SCHEDULE OF BENEFITS SUMMARY

BlueEssentials Option 3

(With Maternity)

	IN-NETWORK	OUT-OF-NETWORK
Your Calendar Year Deductible		
Individual	$1,500	$3,000
Family (embedded)*	$3,000	$6,000
The calendar year deductible is applicable before benefits begin, unless otherwise noted.		
Maximum Coinsurance Limit		
Individual	$2,500	$6,000
Family (embedded)*	$5,000	$12,000
Inpatient Facilities**		
Hospital Care	20%	40%
Long Term Acute Care	20%	40%
Skilled Nursing Facility *(30-day per person calendar year maximum)*	20%	40%
Outpatient Facilities		
Hospital Outpatient	20%	40%
Other Outpatient Facility	20%	40%
Emergency Room (facility/professional)	20% *(subject to In-network deductible)*	
Urgent Care (facility/professional)	20%	40%
Cardiac/Pulmonary Rehabilitation *(certification required)*	20%	40%
Physician Services		
Physician Office Services‡	$40 Copay***	40%
Specialist Office Services‡	$40 Copay***	40%
Telehealth Services (by a designated Provider)	$15 Copay	Not Covered
Other Covered Physician Services	20%	40%
NOTE: If more than one physician is seen on the same day, each physician will be accessed a separate copay.		
Pregnancy and Maternity		
Pre/post Natal Care and Delivery	20%	40%
Preventive Care Services[1] (required by PPACA[2])		
a) United States Preventive Services Task Force current recommended items or services with A or B ratings[3]; b) Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention recommended routine immunizations[3]; c) Preventive care and screenings for infants, children and adolescents supported by the Health Resources and Services Administration guidelines[3]; d) Preventive care and screenings for women supported by the Health Resources and Services Administration guidelines[3]	0%***	40%

* *If you have family coverage, no one family member contributes more than the individual amount to satisfy the family amount.*

** *Inpatient notification, certification and concurrent review requirements apply.*

*** *Not subject to deductible and/or coinsurance.*

‡ *Covered office services are: diagnostic office visits; consultations; radiology/ x-ray; pathology/lab; supplies used during the office visit (excluding HME); drugs administered during the visit (excluding injections); medically necessary hearing exams and eye exams as otherwise covered by the plan.*

1 Services may be subject to limitations based on age, gender and/or frequency
2 Patient Protection and Affordable Care Act (PPACA)
3 A listing of these services is available upon request

	IN-NETWORK	OUT-OF-NETWORK
Preventive Care Services (not required by PPACA)		
Exam, Office Visit Cardiac Stress Test Vision (including refractions) and Hearing Exams Radiology/X-ray, Pathology/Lab	$40 Copay*** *Applicable per physician, per day for services performed in the office*	40%
Immunizations, *pediatric*	0%***	40% *(waive deductible)*
Immunizations, *non-pediatric*	0%***	40%
Mammograms (technical/ professional)	0%***	40%
Pap Smears (technical/ professional)	0%***	40%
Radiology/X-ray, Pathology/Lab, *non-physician*	0%***	40%
Colorectal Cancer Screening *(colonoscopy, sigmoidoscopy, proctosigmoidoscopy, barium enema)*	20%	40%
Other Covered Services		
Accident Related Care Supplemental Benefit *($300 first dollar coverage per person)*	0%***	0%***
Ambulance	20%	40%
Autism Spectrum Disorders (up to age 21)	Same as illness	Same as illness
Home (Durable) Medical Equipment	20%	40%
Home Health Aide *(certification required)*	20%	40%
Skilled Nursing Care *(limited to 8 hours per day) (certification required)*	20%	40%
Respiratory Care	20%	40%
Hospice *(certification required)*	20%	40%
Physical, Occupational or Speech Therapy; Manipulations and Adjustments *(40 session per person calendar year maximum combined)*	20%	40%
Miscellaneous Covered Services	20%	40%
Mammography/Pap Smears/Immunizations *(excluding routine)*	20%	40%
Independent Lab	0%***	0%***
Mental Illness and Substance Abuse		
NOT COVERED *(including prescription drugs)*		
Prescription Drug *(Your prescription drug benefits are not subject to the calendar year deductible. The copay is applicable per each 30-day supply.)*		
Generic	$0 Copay	$0 + 25%
Formulary Brand	$30 Copay	$30 + 25%
Non-formulary Brand	$60 Copay	$60 + 25%

*** *Not subject to deductible and/or coinsurance.*

Remember: *If you use an out-of-network provider, you will be responsible for amounts in excess of the Allowable Charge in addition to the applicable copay, deductible and/or coinsurance amounts.*

Please note*: This Schedule of Benefits Summary is intended to provide you with a brief overview of your benefits. It is not a contract and should not be regarded as one.*

A Guide to Your Health Care Benefits

Nebraska Farm Bureau Federation

BLUE ESSENTIALS

BlueCross BlueShield of Nebraska

A not for profit mutual insurance company and
independent licensee of the Blue Cross and Blue Shield Association

98-352 1/2008
rev 1/2012

About Your Certificate Of Coverage

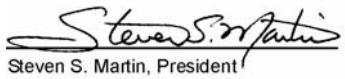
This document is your Certificate of Coverage. It has been written to help you understand your group health coverage with Blue Cross and Blue Shield of Nebraska, an independent licensee of the Blue Cross and Blue Shield Association.

This plan is made available for the exclusive benefit of active members of the Nebraska Farm Bureau Federation. This Certificate of Coverage is only a partial description of the benefits, exclusions, limitations, and other terms of the Master Group Contract to which it refers. It describes the more important parts of that document in a general way. It is not, and should not be considered a contract or any part of one. The Master Group Contract controls the coverage for your health plan.

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

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

NOTICE
This Group Plan does not provide benefits for Pregnancy and Maternity Services or for treatment of Mental Illness, Alcoholism or Drug Abuse



Steven S. Martin, President
and Chief Executive Officer

Blue Cross and Blue Shield of Nebraska
1919 Aksarben Drive
P.O. Box 3248
Omaha, Nebraska 68180-0001

Important Telephone Numbers

member services:

Omaha 402-398-3869
Toll-free 1-800-424-7105
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

Some Important Benefit Maximums

Benefit Maximums Per Covered Person:	
SERVICE	**BENEFIT MAXIMUM**
Skilled Nursing Facility	*30 Days Per Calendar Year*
Hospice Services	
Inpatient Hospice	*30 Day Maximum*
Respite Care	*20 Day Maximum*
Medical Social Services	*8 Session Maximum*
Crisis Care	*15 day Maximum*
Bereavement Counseling	*5 Session Maximum Per Family Member*
Cardiac or Pulmonary Rehabilitation	
Cardiac Rehabilitation	18 sessions following a qualifying diagnosis
Pulmonary Rehabilitation • Chronic lung disease patients • Related to lung; heart-lung transplant or lung reduction surgery	• 18 Session Calendar Year Maximum • 18 Sessions (following referral/prior surgery), and 18 Sessions (following surgical hospitalization)
Other Covered Services	
Therapy Sessions (physical; occupational; speech; chiropractic; osteopathic physiotherapy, manipulative treatments, adjustments)	*40 Sessions Per Calendar Year*

NOTE: *This summary provides a brief overview of some of your benefit limitations. For additional information, including deductible, coinsurance and copayment amounts, please refer to your Schedule of Benefits Summary.*

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Some Important Facts About Your Coverage

This group health plan is a Preferred Provider Organization (PPO) health benefit plan, insured by Blue Cross and Blue Shield of Nebraska (BCBSNE).

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

Blue Cross and Blue Shield Plans in other states (On-site Plans) have also contracted with health care providers in their geographic areas who are referred to as "Preferred Providers."

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

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

Selecting A Provider

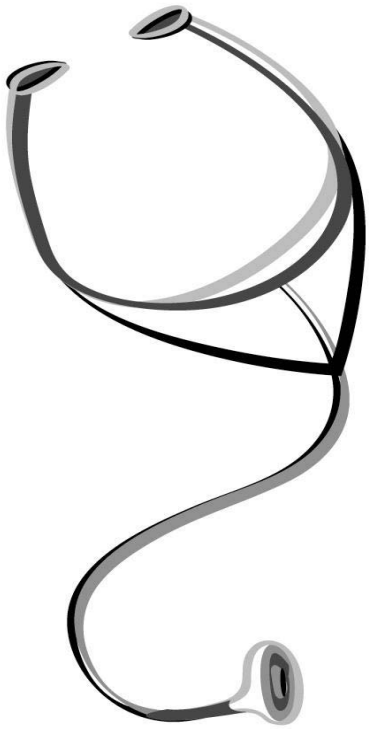
No matter where you are when you require health care services, whether you are in Nebraska or in another state, selection of a provider of care always remains <u>your</u> choice. However, the provider you choose may make a difference in the amount of benefits your coverage provides and, therefore, whether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

<u>USING YOUR BENEFITS WISELY</u>

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.

How The Network Works



Using In-network Providers:

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

Using Out-of-network Providers:

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

Remember, if more than one Physician is involved in your care, it is important for you to check the status of each provider. This is especially important when you are in the Hospital and receiving care from multiple providers. If you wish to stay within the NEtwork Blue provider network, make sure your attending Physician knows this. Ask that you be informed before the Service is performed, if you are being referred to a provider outside the NEtwork Blue provider network.

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.

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 Member Services Department. Remember, only persons who are eligible for coverage under your membership may use your Blue Cross and Blue Shield of Nebraska I.D. card.

Schedule of Benefits

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

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

Eligibility & Enrollment

Eligibility for Coverage

Farm Bureau members in Nebraska who are in good standing with the Nebraska Farm Bureau Federation, and their dependents, are eligible to apply for coverage under this group health plan. Dependents must qualify as eligible dependents.

Premiums and Grace Period

The charges for this coverage are called premiums. Premiums are payable in advance at our offices. A grace period of 31 days will be granted for the payment of monthly premiums. Your coverage will continue in force during this grace period. This provision is subject to our right to cancel in accordance with the Termination of Coverage provision. If payment is not received during the 31-day grace period, the coverage is canceled as of midnight of the last day for which premiums have been paid.

Types of Membership

There are two types of enrollment options offered by this group plan. The enrollment option you have elected is shown on your Schedule of Benefits.

Single Membership: Provides coverage for you only.

Family Membership: Provides coverage for you and all your Eligible Dependents.

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

Note: *Any person who is eligible for Blue Cross and Blue Shield of Nebraska group coverage or Medicare, may not apply for covered under this plan.*

Waiting Period for Pre-existing Conditions

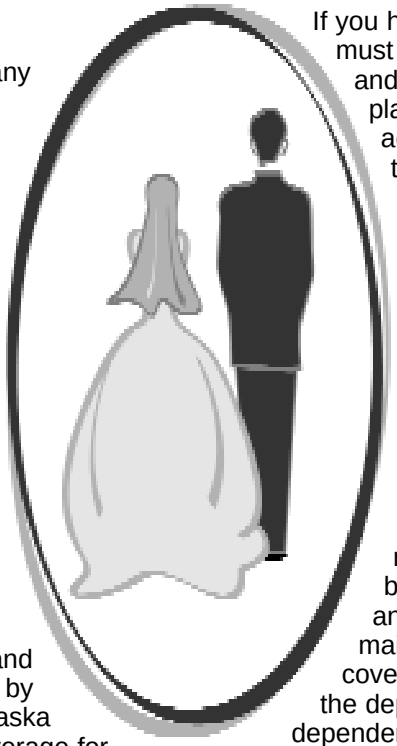
You will be notified if a waiting period for pre-existing conditions applies to your (or your dependent's) coverage. If a waiting period applies, no benefits will be paid for a pre-existing condition or congenital abnormality until Blue Cross and Blue Shield coverage has been in effect for at least 365 continuous days.

The waiting period does not apply to covered persons under 19 years of age.

A **pre-existing condition** is defined as a condition, whether physical or mental, regardless of the cause of the condition, for which diagnosis, care or treatment was recommended or received within the 12-month period prior to the effective date of coverage.

A congenital abnormality is defined as 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.

Marriage



When you marry, your spouse and any other new eligible dependents may enroll for coverage under a family membership. The health history of the new applicant(s) will be reviewed based on Blue Cross and Blue Shield of Nebraska's medical underwriting standards in order to determine acceptance into this health plan.

If accepted, coverage for your new dependent(s) will begin on the next monthly due date following approval of the request for change.

You may request to backdate the effective date of change to the first of the month in which the marriage occurred, if the request for change and the additional premium are received by Blue Cross and Blue Shield of Nebraska within 31 days of the marriage. Coverage for your spouse and any other new eligible dependents will begin (subject to waiting periods) on the date of marriage.

Newborn Children

Coverage shall begin at birth for your newborn child. If you already have a Family Membership in effect on the date of birth, 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, coverage will be provided for the child for 31 days. This includes coverage for injury or illness (including the necessary care and treatment of medically-diagnosed Congenital Abnormalities). To continue coverage for the newborn, you must request a change to Family Membership within this 31-day period, and pay the additional premium.

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 of entry of a court order granting 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, you must request a change to Family Membership and enroll the child within 31 days of the placement for adoption and pay the additional premium, in order to continue the coverage beyond the initial 31-day period. No medical underwriting is required and Waiting Periods will not be applicable if timely enrolled.

Disabled Dependent Children

A physically or mentally disabled child may remain an eligible dependent child upon reaching age 26 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 26th birthday and the dependent must meet all other group coverage eligibility requirements. After that, you will be asked to provide periodic proof of continuing eligibility under this provision; however, after two years of such handicap, such proof will not be required more often than yearly.

An application for extension of dependent coverage is available through Blue Cross and Blue Shield of Nebraska's Member Services Department.

Loss of Dependent Eligibility

If a covered person ceases to be an eligible dependent, Blue Cross and Blue Shield of Nebraska will provide a single membership for that person, provided all other eligibility requirements for Nebraska Farm Bureau Federation are met. For such coverage to become effective; however, that person must make application for this coverage and pay his/her initial premium within thirty-one (31) days of the date his/her dependent eligibility ceases. The new coverage for that individual will be subject to any unexpired waiting periods required by their preceding coverage. Failure to make application for coverage or to make payment to Blue Cross and Blue Shield of Nebraska of the premium, within the specified time limits, will cause all rights and privileges to continue coverage to lapse.

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 Order or Notice will be reviewed, and the affected individuals will be advised of the coverage determination.

You have the right to request a copy of the Plan's procedures governing QMCSO determinations.

Termination Of Coverage

Coverage under your health plan may be canceled for any of the following reasons:

- If the Subscriber fails to pay premiums, coverage will be canceled effective at midnight on the last day for which premium has been paid, subject to the grace period.

- If the Subscriber, or someone acting on his or her behalf, or acting under his or her Membership, commits fraud or an act of misrepresentation, coverage will be canceled on the date notice is given to the Subscriber, or at a later designated date.

- If the Subscriber and/or Eligible Dependents no longer meet eligibility requirements, coverage will be canceled effective at the end of the month in which eligibility ceases.

- If Blue Cross and Blue Shield of Nebraska cancels all coverage under the same contract form number and date, coverage will be canceled on the date notice is given to the Subscriber, or at a later designated date.

- If Blue Cross and Blue Shield of Nebraska receives a written request from you to terminate coverage, it will end on the earlier of the end of the month in which the notice is received, or the end of the month for which premium has been paid.

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

Oral Surgery and Dentistry Benefits

Organ/Tissue Transplant Benefits

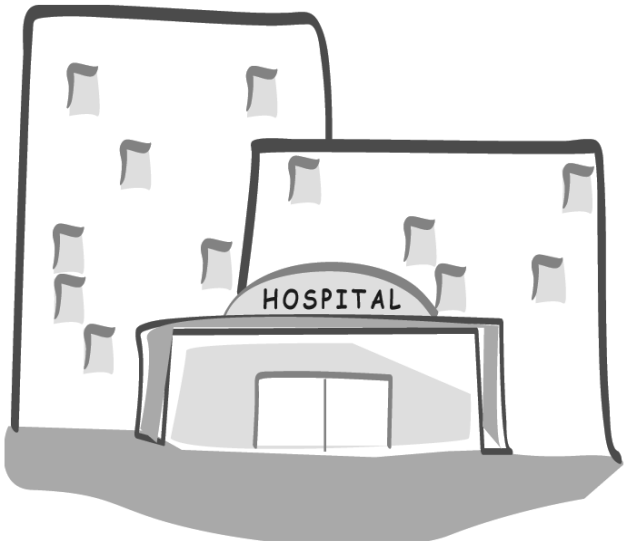
Home Health Aide, Skilled Nursing Care and Hospice Benefits

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 see the section of this document titled “Prescription Drug Network - Rx Nebraska” for additional information.

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

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



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

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

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 use In-network Providers, 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 an Out-of-network Provider.*

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 an In-network 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 unless otherwise indicated on your Schedule of Benefits Summary. 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 Summary, the coinsurance percentage no longer applies for the rest of the calendar year. For a family, the maximum coinsurance amount is limited to twice the individual maximum coinsurance amount per calendar year unless otherwise indicated on your Schedule of Benefits Summary. After that, 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 copay for physician office visits (if applicable).
- The calendar year deductible.
- Amounts you must pay when benefits are reduced or denied due to a denial of certification.
- The coinsurance or co-payment for a prescription drug charge processed under the Rx Nebraska Prescription Drug Program.

Your deductible, copayment, coinsurance and coinsurance limit amounts are shown on your Schedule of Benefits Summary.

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.**

NOTICE

Out-of-network (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 Member Services Department 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.

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.

Payments Made in Error

Payments made in error or overpayments may be recovered by Blue Cross and Blue Shield of Nebraska, as provided by law. Payment for a specific service or erroneous payment shall not make Blue Cross and Blue Shield of Nebraska or the group health plan liable for further payment of the same condition.

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 an In-network hospital notification will be provided by the hospital.

When you are hospitalized in an Out-of-network hospital or in a hospital outside of Nebraska, it is your responsibility to 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.

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.

Certification Requirements

All inpatient admissions related to 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.

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 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 an In-network 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

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 booklet titled: "Organ and Tissue Transplants."

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

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

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

Reminder: Blue Cross and Blue Shield of Nebraska must be notified of all medical/surgical inpatient hospital admissions.

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.

Physical Rehabilitation Program

Benefits for inpatient physical rehabilitation services must be precertified by Blue Cross and Blue Shield of Nebraska prior to admission. 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, and
- prosthetic devices and fitting.

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, 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.

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.

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.

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 Member Services Department 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.

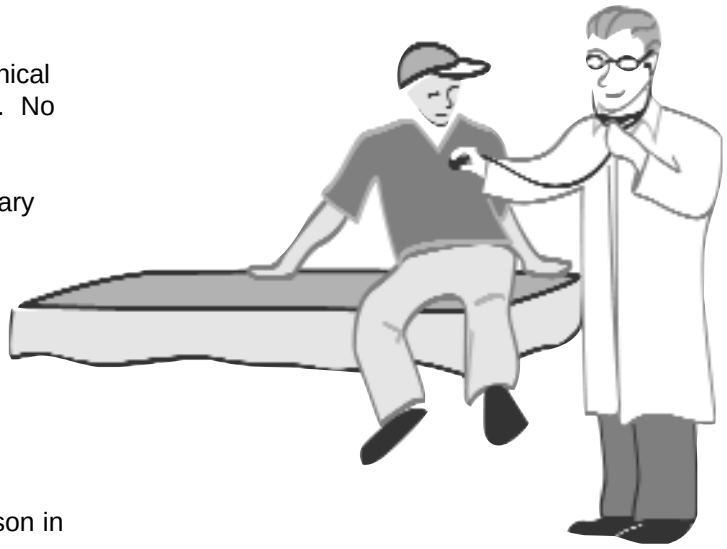
Radiation therapy and chemotherapy, except as excluded (or not specifically listed as covered) under the section titled "Organ and Tissue Transplants."

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

Tissue exams related to covered surgical procedures.

Interpretation of Pap Smears.

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.



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.

Complications Of Pregnancy And Newborn Care

Benefits are available for hospital, and physician covered services provided for complications of pregnancy. These are illnesses or conditions occurring prior to the end of the pregnancy, which are distinct from the pregnancy, but are caused or adversely affected by it. A cesarean section is not considered to be a complication of pregnancy.

Postpartum depression, psychosis or any other mental illness are not considered complications of pregnancy under this part.

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, including medically-diagnosed congenital abnormalities.

If you have a Single Membership in effect, coverage shall begin at birth for a period of 31 days. To continue coverage for the newborn child, you must request a change to a Family Membership and enroll the child within 31 days of the birth and pay the additional premium.

Routine/Preventive Care And Accident-Related Care

Health Care Reform (HCR) required Preventive Services are not subject to Deductible and/or Coinsurance amounts when provided by an In-network Provider. Such covered preventive services may be subject to age, gender and frequency limits. A list of these Preventive Services may be obtained by contacting the Blue Cross and Blue Shield of Nebraska Member Services Department.

When the same HCR required Preventive Services are provided by an Out-of-network Provider, benefits will be provided as indicated on your Schedule of Benefits Summary.

Benefits for Preventive Services that are not HCR required Preventive Services will be provided as indicated on your Schedule of Benefits Summary.

Routine/Preventive Care Services

Covered routine/preventive care services include:

- periodic physical examinations;
- periodic well-child examinations;
- routine office visits;
- routine radiology;
- routine pathology;
- routine mammography:
- routine pap smears;
- routine prostate screening (PSA);
- routine immunizations pediatric and non-pediatric;
- cardiac stress tests;
- vision and hearing exams; and
- colorectal cancer screeing.

Exclusions and Limitations

Covered routine/preventive care services under this part do not include:

- initial newborn well infant examinations; and
- treatment of an existing illness, injury or condition.

Accident-Related Care

Covered Services provided for the care and treatment of injuries caused by an accident that occurred after the effective date of coverage are payable as stated on your Schedule of Benefits Summary. An accident is defined as an unexpected or unforeseen event.

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 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 radiology 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.

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. This includes medically necessary hospitalization and general anesthesia for covered persons under age 8 or developmentally disabled, in order to receive dental care.

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,
- small intestine and multiple viscera, or
- bone marrow transplants, including but not limited to, autologous and allogeneic stem cell transplants.

Preauthorization Procedure

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

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

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

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 live 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 <u>NOT</u> 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 or LVADs;
- 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
- 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."

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.

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
Health Service Programs
P.O. Box 3248
Omaha, Nebraska 68180-0001

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

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

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

Home Health Aide Services

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

Home health aide services must be performed in the home and 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 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.

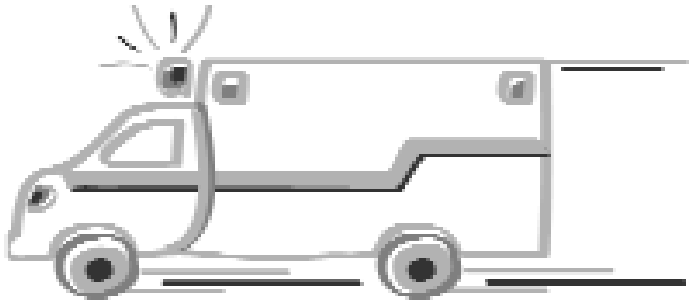
A hospice is a program of care provided for a person diagnosed as terminally ill and their families. The patient must have a life expectancy of six months or less, and the services must be physician-ordered and be appropriate for palliative support or management of a terminal illness.

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 copayment or deductible and/or coinsurance amounts and any benefit maximums (indicated on your Schedule of Benefits Summary) 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 40 outpatient or home sessions for physical, occupational or speech therapy services, chiropractic or osteopathic physiotherapy or manipulative treatments or adjustments, or any combination of these services. A session is defined as one visit. Benefits are not available for ongoing maintenance therapy once the maximum therapeutic benefit has been achieved for a condition, and continued therapy no longer results in some functional or restorative improvement.

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

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.

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

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

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

Prescription Drug Benefits are subject to the applicable Copay, Deductible and/or Coinsurance amounts shown in the Schedule of Benefits Summary for covered drugs dispensed by a registered pharmacist requiring a physician's or dentist's prescription and bearing a label, "Caution — Federal law prohibits dispensing without a prescription."

All covered prescriptions must be FDA approved with a valid National Drug Code (NDC) number. Compounded prescriptions must contain at least one FDA approved ingredient. Injectables are limited to claims from providers who are contracting with Prime Therapeutics, and filed as a pharmacy claim.

Your prescription drug benefit is based on a tiered benefit design that helps control your out-of-pocket prescription drug costs by encouraging the use of generic medications. A drug formulary, which is a list of medications divided into tiers or categories, is used to determine what you must pay for each covered prescription medication. The formulary list classifies drugs as generic and formulary brand-name. A brand-name drug that does not appear on the list is classified as a non-formulary brand name drug. Specialty medications are typically self-administered injectable drugs used to treat serious or chronic medical conditions such as multiple sclerosis, hemophilia, hepatitis and rheumatoid arthritis. The formulary list is available at www.bcbsne.com, or you may contact the BCBSNE Member Service Department.

Whenever appropriate, generic drugs will be used to fill prescriptions. If a generic version is available and the ordering physician did not specify a brand name drug, but the Covered Person requests a brand name drug, he or she may be required to pay the difference in cost between the brand name drug and the generic drug.

ACCESSING BENEFITS

If the prescription or supply is purchased at a Rx Nebraska participating pharmacy, and you present your BCBSNE identification card to the pharmacist at the time of purchase, you will only be required to pay your financial liability at the time the prescription is filled. The Schedule of Benefits Summary shows your financial liability and the dispensing amount for each benefit tier.

NOTE: Prepackaging by the manufacturer may limit the quantity dispensed to an amount which is less than the maximum dispensing amount available under your coverage. If that happens, benefits will be provided in compliance with the manufacturer's packaging guidelines.

If the covered prescription is filled at a pharmacy not participating with Rx Nebraska, or if you do not present your I.D. card at the time of purchase, you will be required to pay the pharmacy's usual retail price. You must file a claim with BCBSNE. Eligible claims will be reimbursed based on the Allowance for the drug less the applicable Copay, Deductible and/or Coinsurance and a 25% penalty.

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

Services Covered Under the Rx Nebraska Drug Coverage Program

- Anti-rejection drugs (immunosuppressants.)
- Compounded prescriptions.
- Dexedrine.
- Diabetic Medication or oral agents other than Insulin including Diazoxide, glucagon, glipizide, glucophage or Glucose Chewable.
- FluMist.
- Human Immunodeficiency Virus (HIV) medications.
- Contraceptive medications which contain an FDA approved hormone or other prescription ingredient.
- Prescription Prenatal Vitamins.

- Prescription Vitamins.
- Self injectable medications, including insulin.
- Preventive Services as required by Health Care Reform (see Preventive Services on Schedule of Benefits Summary.)

Benefits are also available, subject to the applicable Copay, Deductible and/or Coinsurance 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, glucose tablets, syringes and test strips.

UTILIZATION REVIEW
In the event 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 BCBSNE'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 are NOT available under the Rx Nebraska Drug Coverage Program for the following items:

- Over-the-counter medications, including non-prescription vitamins.
- 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.
- Cosmetic alternation drugs, including but not limited to health and beauty aids such as Vaniqa, Propecia and Renova.
- Home infusion therapy. (Covered under Other Covered Services only.)
- Erectile dysfunction agents including, but not limited to, Viagra, Caverject, Muse, Cialis, Levitra and Alprostadil.
- Prescription medications determined to be "less than effective" by the Drug Efficacy Study Implementation Program (DESI).
- Supplies, other than ostomy, designated injectable, diabetic and insulin pump supplies. Insulin pump batteries are not covered under this provision, but are covered under "Other Covered Services."
- Insulin pumps and continuous glucose monitoring devices.
- Home medical equipment or devices of any type including, but not limited to: contraceptive devices; therapeutic devices; or artificial appliances.
- Prescription medications purchased in a foreign country (unless the covered person can prove residency in another country or has an emergency medical condition while traveling in another country).

Limitations (under the Rx Nebraska Drug Coverage Program the following drugs require preauthorization to determine if benefits will be available):

- Growth hormones.
- Topical acne agents.
- Acute migraine medications. Maximum quantities apply.
- Amevive and Raptive.
- Xolair.
- Cox-2 Inhibitors.
- Synagis.
- Other prescription drugs that require preauthorization as determined by BCBSNE.

In addition to the above, preauthorization is required for non-formulary proton pump inhibitors (PPIs). PPIs are used to treat stomach ulcers, erosive esophagitis and gastroesophageal reflux disease (GERD). The preauthorization program requires documentation of attempted use of three of the four formulary PPI Products (the generic drugs omeprazole, lansoprazole and pantaprazole, and the brand name product Aciphex®) before benefits for a non-formulary PPI will be considered. Currently non-formulary PPIs include brand name drugs KapidexTM, Nexium®, Prevacid®, Protonix®, Prilosec® and Zegerid®.

NOTE: *If you are currently taking a non-formulary PPI, preauthorization is necessary to determine if you meet the criteria for continued benefits.*

REQUESTING PREAUTHORIZATION

A written request to BCBSNE 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:

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

Preauthorization forms can be found on the BCBSNE website at
www.nebraskablue.com.

Upon receipt of the necessary information, BCBSNE will respond in writing advising the provider and the covered person whether or not benefits are available.

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.

NOTE: *The limitation, preauthorization and formulary lists may be updated at any time without notice. Additional information about your RX Nebraska pharmacy benefits can be found on the BCBSNE website at www.nebraskablue.com.*

GENERIC DRUGS CAN SAVE YOU MONEY

Generic drugs are drugs that are labeled by their chemical name rather than by a brand name. However, all drugs, whether generic or brand, must meet the same governmental standards for safety and effectiveness. Why pay more for a brand name drug if its generic twin is available at a lower cost? Ask your physician to prescribe generic drugs whenever possible.

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 as specifically provided); external and surgically implantable devices and combination external/implantable devices to improve hearing, including audiant bone conductors or hearing aids and their fitting.
- 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.
- 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.
- Pregnancy assistance treatment including Infertility treatment and related services, which includes: Assisted Reproductive Technology (ART), such as artificial insemination, sperm washing, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), and in vitro fertilization; embryo transfer procedures; drug and/or hormonal therapy for fertility enhancement; ultrasounds, lab work and other testing in conjunction with infertility treatment; and reversal of voluntary sterilization.
- Services provided for, or related to, sex transformation surgery.
- 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.

- Genetic testing, unless specifically allowed by Blue Cross and Blue Shield of Nebraska medical policy.

- 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.

- Services for mental illness, alcoholism or drug abuse, including but not limited to mental health services or psychological or alcoholism and drug abuse counseling services.

  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.

- 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 (except as specifically provided for limited 31-day coverage of a newborn or adopted child);

anyone who does not qualify as an eligible dependent;

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

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 or would receive from Medicare, as permitted by 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, unless authorized by Blue Cross and Blue Shield of Nebraska.

- Services incurred dyring a Phase I or II clinical trial; or during a Phase II or IV clinical trial that is not National Institute of Health (NIH) approved.

- 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.

- Preventive (routine) care, or preventive or periodic physical examinations, except as specifically provided for under the plan.

- Pregnancy and maternity-related services, (except complications of pregnancy), unless you have purchased the optional coverage for such services.

- Services, procedures, supplies or drugs provided for the treatment of sexual arousal disorders or erectile dysfunction, regardless of cause.

- Services, supplies, equipment, procedures, drugs or programs for treatment of nicotine addiction or smoking cessation.

- Charges for a canceled scheduled appointment.

- Services rendered at a school or library.

- Charges for treatment, services and supplies resulting from complications of any treatment, services or supply not covered under this plan's Master Group Contract.

- Hair analysis, prostheses or wigs.

- Private duty nursing services.

YOUR GROUP PLAN DOES NOT PROVIDE BASIC COVERAGE FOR ALCOHOLISM AS DEFINED IN THE STATE INSURANCE CODE. SUCH COVERAGE IS AVAILABLE UPON REQUEST OF THE GROUP POLICYHOLDER, AND THEN ONLY UPON SUCH TERMS AND CONDITIONS AS IT AND BLUE CROSS AND BLUE SHIELD OF NEBRASKA AGREE.

Coordination Of Benefits

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

Definitions for Coordination of Benefits

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

Allowable Expense: A health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense.

The amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of Plan provisions include second surgical options, recertification of admissions, and preferred provider arrangements.

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

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

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

a. Plan includes: group insurance contracts, health maintenance organization (HMO) contracts, Closed Panel Plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental Plan, as permitted by law.

b. Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage other than the medical benefits coverage in automobile “no fault” and traditional “fault” contracts; specified disease or specified accident coverage; limited benefit health coverage, as defined in state law; school accident coverage; benefits for non-medical components of long-term care policies; individual coverage including HMO coverage and subscriber contracts; Medicare supplement policies; Medicaid policies; and coverage under other federal governmental Plans, unless permitted by law.

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

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

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

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

Administration of Coordination of Benefits

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

If this Plan is the Primary Plan, there shall be no reduction of benefits. Benefits will be paid without regard to the benefits of any other Plan.

If this Plan is the Secondary Plan, it may reduce its benefits so that the total benefits paid or provided by all Plans for any claim are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its Plan deductible any amounts it would have credited to its deductible in the absence of other health coverage.

Order of Benefit Determination

1. The Primary Plan pays or provides its benefits according to its terms or coverage and without regard to the benefits under any other Plan.

2. A Plan that does not contain a coordination of benefits provision that is consistent with this Part is always primary unless the provisions of both Plans stated that the complying Plan is primary.

3. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

4. Each Plan determines its order of benefits using the first of the following rules that apply:

Subscriber/Employee or dependent. The Plan that covers the person as the Subscriber is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent and primary to the Plan covering the person as a Subscriber, then the order of benefits between the two Plans is reversed so that the Plan covering the person as a Subscriber is the Secondary Plan and the other Plan is the Primary Plan.

Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:

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

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

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

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

- the plan covering the custodial parent,
- the plan covering the spouse of the custodial parent,
- the plan covering the non-custodial parent, and then,

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

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

Active Employee, Retired Or Laid-Off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither retired nor laid off, is the Primary Plan. The Plan covering that same person as a retired or laid-off employee is the Secondary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the first rule (Subscriber and Dependent) can determine the order of benefits.

COBRA Or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as a Subscriber or covering the person as a dependent of a Subscriber is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the first rule (Subscriber and Dependent) can determine the order of benefits.

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

If the above rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the Primary Plan.

Miscellaneous Provisions

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

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

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

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

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, Blue Cross and Blue Shield of Nebraska 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 or as provided by applicable state law. Blue Cross and Blue Shield of Nebraska's rights shall not be defeated by allocating the proceeds 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, Blue Cross and Blue Shield of Nebraska has a contractual right of reimbursement to the extent benefits were paid under the Contract for the same illness or injury. This contractual right to reimbursement shall be a first priority lien against any proceeds recovered by the covered person, whether or not the covered person has been fully compensated for all his or her losses, or as provided by applicable state law.

Such proceeds may include any settlement, judgment, payments made under group auto insurance, individual or group no-fault auto insurance, another person's uninsured, underinsured or medical payments provision; or proceeds otherwise paid by a third party. This contractual right of recovery is cumulative with, but exclusive of the subrogation right. Blue Cross and Blue Shield of Nebraska's rights shall not be defeated by allocating the proceeds 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 Blue Cross and Blue Shield of Nebraska. The right to recover, whether by subrogation or reimbursement, shall apply to settlements or recoveries of deceased persons, incompetent or disabled subscribers, or their 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: *Blue Cross and Blue Shield of Nebraska shall 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, as permitted by law. 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.

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

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

All submitted claims must include:

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

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

Claims should be filed as soon as possible. A proof of loss must be filed within 90 days. If a claim is not filed, or any revisions or adjustments to a claim are not filed within 12 months of the date of service (unless you are legally incapacitated), 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 certify benefits in advance of a Service being provided, or benefits for the Service may be reduced or denied. This required request for a benefit is a "pre-service" claim". Pre-service claim determinations that are not Urgent Care Claims will be made with 15 calendar days of receipt, unless an extension is needed to obtain necessary information. If additional information is requested, the Covered Person or his or her provider may be given up to 45

calendar days from receipt of notice to submit the specified information. A claim determination will be made within 15 days of receipt of the information, or the end of the 45 day extension period.

(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 24 hours of receipt of the claim, unless further information is needed. If additional information is necessary, the Covered Person or his or her provider will be given no less than 48 hours to provide the specified information. Notification of the decision will be provided not later than 48 hours after the earlier of: our receipt of the information, or the end of the period allowed to submit the information.

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 instructions for filing a post-service claim are outlined earlier in this section. Upon receipt of a completed claim form, a post-service claim will be processed within 30 days, unless additional information is needed. If additional information is requested, the Covered Person may be given not less than 45 days to submit the necessary information. A claim determination will be made within 15 days of receipt of the information, or the expiration of the 45-day extension period. You will receive an EOB when a claim is processed which explains the manner in which your claim was handled.

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

Who Receives The Benefit Payment

Benefit payments for covered services provided by In-network Providers, 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. The front page of the EOB provides you with a summary of the payment including:

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

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

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

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

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 decisions made regarding claims, benefit availability, or other complaint arising under this health plan. This includes "adverse determinations" made by Utilization Review, and those concerning preadmission certification and concurrent review.

Appeal Procedure Defintions

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

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

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

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

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

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

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

- could seriously jeopardize the life or health of the Covered Person or the ability of the Covered Person to regain maximum function; or
- would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

How To Appeal An Adverse Benefit Determination

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

Internal Appeal

A request for an internal appeal must be submitted within 6 months of the date the claim was processed, or Adverse Benefit Determination was made. The request should state that it is a request for an appeal and include:

- the name and relationship of the person submitting the appeal;
- the reason for the appeal;
- any information that might help resolve the issue;
- the date of service/claim; and
- if possible, a copy of the Explanation of Benefits. (EOB)

The information should be submitted to Blue Cross and Blue Shield of Nebraska at the telephone number on the back of the Covered Person's ID Card, or mailed to:

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

If the Adverse Benefit Determination was based on a medical judgment, including a medical necessity or investigative determination, Blue Cross and Blue Shield of Nebraska will consult with health care professionals with appropriate training and expertise in the field of medicine involved in the judgment. The appeal determination will be made by individuals who

were not involved in the original determination. Upon receipt of a written request, the identification of the medical personnel consulted will be provided to the claimant.

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

- Preservice Claims (other than Urgent Care), within 30 calendar days after receipt.
- Postservice Claims, within 60 calendar days after receipt.

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

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

The internal appeal determination will be considered to be the Final Internal Adverse Benefit Decision.

Right to Documentation: Documentation relevant to the claim and Adverse Benefit Determination(s), including any new evidence or rationale considered or relied upon in connection with the claim on review, can be accessed or copies requested by the claimant. In addition, the claimant may submit additional comments, documents or recrods relating to the claim for consideration during the appeal process.

External Review

If the claimant has exhausted the internal appeal process, an external review by an Independent Review Organization (IRO) may be requested. The request must be submitted in writing within four months after receipt of the Final Internal Adverse Benefit Determination.

The request for an External Review may be submitted electronically, by facsimile, or U.S. mail, as stated on the Final Internal Adverse Benefit Determination notice (letter). Request may be e-mailed to DisputedClaim@opm.gov; fax to 202-606-0036; mail to P.O. Box 791, Washington, D.C. 20044.

The IRO and/or Blue Cross and Blue Shield of Nebraska shall review the request to determine whether it is complete and whether the request is eligible for External Review. If the request is not complete, or is not eligible for External Review, the claimant will be notified of the reason for ineligibility, or advised of the information needed to make the request complete.

If the External Review request is eligible, it will be forwarded to the IRO, including documentation and information used to make the initial Adverse of Final Adverse Benefit Determination. The claimant may submit additional information for consideration by the IRO. If the claimaint submits additional information, the IRO will provide Blue Cross and Blue Shield of Nebraska with any information submitted by the claimant. Blue Cross and Blue Shield of Nebraska will have the opportunity to reconsider the original determination.

The IRO will complete its review and provide the claimant with written notification of its decision within 45 days of receipt. No deference shall be given to the prior internal appeal determinations made by Blue Cross and Blue Shield of Nebraska.

Expedited External Review: An expedited External Review of an Adverse Benefit Determination for an Urgent Care Claim may be request at the same time a claimant requests an expedited internal appeal. However, the claimant must first exhaust the internal appeal process unless Blue Cross and Blue Shield of Nebraska agress to waive this requirement.

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

- the Covered Person has a medical condition where the timeframe for completion of a standard External Review would seriously jeopardize his/her life, health, or ability to regain maximum function would be jeopardized.
- the Final Internal Adverse Benefit Determination concerns an admission; availability of care; continued stay, or heath care service for which the Covered Person has received emergency services, but has not been discharged from a facility.

The expedited External Review decision will be made by the IRO within 72 hours after receipt of the request.

Once an External Review decision has been made, the Covered Person or his/her representative may not file a subsequent request for an External Review involving the same Adverse Benefit Determination. The decision of the IRO is the final review decision and is binding on Blue Cross and Blue Shield of Nebraska and the claimant, except to the extent that federal or state law may provide the claimant with other remedies.

The Nebraska Department of Insurance may be contacted at any time during the appeal procedure for assistance. Their address and telephone number is:

Nebraska Department of Insurance
941 O Street, Suite 400
Lincoln, Nebraska 68508
(402) 471-2201
Toll free: (877) 564-7323

Legal Actions

A legal action may not be brought to recover under the Contract for at least 60 days after a claim is filed, nor more than 3 years from the date a claim is required to be filed under the Contract.

Definitions

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.

BCBSNE: Blue Cross and Blue Shield of Nebraska.

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

CERTIFICATION (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 Master Group Application; the BluePreferred Master Group Benefit Contract For Nebraska Farm Bureau Federation (BLUE ESSENTIALS) and any attachments or endorsements; and the individual Subscriber Application.

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: An In-network 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.

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; or
4. may be ventilator dependent or require routine catheter maintenance.

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.

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. Children to age 26.

   "Children" means:
   • the Subscriber's biological and adopted children, •a grandchild who lives with the Subscriber in a regular child-parent relationship; the parent does not provide support or maintenace and the Subscriber is a court-appointed guardian of the grandchild;
   • a stepchild; or
   • a child under a court-appointed guardianship;or
   • a foster child.

3. Reaching age 26 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 26 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 3. 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.

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.

HOSPICE: A program of care provided for persons diagnosed as terminally ill, and their families.

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.

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

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.

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 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. In addition, for the purposes of this group health plan, mental illness includes alcoholism and dug abuse and other controlled substance (drug) abuse.

NONCOVERED PERSON: A person for who benefits are not available under this group health plan.

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 SERVICES: Covered services that do not require admission to an inpatient setting.

PARTICIPATING PROVIDER: A Licensed practitioner of the healing arts, or qualified provider of health care Services, 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.

PRE-EXISTING CONDITION: A condition, whether physical or mental, regardless of the cause of the condition, for which diagnosis, care or treatment was recommended or received within the 12-month period prior to the effective date of coverage.

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

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

PREGNANCY: Includes obstetrics, abortions, threatened abortions, miscarriages, premature

deliveries, ectopic pregnancies, cesarean sections or other Pregnancy-related conditions.

PRIVATE DUTY NURSING: Continuous nursing care (beyond our accepted definition of a skilled nursing care visit) in homes or facilities. Private duty nursing is primarily non-skilled in nature but may include skilled services and is generally provided to chronically ill patients over the long term.

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 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. This term also includes the Schedule of Benefits Summary.

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.

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.

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.

URGENT CARE FACILITY: A facility, other than a hospital, that provides health services that are required to prevent serious deterioration of health, and that are required as a result of an unforeseen illness, injury or the onset of acute or severe symptoms.

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

BlueCross BlueShield of Nebraska

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

AMENDMENT

THIS IS AN AMENDMENT TO THE DEFINITION OF ELIGIBLE DEPENDENT IN YOUR SUMMARY PLAN DESCRIPTION OR CERTIFICATE OF COVERAGE. PLEASE READ IT CAREFULLY. THIS AMENDMENT BECOMES A PART OF YOUR SUMMARY PLAN DESCRIPTION OR CERTIFICATE OF COVERAGE AND SHOULD BE ATTACHED TO IT.

Steven S. Martin, President
and Chief Executive Officer

MICHELLE'S LAW

(Eligible Dependent Definition)

The definition of an "Eligible Dependent" is amended to add the following:

Coverage for dependent children who are full time students will continue during a medically necessary leave of absence, not to exceed one year from the first day of the leave of absence, provided Blue Cross and Blue Shield of Nebraska receives a written certification from the dependent child's treating physician stating that the dependent child is suffering from a serious Illness or Injury and that the leave of absence is medically necessary.

Coverage will end if a child reaches the limiting age while on a medically necessary leave of absence. All other criteria in the definition must be met in order to remain an Eligible Dependent.

BlueCross BlueShield of Nebraska

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

AMENDMENT

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Steven S. Martin, President
and Chief Executive Officer

CONTINUATION OF COVERAGE FOR CHILDREN TO AGE 30

The Continuation of Coverage section is amended to add:

Continuation of Coverage for Children to Age 30

You may elect to continue coverage to age 30 for a dependent child who would otherwise lose coverage when he or she ceases to meet the plan's student criteria or attains an age which exceeds the plan's limiting age (for your plan's specific criteria see Eligible Dependent in the Definitions section of your Summary Plan Description or Certificate of Coverage), provided that the following criteria are met:

- the child remains financially dependent upon you; and
- the child was covered as an Eligible Dependent at the time coverage would have terminated.

Requesting Continuation Coverage

In order to elect continuation coverage for a child under age 30, you must:

- request an election form from Blue Cross and Blue Shield of Nebraska (BCBSNE);
- complete the form; and
- return the form to BCBSNE no sooner than 31 days prior to or no later than 31 days after the date on which the child would otherwise lose coverage.

You should also notify your employer of your decision to continue coverage for your child.

Payment for Continuation Coverage

The premium for continuation coverage will be equal to your plan's full, unsubsidized single adult premium. You are responsible for paying the full premium each month. The first month's premium must be paid to the Group through which your coverage is provided no later than 31 days after the date the child's coverage would have terminated.

Termination of Continuation Coverage

Continuation coverage will terminate if:

1. BCBSNE does not receive the monthly payment on a timely basis;
2. You request coverage to be terminated;
3. Your coverage with BCBSNE terminates;
4. The covered child:
   a) marries;
   b) is no longer a resident of Nebraska;
   c) receives coverage under another health benefit plan or self-funded employee benefit plan; or
   d) attains age 30.

Continuation coverage will terminate at the end of the month in which any event listed above occurs. Coverage may not be reinstated once it has been terminated.

BlueCross BlueShield of Nebraska

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

AMENDMENT

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Steven S. Martin, President
and Chief Executive Officer

PROVIDER NETWORK CHANGES

The terms BluePreferred Hospital, Physician or other Provider and Non-contracting Provider(s) are deleted and replaced as follows:

- BluePreferred Hospital, Physician or other Provider is replaced with In-Network Hospital, Physician or other Provider.

- Non-contracting Provider(s) is replaced with Out-of-network Provider.

In addition, any reference to Participating Provider(s) is deleted.

The Definitions section is amended to add the following definitions:

- **In-network Hospital, Physician or other Provider:** A Licensed practitioner of the healing arts, a Licensed facility or other qualified provider of health care Services who has contracted with Us to provide Services as a part of a Preferred Provider network in Nebraska.

- **Out-of-network Provider:** A provider of health care Services who has not contracted with Us to provider Services as a part of the Preferred Provider network in Nebraska.

The Definitions section is further amended to delete the definition of a Preferred Provider and replace it with:

- **Preferred Provider:** A health care provider (Hospital, Physician or other health care provider) who has contracted to provide Services as part of the network in Nebraska, or if in another state, who is a Preferred Provider with the BlueCard Program PPO network.

BlueCross BlueShield Nebraska

An independent licensee of the Blue Cross and Blue Shield Association

AMENDMENT

THIS IS AN AMENDMENT TO YOUR CERTIFICATE OF COVERAGE OR SUMMARY PLAN DESCRIPTION. PLEASE READ IT CAREFULLY. THIS AMENDMENT BECOMES A PART OF YOUR CERTIFICATE OF COVERAGE OR SUMMARY PLAN DESCRIPTION AND SHOULD BE ATTACHED TO IT.

The Certificate of Coverage (COC) or Summary Plan Description (SPD) to which this Amendment is attached is amended effective September 1, 2012, as stated below. All provisions within the COC or SPD which refer to payments for Out-of-Area Services, Payments to Out-of-Area Contracting Providers and BlueCard, are hereby amended to be consistent with the below paragraphs.

Out-of-Area Services

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

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

A. BlueCard® Program

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

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

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

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

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

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

B. Negotiated (non-BlueCard Program) National Account Arrangements

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

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

C. Non-Participating Healthcare Providers Outside Our Service Area

1. Subscriber Liability Calculation

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

2. Exceptions

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

September 2012

Dear Farm Bureau Member:

Effective October 1, 2012, as a result of the passage of Legislative Bill 882, benefits will be changing for orally administered cancer drugs under your group health care plan.

LB 882 mandates that benefits for orally administered cancer drugs be paid consistent with benefits for cancer drugs administered intravenously.

Beginning October 1, 2012, benefits for orally administered cancer drugs will be paid as follows:

- When the drugs are purchased from a Blue Cross and Blue Shield of Nebraska network specialty pharmacy, benefits will be paid at 100% of the allowable charge.

- When the drugs are purchased from a non-specialty pharmacy, benefits will be paid as follows:
    - *In-network (non-specialty) pharmacy:* You will pay your plan's applicable in-network pharmacy copay or coinsurance amount.
    - *Out-of-network pharmacy:* You will pay your plan's applicable out-of-network pharmacy copay or coinsurance amount, plus a 25% penalty.

A list of the orally administered cancer drugs impacted by this change is included with this letter. A listing of Blue Cross and Blue Shield of Nebraska network specialty and non-specialty pharmacies may be found at www.nebraskablue.com.

Please note: This letter represents an amendment to your certificate of coverage booklet/summary plan description, so please keep this letter with your other health care coverage materials for future reference.

We appreciate your business. If you have any questions, please contact your Farm Bureau agent.

Sincerely,

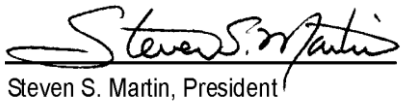
BLUE CROSS AND BLUE SHIELD OF NEBRASKA

ENDORSEMENT

This is an Endorsement. An Endorsement is used by Blue Cross and Blue Shield of Nebraska (BCBSNE) to change your coverage. Please read it carefully. This Endorsement becomes a part of your Contract and should be attached to it. This Endorsement applies to:

Internal Claims and Appeals
and
External Review

Insured Health Plans (Individual & Group)
Self-Funded Non-ERISA Plans



Steven S. Martin, President
and Chief Executive Officer

The Contract to which this Endorsement is attached is amended at the section titled **"PROCEDURE FOR FILING AN APPEAL"** to state as follows:

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

1. **Internal Appeal:**

   a. Requesting an Appeal: A request for an internal appeal must be submitted by the claimant within six (6) months of the date the Claim was processed, or Adverse Benefit Determination was made. The request should include the following information:

      1) state that it is a request for an appeal;
      2) the name and relationship of the person submitting the appeal;
      3) the reason for the appeal;
      4) any information that might help resolve the issue;
      5) the date of service/claim; and
      6) if possible, a copy of the Explanation of Benefits (EOB).

   This information should be submitted to BCBSNE at the address and telephone number listed on the Covered Person's ID card. Within three days after receipt of a request for an appeal, BCBSNE will provide the claimant an acknowledgment of the receipt of the appeal. This notice will include the name, address and telephone number of a person to contact regarding coordination of the review. A claimant does not have the right to attend, nor to have a representative in attendance at the appeal review, but may submit additional information for consideration.

   b. Decision: If the Adverse Benefit Determination was based on a medical judgment, including a Medical Necessity or Investigative determination, BCBSNE will consult with health care professionals with appropriate training and experience in the field of medicine involved in the medical judgment, to make the appeal determination. Identification of the medical personnel consulted, if any, will be provided to the claimant upon written request. The appeal determination will be made by individuals who were not involved in the original determination. Written notification of the decision will be provided to the claimant as follows:

1) for Preservice Claims (other than Urgent Care), within 15 calendar days after receipt;

2) for Postservice Claims involving an Adverse Benefit Determination based on Medical Necessity, Investigative determination or utilization review, within 15 calendar days after receipt; or

3) for all other Post Service Claims, within 15 calendar days after receipt, unless additional time is needed and written notice is provided to the Claimant on or before the 15th day, in which case the decision will be provided within 30 calendar days after receipt.

c. Expedited Appeal: In the case of an Urgent Care Claim, an expedited appeal may be requested orally or in writing. All information, including the decision, will be submitted by telephone, facsimile or the most expeditious method available.

BCBSNE will make a decision and notify the claimant within 72 hours after the appeal is received. Written notification will be sent within the 72-hour period.

Concurrent Care: A request for an expedited appeal of a concurrent care denial must be made within 24 hours of the denial. If requested within this time period, coverage will continue for the health care services pending notification of the review decision, as may be required by law. The decision timeframe will be the same as for other expedited appeals.

d. The decision made pursuant to this appeal is considered a Final Internal Adverse Determination.

2. **Rights to Documentation**: A claimant shall have the right to have access to, and request copies of the documentation relevant to the Claim and Adverse Benefit Determination(s), including any new evidence or rationale considered or relied upon in connection with the Claim on review.

The claimant may submit additional comments, documents or records relating to the Claim for consideration during the appeal process.

3. **Request for External Review:**

a. Standard Review: The claimant may request a review by an Independent Review Organization (IRO) of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination which was based on a judgment as to the Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of the health care service or treatment. The claimant must exhaust the internal appeal process prior to a request for External Review. The request must be submitted in writing within four (4) months after the date of receipt of a notice of the Final Internal Adverse Benefit Determination. The Covered Person will be required to authorize the release of any of his or her protected health information, including medical records, which may be needed for the purposes of the External Review.

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

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

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

If the request is eligible for External Review, the NDOI will assign an IRO to conduct the review, and notify BCBSNE and the claimant of the assignment within one business day. BCBSNE will forward all documentation and information considered in making the initial Adverse or Final Internal Adverse Benefit Determination, including a summary of the Claim and explanation for the determination to the IRO within 5 business days. The claimant will also be allowed an opportunity to submit additional information for consideration by the IRO. The IRO shall provide BCBSNE with any information submitted by the claimant, to allow BCBSNE an opportunity to reconsider its original determination.

The IRO shall complete its review and provide the claimant written notification and rationale for its decision within 45 days of receipt of the request for review. No deference shall be given to the prior determinations made by BCBSNE pursuant to the internal appeal process.

b. Expedited External Review: An expedited External Review may be requested at the same time a claimant requests an expedited internal appeal (1.c., above) of an Adverse Benefit Determination concerning:

1) an Urgent Care Claim; or
2) a denial on the basis that the requested service or treatment is Investigative, if the Covered Person's Treating Physician certifies in writing that the service or treatment would be significantly less effective if not promptly initiated.

However, the claimant must first exhaust the internal appeal process, unless otherwise waived by BCBSNE or directed by the IRO, consistent with state law.

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

1) the Covered Person has a medical condition where the timeframe for completion of a standard External Review, as described in paragraph 3.a., above, would seriously jeopardize the life or health of the Covered Person or would jeopardize his or her ability to regain maximum function; or
2) the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay or health care service for which the Covered Person has received emergency services, but has not been discharged from a facility; or
3) the Final Internal Adverse Benefit Determination is based on a determination that the requested service or treatment is Investigative, if the Covered Person's Treating Physician certifies in writing that the service or treatment would be significantly less effective if not promptly initiated.

The process for coordination of the expedited request between the NDOI, BCBSNE, and the IRO, as described above for a standard review, will be done promptly upon receipt, by telephone, facsimile, or the most expeditious manner available.

An expedited External Review decision shall be made by the IRO within 72 hours after receipt of the request. If notification of the decision to the claimant and BCBSNE was not in writing, the IRO will provide the decision in writing within 48 hours after the oral notification.

An expedited External Review is not available for retrospective Adverse or Final Internal Adverse Benefit Determinations.

c. The decision of the IRO is the final review decision, and is binding upon BCBSNE and the claimant, except to the extent the claimant has other remedies available under applicable federal or state law.

A Covered Person or his or her representative may not file a subsequent request for External Review involving the same Adverse Benefit Determination (initial or Final) for which the Covered Person has already received an External Review decision pursuant to this provision.

4. **Definitions:**

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

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

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

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

ADDITIONAL INFORMATION

The Department of Insurance may be contacted for assistance with the Appeal and External Review process at any time at:

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

ENDORSEMENT

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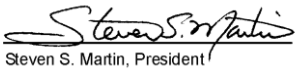
This Endorsement applies to:

Benefits for Autism Spectrum Disorders



Steven S. Martin, President
and Chief Executive Officer

The Contract to which this Endorsement is attached is amended to add:

Covered Services for the screening, diagnosis, and treatment of autism spectrum disorders for individuals under 21 years of age, which may include behavioral health treatment such as applied behavior analysis, subject to Certification.

Coverage for an autism spectrum disorder is not subject to any limits on the number of visits a Covered Person may make for treatment of an autism spectrum disorder and is not subject to dollar limits, deductibles, copayments, or coinsurance provisions that are less favorable than the equivalent provisions that apply to a general physical illness under this Contract. Any applicable cost shares are the same as any other mental illness benefit.

The following definitions apply:

- Applied behavior analysis means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.
- Autism spectrum disorder means any of the pervasive developmental disorders or autism spectrum disorder as defined by the most recent Diagnostic and Statistical Manual of Mental Disorders.
- Behavior analyst means a Certified provider, which may include a Board Certified Behavior analyst approved by the Behavioral Analyst Certification Board, as defined in BCBSNE's medical policy.
- Behavioral health treatment means counseling and treatment programs, including applied behavior analysis, that are: (1) Necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual; and (2) provided or supervised, either in person or by telehealth, by a behavior analyst certified by a national certifying organization or a licensed psychologist if the services performed are within the boundaries of the psychologist's competency.
- Treatment means evidence-based care, including related equipment, that is prescribed or ordered for an individual diagnosed with an autism spectrum disorder by a licensed physician or a licensed psychologist, within the scope of his or her practice, including:
    - Behavioral health treatment;

  - Pharmacy care;
  - Psychiatric care;
  - Psychological care; and
  - Therapeutic care.

In addition to the EXCLUSIONS AND LIMITATIONS stated in the Contract, benefits are not available for:

- Individuals 21 years of age or older;
- Activity therapy, including but not limited to music, dance, art, and play;
- Respite care;
- Day care;
- Recreational care;
- Social services;
- Vocational rehabilitation;
- Transportation;
- Animal-based therapy programs;
- Camps, including all activities and therapies;
- Vitamin therapy and herbal remedies;
- Services provided by relatives;
- Services provided under any state or federal special education program, including Services provided through a school system, for which there is no charge to the person; and
- Services and drugs which are considered by BCBSNE to be Investigative.

Except in the case of inpatient service, BCBSNE reserves the right to request a review of treatment of autism spectrum disorders once every six months, unless the individual's licensed physician or licensed psychologist agrees to more frequent reviews.

Benefits provided according to this Endorsement are subject to all other terms, conditions, exclusions, limitations and definitions set forth in the Contract, which are not in conflict with the provisions of this Endorsement. Provisions or language in the Contract, which are in conflict with this Endorsement, are hereby amended to conform.

ENDORSEMENT

This is an Endorsement. An Endorsement is used by Blue Cross and Blue Shield of Nebraska to change your coverage. This Endorsement becomes a part of the Contract/Benefit Plan Document and should be attached to it.

This Endorsement applies to:

Out-of-network Allowance

Steven S. Martin, President
and Chief Executive Officer

The Contract/Benefit Plan Document is amended to delete and replace the definition of **Out-of-network Allowance** with the following:

> **Out-of-network Allowance**: An amount BCBSNE uses to calculate payment for Covered Services to an Out-of-network Provider. This amount will be determined by BCBSNE or by the On-site Plan for out-of-area providers.

ENDORSEMENT

This is an Endorsement. An Endorsement is used by Blue Cross and Blue Shield of Nebraska to change your coverage. This Endorsement becomes a part of the Contract/Benefit Plan Document and should be attached to it. This Endorsement applies to:

Telehealth Services

Steven S. Martin, President
and Chief Executive Officer

The Contract/Benefit Plan Document is amended to add:

Covered Physician's Services shall include telehealth services for the diagnosis and treatment of a Covered Person's medical condition. Telehealth services shall mean web-based, video or telephonic visits, calls or consultations between a Covered Person and an Approved Provider. Telehealth services are considered a "delivery of care method" and do not constitute medical benefits under the Contract.

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

Telehealth services described in this Endorsement are not applicable to, or available for:

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

Telehealth services are subject to the cost-sharing amounts shown in the Schedule of Benefits Summary (Benefit Summary).

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

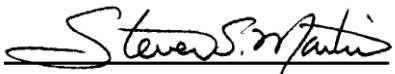
All other terms, conditions, exclusions, limitations and definitions of the Contract/Benefit Plan Document which are not in conflict with this Endorsement remain applicable.

ENDORSEMENT

This is an Endorsement. An Endorsement is used by Blue Cross and Blue Shield of Nebraska to change your coverage. Please read it carefully. This Endorsement becomes a part of your Contract and should be attached to it.

This Endorsement applies to:

Benefits for Pregnancy and Maternity Care



Steven S. Martin, President
and Chief Executive Officer

The Contract to which this Endorsement is attached is amended to provide benefits for Pregnancy and maternity care as follows:

A. PAYMENT: Benefits are payable for Hospital and Physician Covered Services provided to Covered Persons for the treatment of Pregnancy. These benefits are subject to the exclusions and limitations stated in the Contract. Payment for prenatal (excluding the initial visit) and postnatal care is included in the payment for the delivery.

Covered Services include Medically Necessary radiology, pathology or other diagnostic procedures performed in a Physician's office or the Outpatient department of a Hospital, related to the Pregnancy.

B. Under federal law, benefits may not be restricted for any hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, unless otherwise agreed by the patient and her Physician.

Also under federal law, a health insurer 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 mother or newborn than any earlier portion of the stay. In addition, an insurer may not require the provider to obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours), unless otherwise agreed to by the patient and her Physician.

Hospital stays that extend beyond the above time periods should be Certified, as set forth in the Contract.

C. WAITING PERIODS: Benefit payment for Pregnancy shall not be made for any Services provided unless normal childbirth either does or is expected to occur after 270 days of continuous Blue Cross and Blue Shield of Nebraska maternity coverage.

D. Benefits payable under this Endorsement will be subject to all other terms, definitions and conditions stated in the Contract, including Total Benefits accumulation.

November 2011

Dear Blue Cross and Blue Shield of Nebraska Member:

In May 2011, the Nebraska Unicameral passed Legislative Bill 22 (LB22), which prohibits health plans and insurers from providing coverage for voluntary abortions in some circumstances. As a result of LB22, your benefits are changing.

Effective January 1, 2012, benefits will no longer be payable for services for voluntary abortions unless the attending physician certifies that the abortion was necessary to safeguard the life of the woman, or that the unborn child's viability was threatened by the continuation of the pregnancy. Complications related to a voluntary abortion will be covered according to the terms of your coverage.

This letter represents an amendment to your Certificate of Coverage. Contract exclusions and limitations apply. Please keep this letter with your Certificate of Coverage for future reference.

Blue Cross and Blue Shield of Nebraska values its members and wants to provide you with the very best service possible. If you have any questions, please contact our Member Services Department at the number shown on the back of your Blue Cross and Blue Shield of Nebraska I.D. card.

Sincerely,

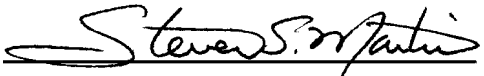
BLUE CROSS AND BLUE SHIELD OF NEBRASKA

ENDORSEMENT

This is an Endorsement. An Endorsement is used by Blue Cross and Blue Shield of Nebraska to change your coverage. Please read it carefully. This Endorsement becomes a part of your Contract and should be attached to it.

This Endorsement applies to:

Identity Theft Proactive Protection Program



Steven S. Martin, President
and Chief Executive Officer

The Contract to which this Endorsement is attached is amended to include an Identity Theft Monitoring and Protection Program at no additional cost to Subscribers/members.

The Identity Theft Monitoring and Protection Program provides 100% of Our eligible members with automatic access to identity repair services. Additionally, eligible members may enroll at their option, in a credit monitoring service.

This Program is administered by a third party vendor pursuant to an agreement with Blue Cross and Blue Shield of Nebraska.

ENDORSEMENT

This is an Endorsement. An Endorsement is used by Blue Cross and Blue Shield of Nebraska to amend your coverage. Please read it carefully. This Endorsement becomes a part of your Contract and should be attached to it.

This Endorsement applies to:

Transgender (Gender Reassignment) Services

Steven S. Martin, President
and Chief Executive Officer

The Contract to which this Endorsement is attached is amended to **remove** the following Exclusions:

"Services provided for, or related to, sex transformation surgery."

"Prescription drugs or other Covered Services for the primary purposes of sex transformation, either prior to or after surgery.

"Testosterone for females."

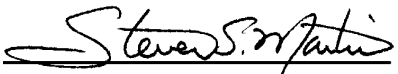
Effective date: Effective at Plan/Policy Year on or after January 1, 2017.

ENDORSEMENT

This is an Endorsement. An Endorsement is used by Blue Cross and Blue Shield of Nebraska to change your coverage. Please read it carefully. This Endorsement becomes a part of your Contract and should be attached to it.

This Endorsement applies to:

Certification (Preauthorization) Requirements



Steven S. Martin, President
and Chief Executive Officer

The Certification provisions of the Contract (including Endorsements thereto) are amended as follows:

1) The list of Services, supplies or drugs requiring Certification (Preauthorization), as stated in the Contract to which this Endorsement is attached, is amended to add:

- Services subject to surgical or other preauthorization programs, as defined by BCBSNE.

A list of services subject to Certification or preauthorization may be obtained at www.nebraskablue.com. Services subject to Certification and preauthorization requirements are subject to change.

2) The Contract is amended to state:

EFFECT ON BENEFITS: If Services are not properly Certified by Us, a penalty may apply and the Covered Person may be responsible for unanticipated costs associated with the expense incurred. Certain surgical or other preauthorization programs require that benefit approval be obtained prior to the Service being provided, with failure to do so resulting in a denial of benefits for the Service. The responsibility for charges denied for failure to obtain Certification or prior authorization rests with the Covered Person, unless the provider is a Contracting Provider with BCBSNE.

3) Previous Endorsements or amendments to the Contract which described a penalty or other reduction for failure to Certify or preauthorize benefits when required are amended to conform as stated above.

All other terms, conditions, exclusions, limitations and definitions of the Contract which are not in conflict are applicable.

Effective date: January 1, 2017

Federally Required Notices

Discrimination is Against the Law

Blue Cross and Blue Shield of Nebraska (BCBSNE) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. BCBSNE does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

BCBSNE:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Customer Service at (800) 991-5840.

If you believe that BCBSNE has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Manager, Corporate Compliance, P.O. Box 3248, Omaha, NE 68180-0001, Toll Free (800) 991-5840, Fax 402-392-4130, civilrights@nebraskablue.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Manager, Corporate Compliance is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services 200
Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION*: This notice may have important information about your application or coverage. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or get help with costs. If you or someone you're helping has questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-800-991-5840.

*This notice is translated as federally required.

Arabic

تنبيه: قد يتضمن هذا الإشعار معلومات مهمة عن تطبيقك أو تأمينك. ابحث عن التواريخ الرئيسية في هذا الإشعار. قد يلزمك اتخاذ إجراء قبل المواعيد النهائية المحددة للحفاظ على التأمين الصحي أو للحصول على مساعدة بشأن التكاليف. إذا كنت أنت أو أحد من تساعدهم لديكم أسئلة، فلك الحق في الحصول على مساعدة ومعلومات بلغتك وبدون تكلفة. للتحدث مع أحد المترجمين الفوريين، اتصل برقم 1-800-991-5840

Chinese Traditional

注意：本通知可能含有與您的申請或保險有關的重要資訊。在本通知中尋找重要的日期。您可能需要在某個截止日期前採取行動，以保持您的健康保險或獲得費用方面的幫助。如果您或者您正幫助的人有疑問，您有權利以您的語言免費獲得提供的幫助與資訊。致電口譯員，請撥打1-800-991-5840。

German

Achtung: Diese Mitteilung kann wichtige Informationen über Ihren Antrag oder die Versicherungsdeckung beinhalten. Beachten Sie wichtige Fristen in dieser Mitteilung. Sie müssen unter Umständen Maßnahmen innerhalb bestimmter Fristen ergreifen, um Ihren Krankenversicherungsschutz zu erhalten oder eine Kostenerstattung zu erhalten. Wenn Sie oder jemand, dem Sie helfen, Fragen hat, können Sie kostenlos Hilfe und Informationen in Ihrer Sprache erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte 1-800-991-5840 an.

Spanish (Mexico)

ATENCIÓN: Este aviso puede contener información importante sobre su solicitud o cobertura. Ponga atención a las fechas clave en este aviso. Puede ser que usted necesite realizar algunas acciones para determinadas fechas y así mantener su cobertura de salud o para obtener ayuda con los costos. Si usted o alguien a quien usted ayuda tiene alguna pregunta, tiene el derecho de recibir información y ayuda en su propio idioma sin costo. Para hablar con un intérprete, llame al 1-800-991-5840.

Farsi

توجه این اعلامیه ممکن است اطلاعات مهمی درباره درخواست یا طرح پوشش بیمه‌تان داشته باشد. تاریخ های اصلی را در این اعلامیه جستجو کنید. ممکن است لازم باشد تا موعد مقرری اقدام کنید تا پوشش بیمه درمانیتان حفظ شود یا هزینه های درمانی را دریافت کنید. اگر شما یا فردی دیگر که به او کمک می کنید، سؤالی دارید، از این حق برخوردار هستید تا راهنمایی و اطلاعات را به صورت رایگان به زبان خودتان دریافت کنید. برای صحبت کردن با یک مترجم، با شماره 1-800-991-5840 تماس بگیرید.

French (Europe)

ATTENTION : Cet avis peut contenir des informations importantes concernant votre demande ou votre garantie. Prêtez attention aux dates clés indiquées. Il vous faudra peut-être prendre des mesures avant une certaine date pour pouvoir conserver votre assurance-santé ou bénéficier d’aides au paiement. Si vous ou une personne que vous aidez avez des questions, vous pouvez obtenir gratuitement de l’assistance et des informations dans votre langue. Pour parler à un interprète, appelez le 1-800-991-5840.

Japanese

ご注意：本通知書には、患者さんの申請や保険について重大な情報が含まれている可能性があります。本通知書の日付をご覧ください。医療保険を利用したり、費用についてサポートを受けるには、本通知書に従って特定の期限までに手続きしてください。患者さん、または付き添いの方が質問がある場合は、母国語で無料で支援を受けたり、情報を受け取る権利があります。通訳と話したい場合は、1-800-991-5840. まで電話をおかけください。

Karen

ဟ်သူဉ်ဟ်သး– တၢ်ဘိးဘဉ်သ့ဉ်ညါအံၤ/ဘဉ်သ့ဉ်သ့ဉ်/ကအိဉ်ဒီးတၢ်ဂ့ၢ်တၢ်ကျိၤလၢ/အရှဒိဉ်ဘဉ်ဃး/နလံာ်ပတံထီဉ်တၢ်/မ့တမ့ၢ်/တၢ်အုဉ်ကီၤသးန့ဉ်လီၤ.
ကွၢ်ယု/မုၢ်နံၤမုၢ်သီအရှဒိဉ်လၢ/လံာ်ဘိးဘဉ်သ့ဉ်ညါအံၤအပူၤတက့ၢ်.
ဘဉ်သ့ဉ်သ့ဉ်/နကဘဉ်/ဟံးဂ့ၢ်ဝီလၢ/မုၢ်နံၤလၢခံကတၢၢ်လၢ/တၢ်ဟ်ပနီဉ်နှၢ်နၤ/လၢနကဟ့ဉ်နတၢ်အိဉ်ဆူဉ်အိဉ်ချ့/တၢ်ဘူးတၢ်လဲတဖဉ်/မ့တမ့ၢ်/မၤန့ၢ်တၢ်မၤစၢၤလၢ/
တၢ်ပှ့ၤလီၤလဲတဖဉ်န့ဉ်လီၤ. /နၤ/မ့တမ့ၢ်/ပှၤတဂၤဂၤလၢ/နမၤစၢၤမ့ၢ်အိဉ်ဒီးတၢ်သံကွၢ်အဃိ,/နအိဉ်ဒီး
တၢ်ခွဲးတၢ်ယာ်လၢ/ကမၤန့ၢ်တၢ်မၤစၢၤဒီးတၢ်ဂ့ၢ်တၢ်ကျိၤလၢ/နကျိာ်လၢ/တလၢာ်ဘူဉ်လၢာ်စ့ၤဘဉ်န့ဉ်လီၤ. /လၢနကကတိၤတၢ်ဒီး/ပှၤကျိးထံတၢ်အဂီၢ်,/ကိး 1-800-991-5840.တက့ၢ်.

Korean

주의: 본고지에는해당신청서또는적용범위에대한중요한정보가있을수있습니다.
본고지의주요날짜를찾으십시오.해당건강보험을유지하거나비용을지원받는특정기한까지조치를취하셔야합니다.본인자신이나본인이돕고있는누군가가질문이있다면무료로모국어로된도움과정보를얻을수있는권리가있습니다.통역사와통화하려면1-800-991-5840. 번으로전화하십시오.

Kurdish

ئاگاداری

ڕەنگە ئەم ئاگاداریە زانیاری گرنگی تێدا بێت دەربارەی داواکاری یان ڕووماڵکردنەکەت.بەدوای بەرواره سەرەکیەکانی ناو ئەم ئاگاداریە بگەڕێ.لەوانەیە پێویست بکات لە هەندێک دوا وادە کردارێک بکەیت بۆ ئەوەی ڕووماڵی تەندروستیت بەردەوام بێت یان یارمەتی بۆ تێچووەکانت دەست بخەیت.ئەگەر تۆ یان کەسێک کە تۆ یارمەتی دەدەیت پرسیاری هەیە، تۆ مافی دەسکەوتنی یارمەتی و زانیاریت بە زمانی خۆت بێ بەرامبەر هەیە.بۆ قسەکردن لەگەڵ وەرگێڕێک، پەیوەندی بە 18009915840. بکە.

Lao

ສິ່ງທີ່ຄວນເອົາໃຈໃສ່: ແຈ້ງການສະບັບນີ້
ອາດຈະມີຂໍ້ມູນທີ່ສໍາຄັນກ່ຽວກັບການສະໝັກ ຫຼື
ການຄຸ້ມຄອງສຸຂະພາບຂອງທ່ານ. ຈົ່ງຊອກຫາວັນທີ່ສໍາຄັນໃນແຈ້ງການສະບັບນີ້.
ທ່ານອາດຈະຕ້ອງດໍາເນີນການໃນຂອບເຂດເວລາໃດໜຶ່ງ
ເພື່ອຮັກສາການຄຸ້ມຄອງດ້ານສຸຂະພາບຂອງທ່ານ ຫຼື
ໄດ້ຮັບການຊ່ວຍເຫຼືອທາງດ້ານງົບປະມານ. ຖ້າຫາກທ່ານ
ຫຼືບຸກຄົນທີ່ທ່ານກໍາລັງຊ່ວຍເຫຼືອຢູ່ນັ້ນ
ມີຄໍາຖາມ,ທ່ານມີສິດໄດ້ຮັບການຊ່ວຍເຫຼືອ ແລະ
ໄດ້ຮັບຂໍ້ມູນທີ່ເປັນພາສາຂອງທ່ານ ໂດຍບໍ່ເສຍຄ່າໃຊ້ຈ່າຍ.
ຕ້ອງການລົມກັບນາຍແປພາສາ, ຈົ່ງໂທຫາເບີ 1-800-991-5840.

Nepali

ध्यानाकर्षण: यो सूचनामा तपाईंको निवेदन वा कभरेजको बारेमा महत्त्वपूर्ण जानकारी हुनसक्छ। यो सूचनामा मुख्य मितिहरू हेर्नुहोस्। तपाईंको स्वास्थ्य कभरेज वा लागतमा मद्दत प्राप्त गर्न तपाईंले निश्चित समयसीमा भित्र कारबाही लिनुपर्ने हुनसक्छ। तपाईं वा तपाईंले सहायता गरेका कसैसँग जिज्ञासाहरू छन् भने तपाईंसँग आफ्नो भाषामा नि:शुल्क सहायता र जानकारी प्राप्त गर्ने अधिकार छ। दोभाषेसँग कुरा गर्न 1-800-991-5840.मा कल गर्नुहोस्।

Oromo

HUBAACHIISA: Beeksisi kun odeeffannoo barbaachisaa waa'ee iyyata keetii yookaan waa'ee tajaajiloota qabaachuu mala. Beeksisa kana irraa guyyoota barbaachisoo ta'an ilaali. Tajaajila fayyaa kee itti fufsiisuuf guyyoota murtaa'an irratti tarkaanfiin ati fudhattu yookaan kaffaltiidhaan gargaarsi ati argattu jiraachu mala. Yoo ati ykn namni ati gargaartu, gaaffii qabaattan, gatii malee gargaarsaa fi oddeeffanno afaan dandeessaaniin argachuun mirga keessaani. Warra afaan hikkaaniif lakkoofsa kanaan bilbilaa 1-800-991-5840.

Russian

ВНИМАНИЕ! В данном уведомлении может содержаться важная информация о вашей заявке или страховке. В нем также указаны ключевые даты. Вам может потребоваться выполнить некоторые действия к определенному сроку для сохранения вашей медицинской страховки или получения помощи в оплате расходов. Если у вас или у человека, которому вы помогаете, возникнут вопросы, вы имеете право получить помощь и информацию на своем языке бесплатно. Чтобы поговорить с переводчиком, позвоните по номеру 1-800-991-5840.

Vietnamese

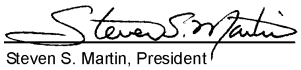
CHÚ Ý: Thông báo này có thể chứa thông tin quan trọng về đơn đăng ký hoặc bảo hiểm của quý vị. Tìm những ngày chính trong thông báo này. Quý vị có thể cần hành động trước một số thời hạn để duy trì bảo hiểm sức khỏe của mình hoặc được giúp đỡ có tính phí. Nếu quý vị hoặc người quý vị đang giúp đỡ, có thắc mắc, quý vị có quyền lấy thông tin và được trợ giúp bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi số 1-800-991-5840.

ENDORSEMENT

This is an Endorsement. An Endorsement is used by Blue Cross and Blue Shield of Nebraska to amend your coverage. Please read it carefully. This Endorsement becomes a part of your Contract and should be attached to it.

This Endorsement applies to:

Coordination of Benefits



Steven S. Martin, President
and Chief Executive Officer

The Contract to which this Endorsement is attached is amended to add the following part, titled "Coordination of Benefits." Previous provisions for Coordination of Benefits (if any), including by Endorsement, are deleted.

COORDINATION OF BENEFITS

The Coordination of Benefits (COB) provision applies when a person has health/dental care coverage under more than one Plan. The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan.

When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans for any Claim are not more than the total Allowable Expenses. In determining the amount to be paid for any Claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health/dental care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the Claim do not exceed the total Allowable Expense for that Claim. In addition, the Secondary Plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage. Also, where the Primary Plan is medical payments coverage under a motor vehicle policy, the Secondary Plan shall credit payments from the motor vehicle insurance policy to deductibles, copayments and coinsurance after discounts under the health plan.

A. WITHIN THIS PART, THE FOLLOWING DEFINITIONS APPLY:

1. **Allowable Expense:** A health/dental care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense.

   The amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical options, precertification of admissions, and preferred provider arrangements.

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

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

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

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

b. Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage other than the medical benefits coverage in motor vehicle "no fault" and traditional "fault" contracts; uninsured or underinsured coverage under a motor vehicle policy; specified disease or specified accident coverage; limited benefit health coverage, as defined in state law; school accident coverage; disability income insurance; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; and coverage under other federal governmental plans, unless permitted by law.

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

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

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

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

8. Any definitions stated in the Nebraska Coordination of Benefits regulations are hereby incorporated by reference.

B. ORDER OF BENEFITS:

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

1. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

2. A Plan that does not contain a coordination of benefits provision that is consistent with this Part is always primary unless the provisions of both Plans state that the complying plan is primary.

3. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

4. Each Plan determines its order of benefits using the first of the following rules that apply:

a. Subscriber and Dependent. The Plan that covers the person as other than a dependent, such as a subscriber/policyholder/employee, is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent and primary to the Plan covering the person as a subscriber, then the order of benefits between the two Plans is reversed so that the Plan covering the person as a subscriber is the Secondary Plan and the other Plan is the Primary Plan.

b. Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:

1) For a dependent child whose parents are married or are living together whether or not they have ever been married:

a) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or

b) If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.

2) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

a) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, the Plan of that parent's spouse is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;

b) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph 1) above shall determine the order of benefits;

c) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provision of subparagraph 1) above shall determine the order of benefits; or

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

i) the Plan covering the Custodial Parent;

ii) the Plan covering the spouse of the Custodial Parent;

iii) the Plan covering the non-custodial parent; and then

iv) the Plan covering the spouse of the non-custodial parent.

3) For a dependent child covered under more than one Plan of individuals who are not parents of the child, the provisions of subparagraph 1) or 2) above shall determine the order of benefits as if those individuals were the parents of the child.

4) For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in paragraph e., below applies. In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parent's plans, the order of benefits shall be determined by applying the birthday rule in paragraph b.1), above, to the dependent child's parent(s) and the dependent's spouse.

c. Active Employee, Retired or Laid-Off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither retired nor laid off, is the Primary Plan. The Plan covering that same person as a retired or laid-off employee is the Secondary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 4.a. can determine the order of benefits.

d. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as a subscriber/member/employee/retiree or covering the person as a dependent of a subscriber/member/employee/retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 4.a. can determine the order of benefits.

e. Longer or Shorter Length of Coverage. The Plan that has covered the person longer is the Primary Plan and the Plan that has covered the person the shorter period of time is the Secondary Plan.

The start of a new Plan does not include:

1) a change in the amount or scope of a plan's benefits;

2) a change in the entity that pays, provides or administers the Plan's benefits; or

3) a change from one type of Plan to another, such as from a single employer plan to a multiple employer plan.

f. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

C. MISCELLANEOUS PROVISIONS

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

2. To properly administer these COB rules, certain facts are needed. The Plan may obtain or release information to any insurance company, organization or person. BCBSNE need not notify, or obtain

the consent of, any person to do so. Any person who claims benefits under this Contract agrees to furnish the Plan information that may be necessary to apply these rules and determine benefits payable.

3. If another Plan pays benefits that should have been paid under this Contract, this Plan may 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 Contract and This Plan is discharged from liability.

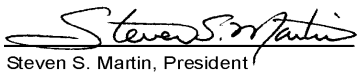
4. If the amount of the benefits paid by This Plan exceeds the amount it should have paid under this Part, then This Plan has the right to recover any excess from any other insurer, any other organization, or any person to or for whom such amounts were paid, including the Subscriber.

5. For COB provisions related specifically to telehealth services, please see the Telehealth Services section.

ENDORSEMENT

This is an Endorsement. An Endorsement is used by Blue Cross and Blue Shield of Nebraska to amend your coverage. Please read it carefully. This Endorsement becomes a part of your Contract and should be attached to it. This Endorsement applies to:

Payment for Out-of-Area Services
(Individual Contracts)



Steven S. Martin, President
and Chief Executive Officer

All provisions within the Contract and its Endorsements which refer to payments for Out-of-Area Services, Payments to Out-of-Area Contracting Providers and BlueCard, are hereby amended consistent with the below paragraphs.

Payments to Out of Area Contracting Providers: Payments made for Covered Services under this Contract by a Blue Cross and/or Blue Shield Plan in another state (Host Blue) for Claims processed through the BlueCard Program may take advantage of any contractual arrangement between that Plan and its Contracting Providers, pursuant to BlueCard policies.

Out-of-Area Services

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

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

Inter-Plan Arrangements Eligibility – Claim Types

All claim types are eligible to be processed through Inter-Plan Arrangements, as described above, except for Dental Care Benefits (except when paid as medical claims/benefits), and those Prescription Drug Benefits or Vision Care Benefits that may be administered by a third party contracted by BCBSNE to provide the specific service or services.

a. **BlueCard® Program**

Under the BlueCard® Program, when You receive Covered Services within the geographic area served by a Host Blue, BCBSNE will remain responsible for doing what We agreed to in the Contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating providers.

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

- The billed charges for Covered Services; or
- The negotiated price that the Host Blue makes available to BCBSNE.

Often, this ”negotiated price” will be a simple discount that reflects an actual price that the Host Blue pays to your health care provider. Sometimes, it is an estimated price that takes into account special arrangements with your health care provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of health care providers after taking into account the same types of transactions as with an estimated price.

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

b. **Negotiated (non-BlueCard Program) Arrangements**

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

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

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

c. **Special Cases: Value-Based Programs**

BlueCard Program

If You receive Covered Services under a Value-Based Program inside a Host Blue’s service area, You will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are part of such an arrangement except when a Host Blue passes these fees to BCBSNE through average pricing or fee schedule adjustments.

Value-Based Programs: Negotiated (non-BlueCard Program) Arrangements

If BCBSNE has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to You, BCBSNE will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees noted above for the BlueCard Program.

d. **Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees**

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

e. **Non-Participating Providers Outside Our Service Area**

(1) Subscriber Liability Calculation

When Covered Services are provided outside of BCBSNE's service area by non-participating providers, the amount You pay for such services will normally be based on either the Host Blue's non-participating provider local payment or the pricing arrangements required by applicable state law. In these situations, You may be responsible for the difference between the amount that the non-participating health care provider bills and the payment BCBSNE will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

(2) Exceptions

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

f. **Blue Cross Blue Shield Global Core**

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

Inpatient Services

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

Outpatient Services

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

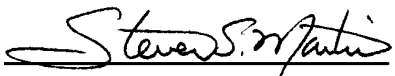
Submitting a Blue Cross Blue Shield Global Core Claim

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

ENDORSEMENT

This is an Endorsement. An Endorsement is used by Blue Cross and Blue Shield of Nebraska to amend your coverage. Please read it carefully. This Endorsement becomes a part of your Contract and should be attached to it. This Endorsement applies to:

Annual Meeting



Steven S. Martin, President
and Chief Executive Officer

The Contract to which this Endorsement is attached is amended at the provision for "Annual Meeting" or "Blue Cross and Blue Shield of Nebraska Membership" to change the date of the Annual Meeting of Members to **"the last Monday of March each year."**

ENDORSEMENT

This is an Endorsement. An Endorsement is used by Blue Cross and Blue Shield of Nebraska to amend your coverage. Please read it carefully. This Endorsement becomes a part of your Contract and should be attached to it. This Endorsement applies to:

GoodLife Partners, Inc. Membership
(Mutual Holding Company change)

BLUE CROSS AND BLUE SHIELD OF NEBRASKA

By: Steven H. Grandfield, President
and Chief Executive Officer

The Contract to which this Endorsement is attached is amended at the provision for "Annual Meeting" or "Blue Cross and Blue Shield of Nebraska Membership" to change the "membership description" as stated in the first sentence as follows:

Current statement:
"You become a member of Blue Cross and Blue Shield of Nebraska"

New statement:
"You become a member of GoodLife Partners, Inc. a mutual holding company and the overall parent company of Blue Cross and Blue Shield of Nebraska, Inc."

Effective Date: July 1, 2018