to support the basics of daily living, in an institution or at home, and
3. is not under active and specific medical, surgical or psychiatric treatment, ordered by a physician which will reduce the disability to the extent necessary to allow the patient to function outside such environment or without such assistance within a reasonable time, not to exceed one year in any event.

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

DEDUCTIBLE: An amount of Allowable Charges that must be paid by the Covered Person each calendar year for Covered Services before benefits are payable by the Contract.

ELIGIBILITY WAITING PERIOD: Applicable to new Subscribers only, the period between the first day of employment and the first date of coverage under the Contract. This period may include the probationary period indicated in the Master Group Application.

ELIGIBLE DEPENDENT:

1. The spouse of the Subscriber unless the marriage has been ended by a legal, effective decree of dissolution, divorce or separation.

2. Unmarried children 18 years of age or less who are dependent on the Subscriber for support and maintenance.

   A child is dependent so long as he or she:

   - lives with the Subscriber, or
   - is provided financial support (voluntarily or by order of the court), or
   - is provided health coverage by order of the court

   "Children" means the Subscriber's biological and adopted children or a child under a court-appointed guardianship, but does not include a foster child. "Children" also means a grandchild who lives with the Subscriber in a regular child-parent relationship as long as the Subscriber has been appointed by the court as a legal guardian; and also means a stepchild who both lives with the Subscriber and is chiefly dependent upon the Subscriber for support and maintenance.

3. Unmarried dependent children (students) 23 years of age or less for whom the Subscriber provides support and who are in full time attendance at an educational institution which has a curriculum, faculty and student body in attendance. Coverage will continue during normal school vacation periods.

4. Reaching age 19, or if a full-time student, age 24, will not end the covered child's coverage under this Contract as long as the child is, and remains, both:

   a. incapable of self-sustaining employment, or of returning to school as a full-time student, by reason of mental or physical handicap, and

b. dependent upon the Subscriber for support and maintenance.

Proof of the requirements of paragraphs a. and b. from the Subscriber must be received within 31 days of the child's reaching age 19 (or if a full-time student, age 24) and after that, as required (but not more often than yearly after two years of such handicap). Determination of eligibility under this provision will be made by Blue Cross and Blue Shield of Nebraska. Any extended coverage under this paragraph 4. will be subject to all other provisions of the Contract.

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.

FAMILY MEMBERSHIP: Membership option providing benefits for Covered Services provided to the Subscriber and his or her Eligible Dependents.

GROUP APPLICANT: The employer or association making application for health coverage under the contract.

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

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

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

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

HOSPITAL: A Hospital is an institution or facility 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.

ILLNESS: A condition that 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 by an external force.

INPATIENT: A patient admitted to a Hospital or other institutional facilities for bed occupancy to receive Services consisting of active medical and nursing care to treat conditions requiring continuous nursing intervention of such an intensity that it cannot be safely or effectively provided in any other setting.

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

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

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

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

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

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

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

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

LICENSURE (LICENSED): Permission to engage in a health profession 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.

MAXIMUM BENEFIT AMOUNT: A maximum amount determined by Blue Cross and Blue Shield of Nebraska to be reasonable. The Maximum Benefit Amount will be the amount agreed upon between Blue Cross and Blue Shield of Nebraska and Participating Providers for the Covered Service. If no amount has been established for a Covered Service, Blue Cross and Blue Shield of Nebraska may consider the charges submitted by providers for like procedures, a relative value scale that compares the complexity of Services provided, or any other factors deemed necessary.

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

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

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

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

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

4. not provided primarily for the convenience of any of the following:
   a. the covered person;
   b. the physician;
   c. the covered person's family;
   d. any other person or health care provider, and

5. not considered unnecessarily repetitive when performed in combination with other prevention, evaluation, diagnoses or treatment procedures.

Blue Cross and Blue Shield of Nebraska will determine whether services are Medically Necessary. Services will not automatically be considered Medically Necessary because they have been ordered or provided by a Treating Physician.

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 are payable providers under this contract. A Mental Health Practitioner may also be a Licensed Professional Counselor or a Licensed Clinical Social Worker who is duly Certified/Licensed for such practice by state law. It also includes, for purposes of this Contract, Auxiliary Providers supervised, and billed for, by a professional as permitted by state law. All mental health Services must be provided under appropriate supervision and consultation requirements as set forth by state law.

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

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

Licensed Mental Health Practitioner: A person Licensed to provide treatment, assessment, psychotherapy, counseling, or equivalent activities to individuals, families or groups for behavioral, cognitive, social, mental, or emotional disorders, including interpersonal or personal situations. Mental health practice shall include the initial assessment of organic mental or emotional disorders (as defined by state law), for the purpose of referral to, or consultation with a qualified Physician or a Licensed Psychologist.

Mental health practice shall not include the practice of psychology or medicine, prescribing drugs or electroconvulsive therapy, treating physical disease, Injury, or deformity, diagnosing major mental illness or disorder except in consultation with a qualified Physician or a Licensed Psychologist, measuring personality or intelligence for the purpose of diagnosis or treatment planning, using psychotherapy with individuals suspected of having major mental or emotional disorders except in consultation with a qualified Physician or Licensed Psychologist, or using psychotherapy to treat the concomitants of organic illness except in consultation with a qualified Physician or Licensed Psychologist.

MENTAL ILLNESS: A pathological state of mind producing clinically significant psychological or physiological symptoms (distress) together with impairment in one or more major areas of functioning (disability) wherein improvement can reasonably be anticipated with therapy.

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

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

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 Ambulatory Surgical Facility, or a Physician's office.

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 Blue Cross and Blue Shield of Nebraska.

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

PHYSICAL REHABILITATION: The restoration of a person who is disabled as the result of an Injury or an acute physical impairment to a level of function that allows the 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.

PREAUTHORIZATION: Preauthorization of benefits is prior written approval of benefits for certain Services such as organ transplants, cardiac and pulmonary rehabilitation, subsequent purchases of Home Medical Equipment, prescription drugs, skilled nursing care, home health and hospice services. Preauthorization is based on the information submitted to Blue Cross and Blue Shield of Nebraska and is subject to the terms of the Contract. It may be effective for a limited period of time.

PREFERRED PROVIDER: A health care provider (Hospital, Physician or other health care provider) who has contracted to provide Services as a part of the BluePreferred Provider 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 related to the Pregnancy. For purposes of this Contract, Pregnancy also includes a condition or complication caused by Pregnancy, but separate from, and not part of the Pregnancy. It occurs prior to the end of the Pregnancy, and is adversely affected by it. Postpartum depression and similar diagnoses are not considered complications of Pregnancy.

PRE-EXISTING CONDITION: A condition, whether physical or mental, regardless of the cause of the 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. A Pre-existing Condition does not include a Pregnancy.

REASONABLE ALLOWANCE: The amount determined by Blue Cross and Blue Shield of Nebraska to be payable to noncontracting providers for a covered service. This amount will be one of the following amounts, not to exceed the billed charges:

- a Maximum Benefit Amount, or
- an amount determined to be reasonable for similar service by similar providers in Nebraska or in another state, or
- a percentage or other discounted amount based on the billed charge, or
- an amount otherwise determined to be reasonable by Blue Cross and Blue Shield of Nebraska.

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

SCHEDULE OF BENEFITS: A summarized personal document which provides information about Copayments, Deductibles, percentages payable, special benefits, maximums and limitations of coverage. It also indicates the type of Membership Unit selected and whether or not Waiting Periods are in effect.

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 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 net health outcome.

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

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

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

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.

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

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

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

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

SUBSCRIBER: An 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 an employer who makes application for health coverage for its employees.

SUBSCRIBER/SPOUSE MEMBERSHIP: This option provides benefits for Covered Services provided to the Subscriber and his or her spouse.

SUBSTANCE ABUSE: For purposes of this Contract, this term is limited to alcoholism and drug abuse.

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

UTILIZATION REVIEW: The evaluation by Blue Cross and Blue Shield of Nebraska or its designees, of the use of Services, including medical, diagnostic or surgical procedures or treatments, the utilization of medical supplies, drugs, or Home Medical Equipment or treatment of Mental Illness, Substance 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.

WAITING PERIOD FOR PRE-EXISTING CONDITIONS: The period of time during which no benefit payment will be made for Services provided for a Pre-existing Condition.

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