
NEBRASKA COMPREHENSIVE HEALTH INSURANCE POOL (NECHIP)

This Policy, developed pursuant to the Comprehensive Health Insurance Pool Act, is made in and governed by the laws of the State of Nebraska.

The Policy consists of Your Application, Schedule of Benefits, this document, and any endorsements thereto. It provides one-person coverage, for You, the insured person only.

This Policy is a Preferred Provider Organization (PPO) benefit plan, providing benefits for the health care services described, defined and limited herein, during the term of this Policy. The Physicians, Hospitals and other providers within the Preferred Provider Organization have agreed to furnish services to covered persons in a manner reasonably expected to manage health care costs.

Nebraska Comprehensive Health Insurance Pool

By: *Victor Kessler*
Chairman, Board of Directors

PART I. EFFECTIVE DATE AND RENEWABILITY

Your coverage starts at 12:01 a.m. Standard Time, at Your principal place of residence in the state of Nebraska, on the Policy effective date indicated in Your Application. Your Policy effective date is shown on Your Schedule of Benefits. This Policy will be renewed each month by paying the premium within the 31-day grace period. This Policy will be canceled if You fail to pay Your premium when due, or for the reasons stated in Part V.

PART II. PLEASE READ APPLICATION

A copy of Your Application is attached. Please read the copy of Your Application. If anything is not correct or incomplete, You must tell Us. Your Policy was issued on the basis that all information in the Application is correct and complete. If it is not, Your Policy may not be valid, or a claim may be reduced or denied.

PART III. 10-DAY RIGHT TO EXAMINE POLICY

Please read Your Policy. If You are not satisfied for any reason, send it back to Us within 10 days after You receive it. If returned, any premium paid will be refunded, and the Policy will be void and considered to never have been issued.

NEBRASKA CHIP

PPO INSURANCE POLICY

TABLE OF CONTENTS

	PAGE
PART I. EFFECTIVE DATE AND RENEWABILITY	Face Page
PART II. PLEASE READ APPLICATION	Face Page
PART III. 10-DAY RIGHT TO EXAMINE POLICY	Face Page
PART IV. PREMIUM CHANGES AND POLICY CHANGES.....	1
PART V. GRACE PERIOD; CANCELLATION; TERMINATION	1
PART VI. PRE-EXISTING CONDITION LIMITATION	2
PART VII. BENEFITS OVERVIEW	2
PART VIII. COST CONTAINMENT PROVISIONS	5
PART IX. DEDUCTIBLE, COINSURANCE, COPAYMENT, MAXIMUM OUT-OF-POCKET EXPENSE AMOUNT	8
PART X. BENEFITS FOR HOSPITAL SERVICES	10
PART XI. BENEFITS FOR SERVICES IN A SKILLED NURSING FACILITY	11
PART XII. BENEFITS FOR INPATIENT PHYSICAL REHABILITATION.....	11
PART XIII. BENEFITS FOR PHYSICIAN'S SERVICES	12
PART XIV. BENEFITS FOR ROUTINE CARE SERVICES	14
PART XV. BENEFITS FOR COMPLICATIONS OF PREGNANCY	15
PART XVI. BENEFITS FOR MENTAL DISEASE OR DISORDERS, OR ALCOHOLISM OR DRUG DEPENDENCY	15
PART XVII. BENEFITS FOR ORAL SURGERY AND DENTISTRY	17
PART XVIII. BENEFITS FOR OUTPATIENT PHYSICAL, SPEECH AND OCCUPATIONAL THERAPY SERVICES.....	18
PART XIX. BENEFITS FOR OUTPATIENT CARDIAC AND PULMONARY REHABILITATION	18
PART XX. BENEFITS FOR HOSPICE CARE AND HOME HEALTH CARE	19
PART XXI. BENEFITS FOR ORGAN AND TISSUE TRANSPLANTATION	21
PART XXII. BENEFITS FOR OTHER COVERED SERVICES	25
PART XXIII. PRESCRIPTION DRUG PLAN BENEFITS.....	26
PART XXIV. EXCLUSIONS AND LIMITATIONS.....	32
PART XXV. HOW TO FILE A CLAIM.....	35
PART XXVI. GENERAL POLICY PROVISIONS	36
PART XXVII. APPEAL PROCEDURES	37
PART XXVIII. DEFINITIONS.....	40
ENDORSEMENT -- BLUECARD PROGRAM.....	47

PART IV. PREMIUM CHANGES AND POLICY CHANGES

A. **PREMIUM CHANGES:** Your premium is based on factors such as gender and age, as well as the coverage option elected by You. The amount of Your monthly premium will change for the following reasons:

1. **Because of Age:** Based on Your attained age, the premium will change each year. This change will only be made on the renewal date that coincides with or next follows each anniversary of Your Policy effective date.

2. **Revised Rate Schedule:** The premium may also change on the basis of a revised schedule of rates. Such a change will be applied only when the same change is made on all policies of this form, with the same provisions and benefits, issued to persons of the same classification. The change may be made on any renewal date.

B. **POLICY CHANGES:** Any provision of this Policy, including but not limited to Deductibles, Coinsurance percentages, Copayments, Out-of-Pocket Maximums, and Policy maximums are subject to change as determined by the Nebraska Comprehensive Health Insurance Pool. You will receive written notice of any Policy changes in advance.

PART V. GRACE PERIOD; CANCELLATION; TERMINATION

A. **GRACE PERIOD:** **Premium payments are due on the first day of the month.** A grace period of 31 days will be granted for the payment of monthly premiums. During the grace period, the Policy will remain in force, subject to Our right to cancel in accordance with the cancellation provision below. Subject to the grace period, if You fail to pay premiums, Your Policy ceases effective as of midnight of the last day for which premium has been paid.

B. **CANCELLATION:** This Policy will be cancelled and all insurance will cease:

1. On the date We decline to renew all policies issued on this form subject to approval by the Director of Insurance. We will provide written notice to You by certified or registered mail at Your last known address, as shown on Our records, 30 days prior to the date We decline to renew the Policy.

If Your Policy is cancelled pursuant to this non-renewal provision, We will issue You a new Policy, on the form then being issued (if any) to new enrollees of NECHIP. The premium will be based on Your original issue class and Your current age. Coverage will begin the day after this Policy ends, provided the required premium is paid within the grace Period. Any waiting periods set forth in the new Policy will be considered as being met to the extent they were met under this Policy.

2. If You, or someone acting on Your behalf, commits fraud or an act of misrepresentation involving the Application or Policy, or benefits payable under the Policy. In cases of fraud or misrepresentation in claims for benefits, coverage will cease upon the date We give notice to You or any later date designated by Us. In cases of fraud or misrepresentation of Your eligibility for coverage, Your coverage may be rescinded and will be considered to have never been issued.

3. On the date You:

- a. become eligible for Medicare based on turning age 65,
- b. become eligible for Medicaid,
- c. become a resident or inmate of a correctional facility,
- d. are no longer a resident of Nebraska, or

e. have been paid one million dollars (\$1,000,000) in benefits from all NECHIP policies which have ever been issued to You.

4. On the date of Your death.

5. On nonpayment of premiums when due, subject to the grace period clause in Part V.A.

6. On the date We receive a request from You to terminate the Policy or any later date stated in Your request.

NOTE: If Your Policy ceases pursuant to 5. or 6. above, You are not eligible to apply for NECHIP coverage until 12 months has elapsed since Your Policy ended, except as otherwise provided by state law.

C. **REINSTATEMENT:** This Policy does not provide for reinstatement if it lapses due to nonpayment of premium. If Your premium is received after the grace period, the premium will be returned to You.

D. **TERMINATION BY YOU:** You may terminate this Policy by notifying Us in writing. Following such notification, Your Policy will cease at the end of the period for which premiums have been paid. The grace period is not applicable. If You request an earlier termination date, Your Policy will cease on the later of Your request date or the date We receive notification.

E. Any premium paid and not earned will be refunded if Your Policy ends. Termination will not affect any claim for services provided prior to the date Your Policy ends.

PART VI. PRE-EXISTING CONDITION LIMITATION

Benefits will not be payable under this Policy for any Pre-existing Condition for the first six months following Your Policy effective date.

This limitation does not apply to You if are eligible for, and were granted, a waiver of the Pre-existing Condition waiting period, pursuant §44-4228 of the Comprehensive Health Insurance Pool Act. To be eligible for this waiver, an individual must meet all eligibility criteria stated in the Act and in the Application, and provide the necessary documentation at time of application for Pool coverage. Individuals eligible for this waiver include “federally-eligible individuals” and those others described in the Act.

Your Schedule of Benefits will indicate Your waiting period for Pre-existing Conditions.

PART VII. BENEFITS OVERVIEW

A. **PAYMENT FOR SERVICES:** This Policy provides benefits for Covered Services provided to You, subject to the Exclusions and Limitations and other conditions stated in the Policy. For benefits to be payable, all Covered Services must be Medically Necessary. The benefit payment is determined by the following guidelines:

1. **PPO Providers:** Our Administrator has contracted with a panel of PPO Providers consisting of Physicians, Hospitals, and other health care providers, to furnish services in a manner reasonably expected to effectively manage health care costs, through a Preferred Provider Organization. The Preferred level of benefits will be available when services are provided by a PPO Provider. This means the Deductible, Coinsurance or Copayment You pay will usually be less when Covered Services are received from PPO Provider. These PPO Providers have agreed to be reimbursed a Contracted Amount for Covered Services. The PPO Providers agree to accept Our payment, plus Your payment of any Deductible, Coinsurance or Copayment, and any charges for Noncovered Services, as payment in full.

If a claim is submitted for a service which is not approved by Utilization Review as Medically Necessary, the PPO Provider agrees not to charge, collect, or seek collection from You or from Us, except as set forth in Part VII.B.

2. Non-PPO Providers: Benefits for Covered Services from a Non-PPO Provider will be based on the Reasonable Allowance, whether services are provided in Nebraska or in another state.

You are responsible for payment of the Non-PPO Deductible and Coinsurance, charges for Noncovered Services and any excess charge over the amount payable under the Policy. You are also responsible for services determined to be not Medically Necessary when provided by a Non-PPO Provider.

a. **Emergency Medical Condition:** If You receive initial Inpatient or Outpatient care at a Non-PPO Hospital or by a Non-PPO Physician or Provider for an Emergency Medical Condition, benefits will be paid for Covered Services subject to the PPO Deductible and Coinsurance rates for the initial care.

b. **Participating Providers:** If a Non-PPO Provider has contracted with the Administrator under another Participating Provider program, benefits will be payable as agreed to by the parties to the Participating Provider Agreement. These Participating Providers have agreed to accept the Contracted Amount and Your payment of the non-PPO Deductible and Coinsurance as payment in full; the excess over the Contracted Amount will not be Your responsibility. Charges for Noncovered Services are Your responsibility. If a claim is submitted for a service which is not approved by Utilization Review as Medically Necessary, these Participating Providers agree not to charge, collect, or seek collection from You or from Us, except as set forth in Part VII.B.

c. You may contact the Administrator for a good faith estimate of the dollar amount of the Allowable Charge for a specific covered procedure provided in Nebraska by a Non-PPO Provider. The request must include the service or procedure code number or diagnostic-related group provided by the Non-PPO health care provider, and the provider's estimated charge.

B. UTILIZATION REVIEW: Services provided by Hospitals, Physicians and all other health care providers are subject to Utilization Review. Utilization Review is the evaluation by the Administrator of the use of a medical, diagnostic, or surgical procedure or service or the utilization of medical supplies, drugs or Home Medical Equipment compared with criteria established by the Administrator in order to determine benefits. Benefits may be excluded for services, procedures, supplies, drugs or Home Medical Equipment found by the Administrator to be not Medically Necessary. PPO Providers have agreed that You will not be responsible for the charges for services which are determined to be not Medically Necessary. If a claim is submitted for a service which is not Medically Necessary, the PPO Provider agrees not to charge, collect or seek collection from You or Us. If benefits for a service by a Non-PPO Provider are denied as not Medically Necessary and that provider does not have a contracting arrangement with the Administrator, You will be responsible for payment of the charge.

Exception: The PPO Provider or Contracting Provider may collect from You, however, for a specific service, procedure, drug, supply or item of medical equipment determined to be not Medically Necessary if, prior to the services being provided, the Provider has advised You, in writing, and You have agreed in writing to be responsible for the payment. If written agreement cannot be obtained, prior verbal notification may be given by the Provider and must be documented in the patient's medical record at the time that such notification is given. Use of this procedure must be limited to a specific instance and not done as a usual practice.

C. EXPANSION OF BENEFITS: We may expand the scope of benefits in an individual case to include payment for specific services which would not ordinarily be included as Covered Services if it appears to Us that use of such services will equal or reduce costs, improve the quality of care or will be more medically appropriate than an alternate Covered Service. You and the provider will be advised in writing when, and to what extent, payment of such services will be made. Such expansion of the scope of benefits will not constitute an amendment to this Policy, nor provide a continuing right to receive such services.

D. We reserve the Administrator's right to change or terminate their agreements with health care providers and to alter benefit payment procedures to PPO Providers. Benefit payments may be calculated on a charge basis, a per diem basis, a global fee basis, a Maximum Benefit Amount or similar charge, through a Preferred Provider Organization, or in any other manner agreed upon between the Administrator and the provider. However, any payment method agreed to between the Administrator and the providers will not affect the method of calculating Your Deductible, Coinsurance and Out-of-Pocket Expense Amount.

E. DIRECT PAYMENT: All payments for Covered Services provided by PPO Hospitals, PPO Physicians and other PPO Providers, or any provider who is participating with the Administrator pursuant to any other reimbursement program, will be made directly to such Contracting Providers. In all other cases, payments will, at Our option, be made to You, Your estate, or the provider. No assignment for services which are provided within the state of Nebraska, whether made before or after services are provided, of any amount payable according to this Policy shall be recognized or accepted as binding upon Us or the Administrator.

F. All benefits payable under this Policy will be paid as soon as possible after the claim has been filed.

G. This Policy provides one-person coverage, for You, the insured person only. This Policy shall also provide coverage for Your newly-born child, from the moment of birth, for a period of 31 days. The coverage for the newly-born child shall include coverage of Injury or Sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. Coverage does not include well-baby care, except as may be otherwise considered a Covered Service under the Policy. Coverage under this Policy for the child shall terminate at the end of the 31-day period, unless the Policy is terminated prior to that date.

H. MEDICAL RECORDS: In consideration for the processing of claims, the Administrator will be entitled to receive without charge, from You and all providers of services, such facts, records, and reports about the examination or treatment of You as may be needed to process claims or to determine the appropriateness of benefit payment.

PART VIII. COST CONTAINMENT PROVISIONS

Certain provisions are included in Your Policy which are designed to reduce the total cost of medical care for Covered Services, or to determine if health care services are Medically Necessary pursuant to the terms of the Policy. These provisions may:

REQUIRE You to receive approval from the Administrator, before benefits are payable for Covered Services;

REQUIRE You to receive approval from the Administrator before benefits are payable for Covered Services at greater benefits or without a Deductible, Coinsurance or Copayment; or

ALLOW You to receive greater benefits if certain services or supplies are used.

A. Preadmission or Admission Certification and Concurrent Review:

Certification of an Inpatient admission is based on a review and assessment by the Administrator of the Medical Necessity of the admission. The appropriateness of the setting and level of care is assessed along with the timing and duration of the treatment. Certification is not a guarantee of payment. Payment is subject to the other terms of the Policy, including, but not limited to, determination of eligibility, Pre-existing Conditions, and all exclusions and limitations.

Benefits for Covered Services provided for a nonemergency Hospital Inpatient Admission to a Non-PPO Hospital must be Certified. When You are hospitalized in a PPO Hospital, there is no requirement for Certification, except as provided below. An admission for childbirth does not require Certification.

Exception: Benefits for Covered Services for all Inpatient admissions to a Hospital or Treatment Center for treatment of Mental Disease or Disorders or Alcoholism or Drug Dependency must be Certified, regardless of the facility's PPO status.

1. Preadmission Certification: Benefits for all Covered Services provided for a nonemergency Hospital Inpatient admission to a Non-PPO Hospital must be precertified. In addition, benefits for Covered Services for all Inpatient admissions for the treatment of Mental Disease or Disorders or Alcoholism or Drug Dependency must be precertified. If Certification is not possible prior to admission, then it must be obtained within 24 hours of the admission or the next business day, whichever occurs first.

2. Admission Certification: The Administrator must be notified of a nonelective admission or an emergency admission as described in paragraph 3. below, within 24 hours of the admission, or the next business day, whichever occurs first, if You are admitted to a Non-PPO Hospital, or to any Hospital or Treatment Center for Inpatient treatment of Mental Disease or Disorders or Alcoholism or Drug Dependency.

3. Medical Emergency Admission: The admission will be reviewed by the Administrator to determine if it was for an Emergency Medical Condition and to determine if You required Inpatient care. If You have not requested Inpatient Certification within 24 hours of the admission or the next business day, the 24-hour period prior to the time of admission and the 24-hour period after such admission will be reviewed to determine if Your condition and treatment would have hindered Your ability to notify the Administrator. (Admission through the emergency room does not necessarily constitute an emergency admission.)

If notification of an admission by You was possible, and not made, Allowable Charges for all related Covered Services will be reduced by 25%, and benefits for all services which are not Medically Necessary will be denied.

4. Concurrent Review: Concurrent Review is a review of an ongoing Inpatient Hospital admission to assure that it remains the most appropriate setting for the care being provided. If additional days beyond the number of days originally Certified for benefit consideration are needed, those days also must be Certified in advance. The Administrator will contact the Hospital, Treatment Center or the Physician to determine the treatment plan. If additional days are Medically Necessary, benefits will be Certified. The Administrator will notify the Physician, Hospital, Treatment Center, You, or someone acting on Your behalf, whether or not benefit payment will be Certified for additional days. If the treatment is no longer Medically Necessary beyond the length of stay Certified by the Administrator, benefits for services which are not Medically Necessary will be denied.

5. Notification: When Certification is required, it is always Your responsibility to see that the Administrator is notified. Submission of a related claim prior to hospitalization does not constitute notification. Actual notification to the Administrator may be made by the Physician, a Hospital or Treatment Center, You or someone acting on Your behalf. The Administrator will notify the Physician, the Hospital, Treatment Center, You or someone acting on Your behalf:

- 1) whether or not benefits will be Certified for an Inpatient admission; and
- 2) the number of days which will be considered Medically Necessary for such admission.

Notification to any one of the above-named constitutes notice to You.

If the anticipated admission date changes, the Administrator must be notified.

6. Denial of Certification: If Certification for an Inpatient admission to a Hospital or Treatment Center is denied because it is determined by the Administrator to be not Medically Necessary, benefits for all services which are not Medically Necessary will be denied.

7. No Request Made: If You do not request Certification of benefits as required and are admitted as an Inpatient, the Allowable Charges for all related Covered Services will be reduced by 25%. In addition, if the admission is determined to be not Medically Necessary, benefits for all services which are not Medically Necessary will be denied.

8. Liability: Liability for charges for services which are determined to be not Medically Necessary will be as stated in Part VII.B. You will remain liable for the 25% reduction in benefits for failure to Certify benefits for an admission to a Non-PPO Hospital, or for failure to certify benefits for any Inpatient admission for Mental Disease or Disorders or Alcoholism or Drug Dependency. **Any such reductions in benefits are not considered in computing the Out-of-Pocket Expense Amount.**

B. Preauthorization Requirements: Payment for certain procedures or services may require Preauthorization of benefits. This includes, but is not limited to:

1. Inpatient physical rehabilitation;
2. Skilled Nursing Facility care;
3. Outpatient cardiac or pulmonary rehabilitation;
4. Home health and hospice care;
5. Certain oral surgical procedures;
6. Certain purchases of Home Medical Equipment; and
7. Organ and tissue transplant surgeries for liver, heart, lung (single and double), combination heart-lung, pancreas, pancreas-kidney, parathyroid and bone marrow transplantation. If benefits are authorized, they will be payable as stated in Part XXI. If the transplant surgery is not Preauthorized, benefits will not be payable for any services or supplies incurred for such transplant.

When required by the terms of this Policy, Preauthorization must be initiated in writing by You or Your Provider prior to the procedure or service. This request must be accompanied by documentation from Your Physician or other medical provider describing the proposed treatment or procedure and demonstrating the Medical Necessity of the procedure or service. This request should also indicate the location of the service. This written request should be directed to:

Nebraska Comprehensive Health Insurance Pool
Medical Support Department
P.O. Box 3248
Omaha, Nebraska 68180-0001

The Administrator will respond in writing advising You as to whether or not benefits are available. A penalty will be applied for noncompliance with this paragraph, if so indicated in the Part of this Policy describing a particular benefit.

C. OTHER COST CONTAINMENT PROVISIONS:

1. **Hospital Preadmission Testing Benefit:** We pay Covered Services as outlined in Part XXII.B, not subject to the Deductible or Coinsurance.
2. **Home Health Care Benefit:** Covered Services in excess of the Deductible are payable as stated in Part XX.
3. **Diabetes Education Benefit:** Covered Services for enrollment, participation and completion of a Diabetes Patient Education Program are payable as stated in Part XXII.D.
4. **Skilled Nursing Facility Benefit:** Covered Services in excess of the Deductible are payable as stated in Part XI.

PART IX. DEDUCTIBLE, COINSURANCE, COPAYMENT, MAXIMUM OUT-OF-POCKET EXPENSE AMOUNT, AND MAXIMUM BENEFITS

A. **DEDUCTIBLE:** This is the amount of Allowable Charges for Covered Services You must pay each calendar year before any benefits are payable. Your PPO Provider Deductible and Your Non-PPO Provider Deductible are shown on Your Schedule of Benefits. Only charges for Covered Services may be used to satisfy the Deductible. The Deductible credited to charges by either PPO Providers or Non-PPO Providers will be credited and totaled for application to both.

If You do not meet Your Deductible in a calendar year, Allowable Charges for Covered Services incurred during October, November and December of that year may be carried over and applied against the Deductible for the next calendar year.

B. **COINSURANCE:** This is the percentage of Allowable Charges which You must pay, after the Deductible is applied. Your Coinsurance percentages are shown on Your Schedule of Benefits.

Except as otherwise specifically stated in this Policy for certain Covered Services or otherwise specifically limited:

- for Covered Services by a PPO Provider, Your Coinsurance is 20% (PPO).
- for Covered Services by a Non-PPO Provider, Your Coinsurance is 30% (Non-PPO).

C. **COPAYMENTS:** You may be required to pay a fixed Copayment for certain Covered Services at the time of service, as indicated in the Policy and on Your Schedule of Benefits. The Copayment does not apply to the Deductible or Out-of-Pocket Expense Amount.

D. **OUT-OF-POCKET EXPENSE AMOUNT (Coinsurance Limit):** Your Maximum Out-of-Pocket Expense Amount is the total amount of Coinsurance You must pay during a calendar year. The following expenses do not count toward Your Maximum Out-of-Pocket Expense Amount:

1. Coinsurance paid for treatment of Mental Disease or Disorders, Alcoholism or Drug Dependency.
2. Your Deductible Amounts.
3. Physician office visit or emergency room Copayment amounts.
4. Prescription drug plan Copayment, Coinsurance or penalty amounts, unless otherwise stated.
5. The reduction amount for failure to Certify an Inpatient admission.
6. Noncovered Services, or amounts in excess of the Contracted Amount.

Your Maximum Out-of-Pocket Expense Amounts for PPO and Non-PPO Providers are shown on Your Schedule of Benefits. After You have incurred that amount, benefits will be paid for additional Covered Services without further application of the Coinsurance percentage for the remainder of that year, unless stated otherwise.

E. **MAXIMUM NECHIP BENEFITS:**

1. The maximum benefit for the treatment of all conditions is a total of \$1,000,000, payable from any and all NECHIP policies issued during Your lifetime.
2. The maximum benefits payable for the treatment of Mental Disease or Disorders, Alcoholism and Drug Dependency, combined, are \$25,000, payable from any and all NECHIP policies issued during Your lifetime.
3. The maximum benefits payable for diabetes education are \$500 within a two-year period.

4. Organ and Tissue Transplants: If a Preferred Transplant Center is available, and You elect not to have a covered transplant performed at such center, benefits will be limited as follows:

- a. limited to a \$100,000 maximum per transplant; and
- b. only one transplant of each type listed in paragraphs A.1. and A.2. of Part XXI. Second and subsequent transplants of the same type are not covered unless performed at a Preferred Transplant Center.

The following expenses will be included in calculation of the above \$100,000 limit:

- a. For bone marrow transplants: (1) the harvest of stem cells, whether from the bone marrow or from the blood, from a donor or from the patient; (2) processing and/or storage of the stem cells so harvested; (3) the administration of High Dose Chemotherapy and/or High Dose Radiotherapy (this step may be absent in certain applications); (4) the infusion of the harvested stem cells; and (5) hospitalization, observation and management of reasonably anticipated complications such as graft versus host disease, infections, bleeding, organ or system toxicities and low blood counts. Expenses for services rendered more than 30 days after the infusion will not be considered in calculating the \$100,000 limit.
- b. For all other transplants: organ acquisition expense, donor expenses, the transplant procedure and all related expenses, including professional and facility fees, incurred during the hospital stay during which the transplant was performed.

A Preferred Transplant Center is a hospital selected by the Pool, as reflected on a list maintained by the Administrator, that has agreed to provide quality care on a cost efficient basis. One or more Preferred Transplant Centers is available for most of the transplant types listed in Part XXI. You may contact the Administrator to obtain the list.

F. **WAIVER OF COINSURANCE OR DEDUCTIBLE:** If a provider routinely waives (does not require You to pay) or reduces the Coinsurance, Deductible, or Copayment for Covered Services, he or she is misstating the actual charge. The Administrator and the Pool are not obligated to pay the full percentage of the provider's original charge, but instead, will pay benefits based on the lower fee actually charged.

PART X. BENEFITS FOR HOSPITAL SERVICES

A. OVERVIEW: Admission to a Hospital and all services must be ordered by a Physician. The following Hospital services are Covered Services under this Policy. This means that, subject to the Exclusions and Limitations and all other provisions of the Policy, benefits will be available for these services when provided to You.

B. COVERED HOSPITAL INPATIENT SERVICES:

1. **Hospital Room:** Benefits will be provided for Hospital room and board. Any special diet and all nursing services are considered included in the Hospital room charge. Benefits will be based upon the Allowable Charge for a semiprivate room. If You are confined to a private room, benefits will be based upon the average charge for a semiprivate room in that Hospital, unless You are confined to a private room to prevent contagion and isolation was ordered, utilized and Medically Necessary. Benefits will be based on the Allowable Charge for a private room in those situations.

If an intensive care unit, cardiac care or similar type of room is Medically Necessary, benefits will be based upon the charge for such room. If more than one room is used during a twenty-four (24) hour period, only one room charge will be payable and benefits will be based on the most intensive care provided during that period.

2. **Treatment rooms:** Includes use of operating, cystoscopic, cast, recovery and other surgical treatment rooms and equipment.

3. **Anesthetics** and their administration.

4. **Respiratory care including oxygen.**

5. **FDA-approved drugs**, intravenous solutions, vaccines, biologicals, and medicines, including chemotherapy.

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

7. **Supplies, materials and equipment**, including dressings, splints and plaster casts, except "take-home" supplies and convenience items.

8. **Radiology, pathology and other diagnostic services** when billed by the Hospital. Benefits are also payable for radiation therapy.

9. **Physical therapy** when provided by a Licensed physical therapist, or Licensed physical therapist assistant supervised by and assigned to a physical therapist.

10. **Occupational therapy services** when provided by a Licensed occupational therapist or Licensed occupational therapist assistant supervised by an occupational therapist.

11. **Speech therapy** when provided by a Licensed speech-language pathologist or registered speech-language pathology assistant practicing under the direct supervision of a Licensed speech-language pathologist.

C. COVERED HOSPITAL OR FACILITY OUTPATIENT SERVICES:

1. Benefits are available for Outpatient Covered Services provided by a Hospital, Ambulatory Surgical Facility, Urgent Care Facility or other Outpatient facility, including but not limited to those stated in paragraph B., above.

2. Payment will be made for an observation room or postoperative holding room charge, not to exceed the average cost of a semiprivate room in Nebraska, for a period of twenty-four (24) hours.

3. Benefits for a Hospital emergency room charge shall be subject to a Copayment amount, to be paid by You. The Copayment is stated on the Schedule of Benefits. Allowable Charges in excess of

the Copayment amount shall be payable subject to the applicable Deductible and Coinsurance. If You are admitted as an Inpatient within 24 hours for the same diagnosis, the Copayment shall not apply.

PART XI. BENEFITS FOR SERVICES IN A SKILLED NURSING FACILITY

A. Covered Services under the Policy include up to 30 days per calendar year for Skilled Nursing Facility confinement. Charges in excess of the average semi-private room charge will not be considered Allowable Charges. Charges for more than 30 days of Skilled Nursing Facility confinement in a calendar year are not payable and will not be used towards satisfying the Deductible or Out-of-Pocket Expense Amount.

B. Benefits are payable only if the Skilled Nursing Facility confinement:

1. begins within 14 days from the last day of an Inpatient hospitalization of at least three days in a row (this does not apply to readmission to a Skilled Nursing Facility if such readmission occurs within 60 days of the previous Skilled Nursing Facility discharge date);
2. is for the purpose of receiving the care for the condition which caused the hospitalization; and
3. is Medically Necessary and under the supervision of a Physician.

C. Benefits for Skilled Nursing Facility care must be Preauthorized, as stated in Part VIII.B.

PART XII. BENEFITS FOR INPATIENT PHYSICAL REHABILITATION

A. **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 which allows that person to live as independently as possible. A person is disabled when such person has physical disabilities and needs active assistance to perform the normal activities of daily living, such as eating, dressing, personal hygiene, ambulation and changing body position.

1. **Benefit Provisions:** Covered Services under the Policy include up to sixty (60) Inpatient days per calendar year for Inpatient Physical Rehabilitation as described by this Part. Benefits must be Preauthorized, as set forth in paragraph C. of this Part. The provider must meet the requirements of the Physical Rehabilitation Program, as defined herein.

2. **Covered Hospital Services:** All services defined as Covered Services for Inpatient care by Part X. of this Policy. In addition to such services, the following will be Covered Services when provided as part of the Physical Rehabilitation Program:

- a. recreational therapy;
- b. social service counseling;
- c. prosthetic devices and fitting;
- d. psychological testing.

3. **Covered Physician Services:** All Covered Physician Services as defined by Part XIII. which are provided to an Inpatient.

4. **Eligibility:** You will be eligible for the benefits provided by this Part, if You meet the following criteria:

- a. **Diagnoses:** Services will be provided for patients who are disabled and who meet defined specifications for coverage as determined by the Administrator.
- b. The Covered Person must require intense daily involvement in two or more of the following treatment modalities:

- 1) physical therapy;
- 2) occupational therapy;
- 3) speech therapy.

c. Inpatient rehabilitation must immediately follow the acute hospitalization for the Injury, Sickness, or condition causing the disability.

d. Benefits for further rehabilitation will stop when:

- 1) further progress toward the established rehabilitation goal is minimal or unlikely;
- 2) such progress can be achieved in a less intensive setting;
- 3) treatment could be continued on an Outpatient basis;
- 4) patient no longer meets criteria for eligibility as stated in a. and b., above.

B. Provider Requirements: For benefits to be available for a Physical Rehabilitation Program, the provider must be accredited for Comprehensive Inpatient Rehabilitation by the Commission on the Accreditation of Rehabilitation Facilities (CARF), Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or otherwise approved by Us.

C. Preauthorization Procedure: Benefits must be Preauthorized for a Physical Rehabilitation Program as set forth below. If benefits are not Preauthorized, claims for such benefits may be denied if Your condition or the program does not meet the criteria established by this Part for a Physical Rehabilitation Program.

1. Initial Preauthorization: An initial notification must be made by the Hospital or provider to the Administrator prior to or within five (5) days of the date of admission to the program. Initial approval will be limited to a maximum of thirty (30) days. The history and physical, Physician's orders and progress notes, nurses' notes, and therapy notes are to be submitted with the notice of admission. If the admission is not approved by the Administrator, benefits will not be provided for those days prior to the receipt of notification.

2. Extension of Benefits: After the initial approval, requests for an extension of benefits must be submitted by the Hospital or provider to the Administrator as requested. Subsequent approvals are limited to a maximum of fifteen (15) days. The Physician's orders and progress notes, nurses' notes, therapy notes, and the request for an extension of benefits are 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 the Administrator, benefits will not be guaranteed beyond the previous approval date.

The provider will notified 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. The Administrator will notify You in writing about the initial decision and any subsequent approval or disapproval.

PART XIII. BENEFITS FOR PHYSICIAN'S SERVICES

A. **OVERVIEW:** Benefits will be available for the following Physician's Covered Services under this Part XIII., subject to the Exclusions and Limitations and all other provisions of the Policy. Benefits are available for Covered Services provided by a Physician or oral surgeon, Certified nurse practitioner, Certified nurse midwife or Certified physician assistant, within the practitioner's scope of practice.

B. Covered Services include:

1. **Surgery:** Operative invasive procedures and the treatment of fractures and dislocations provided by the Physician in charge of the case. The amount payable for an Inpatient or Outpatient major surgical procedure will include normal preoperative and postoperative care.

- a. Benefits payable for procedures in which two or more physicians may be involved, shall not exceed the Allowable Charge for the procedure.
- b. When multiple or bilateral surgical procedures are performed which add significant time or complexity at the same operative session, benefits will be paid for the primary procedure as determined by the Administrator. The payment for the secondary procedure will be calculated to be 50% of the Allowable Charge had the second procedure been primary. An additional procedure will be payable at 50% of the Allowable Charge had the procedure been primary. The Administrator will determine the rate at which procedures will be reimbursed.
- c. When a surgical procedure is performed in two or more steps or stages, payment will be limited to the amount provided for a single procedure.

2. Surgical Assistance: Benefits are payable for surgical assistance by a Physician or other practitioner listed in Part XIII.A., who actively assists the operating Physician. The amount payable will not exceed 20% of the Allowable Charge for the surgery, and is subject to the multiple surgery payment provisions in 1.b., above. Surgical procedures for which benefits for a surgical assistant are provided are those specifically identified by the Administrator. Such information may be obtained from the Administrator prior to surgery.

3. Anesthesia Services: Benefits are payable for the administration of anesthesia by a Physician or a Certified registered nurse anesthetist. Benefits are also payable 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; nor for the administration of anesthesia by the attending or assisting surgeon (except general anesthesia for covered oral surgery and dentistry procedures, or spinal, saddle or caudal blocks related to pregnancy if You have the Maternity Endorsement).

4. Nonsurgical Inpatient Hospital Visits: Nonsurgical Inpatient care or treatment of a condition for which surgical care is not required.

5. Concurrent Inpatient Hospital Visits: An Inpatient Hospital visit provided by two or more Physicians on the same day is payable if, in the Administrator's opinion, the services are:

- a. For unrelated nonsurgical medical diagnoses which require the services and skills of two or more Physicians with unrelated specialties; or
- b. Necessary because of medical complications requiring supplemental skills not possessed by the attending surgeon or his or her assistants, and requiring nonsurgical care not related to surgery and not a part of the usual, necessary and related preoperative and postoperative care.

6. Consultation Services: Benefits are payable for consultations by providers with different specialties or sub-specialties. Follow-up consultations will be paid according to the guidelines for concurrent care, as set forth in paragraph 5., above. Benefits for consultations are subject to the following requirements:

- a. the consultation is requested by the attending Physician; and
- b. it is required by Your Sickness or Injury and beyond the special knowledge or practice specialty of the attending or other consulting Physician; and
- c. the consultation includes a physical examination of You by the consulting Physician; and
- d. a written report from the consulting Physician is included in Your Hospital chart.

7. **Intensive Medical Service:** Unusual, repeated and prolonged attendance at bedside is payable when required by the Sickness or Injury.

8. **Radiation Therapy, Chemotherapy and nuclear medicine.**

9. **Tissue Examinations:** Tissue examinations in connection with Covered Services for surgical procedures are payable, whether performed in a Hospital Inpatient or Outpatient facility, Ambulatory Surgical Facility, or in the Physician's office.

10. **Radiology, Pathology and Other Diagnostic Services.**

11. **FDA-approved drugs, intravenous solutions,** vaccines, biologicals, and medicines which are prescribed and administered in the Physician's office.

12. **Physician Home, Office and Outpatient Visits:** Payment will be made for such Covered Services. Renal dialysis, not billed pursuant to another procedure, is included within this service. If You receive services from a PPO Physician, You must pay a Copayment amount for the office visit charge, and benefits for the balance of the office visit charge will be paid at 100% of the Allowable Charge. Additional Covered Services provided during the office visit are subject to the PPO Deductible and Coinsurance. Your Copayment amount is stated on the Schedule of Benefits.

If You receive services from a Non-PPO Physician, benefits will be payable subject to the Non-PPO Deductible and Coinsurance amounts.

13. **Medically Necessary allergy tests** and injections of allergy extracts.

14. **Childhood immunizations,** which shall mean the complete set of vaccinations for children from birth to six years of age for measles, mumps, rubella, poliomyelitis, diphtheria, pertussis, tetanus, haemophilus influenzae type B, and chicken pox, and as otherwise provided by state or federal law. Such Covered Services shall not be subject to the Deductible.

15. **Screening mammograms:** Payment includes benefits for corresponding technical and professional interpretation fees for screening mammograms ordered by a Physician. No Pre-existing Condition waiting period shall apply to mammograms or resulting biopsies or other tests used to clarify a diagnosis. Diagnoses other than benign mammary dysplasia will be subject to such waiting period.

PART XIV. BENEFITS FOR ROUTINE CARE SERVICES

A. Benefits will be available for the Covered Services stated below provided for routine preventive care, up to \$150 per calendar year:

1. office visits;
2. cardiac stress test;
3. radiology;
4. laboratory testing;
5. pap smears; and
6. immunizations, (except childhood immunizations, which are payable under Part XIII).

Routine preventive care under this Part does not generally include services intended to treat or manage an existing Sickness, Injury or condition.

B. Benefits for the above routine preventive care Covered Services, if provided by a PPO Provider, **shall not** be subject to the PPO Provider Deductible or Coinsurance. Such Covered Services provided by a Non-PPO Provider shall be subject to the Non-PPO Provider Deductible and Coinsurance.

PART XV. BENEFITS FOR COMPLICATIONS OF PREGNANCY

A. Benefits shall be paid for Hospital and Physician Covered Services listed in Parts X. and XIII. of this Policy as the result of Complications of Pregnancy, when the pregnancy had its inception after Your Policy effective date (unless the Pre-existing Condition waiting period has been waived on Your Policy).

Complications of Pregnancy include the following:

1. Conditions (when pregnancy is not ended) whose diagnoses are distinct from pregnancy, but are caused or adversely affected by pregnancy. These include acute nephritis, nephrosis, cardiac decompensation, and missed abortion. Similar medical conditions of an equally serious nature shall be included.

2. Cesarean section.

3. Spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible.

B. Complications of Pregnancy do not include:

1. False labor, occasional spotting, doctor-prescribed rest, morning sickness;

2. Post partum depression, psychosis or any other mental disease or disorder; or

3. Similar conditions which occur in a difficult pregnancy.

PART XVI. BENEFITS FOR MENTAL DISEASE OR DISORDERS, OR ALCOHOLISM OR DRUG DEPENDENCY

A. OVERVIEW: Benefits will be available for Covered Services provided for treatment of Mental Disease or Disorders, or Alcoholism or Drug Dependency, or any combination of these services. Benefits are subject to the Exclusions and Limitations and all other provisions of the Policy. Benefits are subject to the applicable Deductible Amount, and the Coinsurance stated in paragraph D. of this Part.

B. INPATIENT CARE: Covered Services for the acute care of Mental Disease or Disorders, or Alcoholism or Drug Dependency, or any combination of these services, shall be those Hospital and Physician services listed in Parts X. and XIII. of Your Policy. **Benefits will be available for acute Inpatient treatment for up to thirty (30) days per calendar year.** Benefits for all Inpatient services must be precertified by the Administrator. Such precertification review may be performed by the Administrator or persons designated by them. A person shall be considered an Inpatient if he or she is confined to a Hospital, or to an Alcoholism and Drug Abuse Treatment Center (Treatment Center) and spends less than six hours daily outside of such facility at work, or school, or independent of direct facility supervision.

1. **Inpatient Covered Services also include:** Mental Health Services, psychological or alcoholism and drug abuse counseling services by:

a. a qualified Physician or Licensed psychologist;

b. a Licensed special psychologist, Licensed clinical social worker, Licensed professional counselor, or Licensed Mental Health Practitioner;

c. Auxiliary Providers working under the supervision and billed by a professional listed in a. or b., above.

All licensing or Certification shall be by the appropriate state authority. Supervision and consultation requirements also shall be governed by state law.

C. **OUTPATIENT CARE:** Covered Services for Outpatient care shall include the Outpatient services listed below. Benefits for day treatment, partial care and Outpatient programs must be provided in a Hospital or facility which is Licensed by the Department of Health and Human Services Regulation and Licensure (or equivalent state agency), and/or accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the Commission on the Accreditation of Rehabilitation Facilities (CARF).

Benefits will be available for up to sixty (60) units of the following Outpatient treatment per calendar year.

1. One unit of Outpatient treatment is defined as:

- a. one individual or group therapy session;
- b. an office or clinic visit, or consultation;
- c. one day in a Licensed day or partial hospitalization program for Mental Disease/Disorder which bills one charge for all-inclusive services for each Outpatient treatment day;
- d. one day in a certified Alcoholism and Drug treatment program which bills one charge for all-inclusive services for each Outpatient treatment day;
- e. one biofeedback procedure or other treatment as approved by Utilization Review for treatment of Mental Disease or Disorders.

2. Outpatient Covered Services include Mental Health Services, psychological or alcoholism and drug abuse counseling services by:

- a. a qualified Physician or Licensed psychologist;
- b. a Licensed special psychologist, Licensed clinical social worker, Licensed professional counselor, or Licensed Mental Health Practitioner;
- c. Auxiliary Providers working under the supervision of, and billed by, a professional listed in 2.a. or 2.b., above.

3. Outpatient Covered Services also include appropriate laboratory and diagnostic care for treatment of Mental Disease/Disorders, Alcoholism and Drug Dependency, psychiatric/psychological testing and other Covered psychiatric services.

D. **PAYMENT FOR SERVICES:** You are responsible for payment of the applicable Deductible Amount, Coinsurance, charges for Noncovered Services, and charges for care in excess of the maximum day and visit limitations, above.

Your Coinsurance for Covered Services provided by PPO Providers is 50%.

Your Coinsurance for Covered Services provided by Non-PPO Providers is 60%.

E. **EXCLUSIONS AND LIMITATIONS:** Benefits will not be provided for treatment modalities which are identified as Noncovered Services in Your Policy. (See Part XXIV., Exclusions and Limitations.)

F. **MAXIMUM BENEFITS:** The Maximum Benefits payable for the treatment of Mental Disease or Disorders, Alcoholism or Drug Dependency are \$25,000. Coinsurance payable by You for these services will not be considered in computing the Maximum Out-of-Pocket Expense Amount under the Policy.

PART XVII. BENEFITS FOR ORAL SURGERY AND DENTISTRY

A. Benefits will be provided for the following Covered Services:

1. The removal of impacted teeth in a Provider's office, Ambulatory Surgical Facility or Hospital Outpatient department.
2. Incision and drainage of cellulitis.
3. Excision of exostoses, tumors and cysts, whether or not related to the temporomandibular joint of the jaw.
4. Invasive surgical procedures of the jaw or the temporomandibular joint of the jaw.
5. Bone grafts to the jaw except those done to prepare the mouth for dentures, or for periodontal purposes.
6. Reduction of a complete dislocation or fracture of the temporomandibular joint of the jaw required as a direct result of an accidental Injury occurring while You were covered under this Policy (unless the Pre-existing Condition waiting period has been waived). Benefits for such services are limited, however, to services provided within twelve (12) months of the date of Injury. Benefits shall not be provided for such services when the dislocation or fracture occurs as the result of eating, biting or chewing.
7. Services, supplies or appliances for dental treatment of natural healthy teeth required as the direct result of an accidental injury occurring while this Policy is in effect (unless the Pre-existing Condition waiting period has been waived). Benefits for such services are limited, however, to services provided within twelve (12) months of the date of Injury. Benefits shall not be provided for such services when the Injury occurs as the result of eating, biting or chewing.
8. Osteotomy performed for a gross congenital abnormality of the jaw which cannot be treated solely by orthodontic treatment or appliances. This procedure must be Preauthorized pursuant to Part VIII.B., **or available benefits will be reduced by 20%**.
9. Radiology or laboratory or other diagnostic services for the temporomandibular joint of the jaw.

B. Benefits will be provided for Hospital Inpatient or Outpatient or Ambulatory Surgical Facility charges related to Covered Services for oral surgery and dentistry, if Medically Necessary as determined by the Administrator. In addition, benefits for Hospital Inpatient, Outpatient or Ambulatory Surgical Facility charges will be provided for Covered or Noncovered dental procedures if the Hospital admission is essential to safeguard Your health due to a specific nondental physical and/or organic impairment. Benefit payments will be made as stated in Part VII.

C. **Exclusions:** No payments shall be made under this Part nor under any other Part of this Policy, except for services expressly described in paragraph A., above, for:

1. Care in connection with the treatment, filling, removal, repositioning or replacement of teeth.
2. Root canal therapy or care.
3. Preparation of the mouth for dentures.
4. Treatment of the dental occlusion or temporomandibular joint of the jaw by any means or for any reason, except as described in Paragraph A. of this Part XVII. No benefits will be provided for any other treatment of temporomandibular joint (TMJ) syndrome or dysfunction.

5. All other procedures involving the teeth or structures directly related to or supporting the teeth, including:

- a. the gums;
- b. the alveolar processes; and
- c. temporomandibular joint of the jaw.

PART XVIII. BENEFITS FOR OUTPATIENT PHYSICAL, SPEECH AND OCCUPATIONAL THERAPY SERVICES

Benefits are payable, subject to the applicable Deductible and Coinsurance amounts for the following Covered Services:

A. Physical therapy when provided by a Licensed physical therapist, or Licensed physical therapist assistant supervised by and assigned to a physical therapist. Chiropractic or osteopathic physiotherapy, provided by a Licensed practitioner is also a Covered Service under this Part.

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

C. Occupational therapy provided by a Licensed occupational therapist or Licensed occupational therapist assistant, under the direct supervision of a Physician. Outpatient sessions will be limited to no more than 60 sessions per year, and an Outpatient session shall be defined as a visit to the occupational therapist not to exceed 4 hours per day.

PART XIX. BENEFITS FOR OUTPATIENT CARDIAC AND PULMONARY REHABILITATION

A. **Cardiac or Pulmonary Rehabilitation Program:** Cardiac or Pulmonary Rehabilitation is defined as 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.

1. **Benefit Provision:** Covered Services under the Policy include up to six (6) consecutive weeks of Hospital Outpatient Rehabilitation Program services, to begin within four (4) months of a diagnosis set forth in paragraph 2. of this Part. Benefits for Outpatient rehabilitation services must be Preauthorized, as stated in Part VIII.B.

a. Covered Hospital Services: All services defined as Covered Services for Outpatient care by Part X. of this Policy. In addition to such services, the following will be Covered Services when provided as part of the Rehabilitation Program:

- 1) initial rehabilitation evaluation;
- 2) exercise sessions;
- 3) concurrent monitoring during the exercise session for high risk patients.

b. Covered Physician Services: All Covered Physician Services as defined by Part XIII. which are provided on an Outpatient basis.

c. No coverage will be provided for:

- 1) diet or dietetic instructions;
- 2) smoking cessation classes;
- 3) medication instruction;
- 4) weight control and/or instruction;

- 5) recreational therapy, educational therapy, or forms of nonmedical self-care or self-help therapy;
- 6) environmental control items such as air conditioners and dehumidifiers.

2. **Eligibility:** You will be eligible for the benefits provided by this Part, if You meet the following criteria:

a. Cardiac Rehabilitation: Services will be provided for cardiac rehabilitation, at any therapeutic level, for the following diagnoses occurring during the preceding four months:

- 1) an acute myocardial infarction;
- 2) heart surgery or coronary artery surgery;
- 3) coronary artery angioplasty, with or without stent placement, or other scientifically validated procedure to clear blocked vessels;
- 4) heart transplant;
- 5) heart-lung transplant;
- 6) treatment of congestive heart failure and stable angina initially and after significant changes in clinical status as determined by the Administrator.

b. Pulmonary Rehabilitation: Services will be provided for pulmonary rehabilitation, at any therapeutic level, under the following circumstances:

- 1) lung transplant during the preceding four (4) months;
- 2) heart-lung transplant during the preceding four (4) months;
- 3) preoperative and postoperative care for lung volume reduction surgery.

c. Benefits are not available for pulmonary rehabilitation if cardiac rehabilitation is provided at paragraph 2.a.5), above.

d. Your condition must be such that rehabilitation can only be carried out safely under the direct, continuing supervision of a Physician and in a controlled Hospital environment.

B. Cardiac or Pulmonary Rehabilitation Program Qualifications: The Cardiac or Pulmonary Rehabilitation Program must be accredited by the Joint Commission on the Accreditation of Healthcare Organizations, or as otherwise approved by Us.

PART XX. BENEFITS FOR HOSPICE CARE AND HOME HEALTH CARE

A. **HOSPICE CARE:** Benefits are available for Preauthorized Covered Services for Hospice care. Services must be provided by a Hospital or related institution, Home Health Agency, Hospice or other Licensed facility which would be approved under Medicare or any applicable state law as a Hospice Care Program. Such services must be a part of a Hospice Care Program. Benefits are payable only if You are the terminally ill person. Covered Services include:

1. Room and board in a Hospice while You are an Inpatient.
2. Home health aide services.
3. Respite Care: Short-term Inpatient care which is necessary for You in order to give temporary relief to the person who regularly assists with the care at home. Respite care must be provided in a skilled or intermediate care nursing facility that is affiliated with the Hospice that is providing services to You. Respite care in a skilled or intermediate care nursing facility need not meet Our normal Medically Necessary criteria ordinarily applied to Inpatient admissions.
4. The rental of medical appliances and equipment while You are in a Hospice Care Program to the extent that such items would have been covered under the Policy had You been confined in a Hospital.

5. Medical, palliative and supportive care, and the procedures necessary for pain control and acute and chronic symptom management.

6. Counseling (other than bereavement counseling) for Your immediate family, not to exceed a total maximum benefit of \$500. (Your immediate family is Your spouse, children, and parent.)

7. Bereavement counseling for Your immediate family, not to exceed a maximum benefit of \$100.

Charges for services in excess of the above maximums will not be used in satisfying the Deductible or Out-of-Pocket Expense Amount.

In addition to the exclusions and limitations found in Part XXIV., benefits for Hospice Care will not be provided for:

1. services performed by volunteers;
2. pastoral services, or legal or financial counseling services;
3. services which are primarily for the convenience of a person other than the patient;
4. home delivered meals;
5. any maintenance therapy for non-hospice related Home Health Aide services, which is therapy not designed to improve Your condition; or
6. services for mental disease or disorders.

B. HOME HEALTH CARE: Benefits will be payable for Preauthorized Home Health Aide Services and Skilled Nursing Care received in lieu of hospitalization and furnished under a planned program by a Home Health Care Agency Licensed to provide Home Health Care. The care must be ordered and directed by Your Physician.

Benefits are payable, subject to the applicable Deductible for up to 40 Home Health Care visits per calendar year. The applicable Coinsurance shall be 20% of the Allowable Charges, for PPO and Non-PPO Providers.

Expense incurred for Home Health Care beyond the 40th day in a calendar year will not be payable, nor will it be used towards satisfying the maximum Out-of-Pocket Expense Amount or Deductible.

C. DEFINITIONS as used in this Hospice Care and Home Health Care section:

Bereavement Counseling: Counseling of Your immediate family that is designed to aid them in adjusting to Your death.

Hospice: A public or private agency or organization which administers and provides Hospice Care and is either:

1. Licensed or Certified as such by the state in which it is located;
2. Certified to participate as such under Medicare;
3. accredited as such by the Joint Commission on the Accreditation of Hospitals; or
4. meets the standards established by the National Hospice Organization.

Hospice Care Program: A coordinated, interdisciplinary program to meet the physical, physiological and social needs:

1. of terminally ill persons and their families;
2. by providing palliative (pain controlling) and supportive medical, nursing and other health services;
3. through home or Inpatient care during the sickness or bereavement.

Home Health Aide Services: Personal care services provided to You that relate to the treatment of Your medical condition. Such services include, but are not limited to bathing, feeding and performing household cleaning duties directly related to You. Such services must be ordered by a Physician, and performed under the supervision of a registered nurse.

Skilled Nursing Care: Medically Necessary Skilled Nursing services for the treatment of Sickness or Injury which must be ordered by a Physician, and performed under the supervision of a registered nurse (R.N.) or a Licensed practical nurse (L.P.N.). The classification of a particular nursing service as skilled is based on the technical or professional health training required to effectively perform the service.

Terminally Ill: No reasonable prospect of cure and, as estimated by a Physician, having a life expectancy of less than six months.

D. Benefits must be Preauthorized for Hospice and Home Health Care services. If benefits are not Preauthorized, claims for such care will be denied if the care is not Medically Necessary. Documentation must be submitted demonstrating the Medical Necessity of the care, and the treatment plan.

PART XXI. BENEFITS FOR ORGAN AND TISSUE TRANSPLANTATION

A. BENEFITS FOR YOU IF YOU ARE A RECIPIENT:

1. Benefits will be provided for Covered Services directly related to, or resulting from a transplant of body organs or tissues as follows:

- a. liver;
- b. heart;
- c. lung (single and double);
- d. lobar lung;
- e. combination heart-lung;
- f. pancreas;
- g. pancreas-kidney;
- h. kidney (renal);
- i. cornea;
- j. parathyroid;
- k. heart valve (heterograft); or
- l. bone graft.

2. Benefits for Covered Services for Allogeneic and Autologous Bone Marrow Transplants:

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

- 1) advanced non-Hodgkin's lymphoma;
- 2) advanced Hodgkin's disease (lymphoma);
- 3) advanced neuroblastoma;

- 4) acute lymphocytic or nonlymphocytic leukemia (acute leukemia);
 - 5) multiple myeloma treated with up to one course of chemotherapy;
 - 6) gonadal germ cell tumor; or
 - 7) chronic myelogenous leukemia.
- b. Benefits will be provided for Allogeneic Stem Cell Transplantation for primary diseases of the bone marrow for:
- 1) aplastic anemias and myelodysplastic syndromes: hereditary or congenital, acquired, toxic or radiation induced;
 - 2) Wiskott-Aldrich syndrome;
 - 3) severe congenital combined immunodeficiency;
 - 4) thalassemia major;
 - 5) infantile malignant osteopetrosis (Albers-Schonberg);
 - 6) mucopolysaccharidoses: Hurler's, Hunter's, Sanfilippo, Maroteaux-Lamy, Morquio's;
 - 7) mucopolipidoses: Gaucher's, metachromatic leukodystrophy, adrenoleukodystrophy;
 - 8) severe sickle cell disease; or
 - 9) polycythemia vera.
- c. Benefits will be provided for myeloablative (high dose) chemotherapy with autologous stem cell support only when prescribed for:
- 1) acute lymphocytic or non-lymphocytic leukemia (acute leukemia);
 - 2) advanced Hodgkin's disease (lymphoma);
 - 3) advanced non-Hodgkin's lymphoma;
 - 4) advanced neuroblastoma;
 - 5) multiple myeloma treated with up to one course of chemotherapy;
 - 6) Wilm's tumor;
 - 7) gonadal germ cell tumor; or
 - 8) stage III inflammatory breast cancer and all stage IV breast cancer.

No benefits will be provided for any other use or application of Allogeneic Bone Marrow Transplant or Autologous Bone Marrow Transplant.

This Part provides limited benefits for Allogeneic and Autologous Bone Marrow Transplants only for certain diseases or conditions and specifically excludes benefits for those procedures for all other diseases or conditions. You should carefully review the entire Policy, including the definitions of Allogeneic and Autologous Bone Marrow Transplants, High Dose Chemotherapy and High Dose Radiotherapy. The limited benefits provided in this Part for Allogeneic and

Autologous Bone Marrow Transplants are an exception to the exclusion for Investigative procedures (see Part XXIV.B.18.)

The exception of these procedures in limited circumstances from the exclusion for Investigative procedures is not intended to, and does not operate as, a waiver of the exclusion for Investigative procedures. The limited benefit provided in this Part for Allogeneic and Autologous Bone Marrow Transplants are subject to all other conditions and provisions of the Policy including, without limitation, the requirement that the procedure be Medically Necessary.

3. Additional benefits for donation of organs or tissue: Benefits up to \$20,000 will be provided for the following Medically Necessary Covered Services directly related to, or resulting from, a transplant procedure listed as covered in this Part:

- a. hospital, medical, surgical or other Covered Services provided to a donor who is a Noncovered Person under this Policy;
- b. services provided for the evaluation of organs or tissue including, but not limited to, the determination of tissue matches;
- c. services provided for the removal of organs or tissue from nonliving donors;
- d. services provided for the transportation and storage of donated organs or tissue.

Benefits provided to Noncovered Persons will be secondary to benefits provided to those persons pursuant to their own hospital, medical, or major medical coverage.

B. EXCLUSIONS AND LIMITATIONS: In addition to the Exclusions and Limitations set forth in Part VIII.B., PART IX.E. and Part XXIV., benefits will also be subject to the specific limitations below:

1. The benefits provided by this Part XXI. shall not be subject to the Exclusion at Part XXIV.B.18. for services considered to be Investigative. Otherwise, the Exclusions and Limitations set forth in Part XXIV. apply to benefits for services under this Part.

2. Benefits will not be provided for High Dose Chemotherapy or Radiation Therapy when supported by bone marrow and/or stem cell transplant procedures for breast cancer, ovarian cancer and all additional diagnoses other than those identified in paragraph A.2. of this Part XXI.

3. Benefits will not be provided for services for or related to human organ or tissue transplants not listed as Covered in this Part XXI. Related services include administration of high dose chemotherapy or radiation therapy when supported by transplant procedures.

4. Purchased Organs or Tissue: Benefits will not be provided for the purchase of human organs or tissue which are sold rather than donated to the recipient.

5. Nonhuman or Artificial/Mechanical Organs or Tissue: Benefits will not be provided for transplantation of any nonhuman organ or tissue to a human recipient, or the implantation of an artificial/mechanical organ into a human recipient. This provision does not apply to the implantation of pacemakers.

6. Benefits are not available for an activation search fee.

C. PREAUTHORIZATION: All benefit payments for liver, heart, lung (single and double), combination heart-lung, pancreas, pancreas-kidney, parathyroid and bone marrow transplantation must be Preauthorized in writing (see Part VIII.), **or benefits will be denied.**

D. PREFERRED TRANSPLANT CENTERS: The Administrator maintains a list of Preferred Transplant Centers. One or more Preferred Transplant Centers is available for most of the transplant types listed in

this Part XXI. Failure to use a Preferred Transplant center may result in reduced benefits. See Part IX., "Maximum NECHIP Benefits" for additional information.

E. DEFINITIONS AS USED IN THIS PART:

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

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

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

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

PART XXII. BENEFITS FOR OTHER COVERED SERVICES

A. **OVERVIEW:** Benefits will be payable for the Covered Services and supplies listed in this Part when not covered elsewhere under this Policy. Unless otherwise specifically stated, the PPO and Non-PPO Deductible and Coinsurance Amounts are applicable, based on the provider's PPO status.

B. **Hospital Preadmission Testing Benefit:** When You receive Covered Services for Hospital preadmission testing, We will pay 100% of the Allowable Charge for such Covered Services subject to the limitations outlined below. The Deductible does not apply.

The following conditions apply:

1. You must be admitted to the Hospital as an Inpatient within seven days after the preadmission testing for the same condition for which the tests were performed. If not, benefits for these tests will be paid subject to the applicable Deductible and Coinsurance.
2. The preadmission tests must not be duplicated on an Inpatient basis. If a test is duplicated, benefits for the original and duplicated tests will be considered subject to the applicable Deductible and Coinsurance.
3. Any preadmission tests must be the kind that would be Covered Services if Hospital confined.

C. **Ambulance Services:**

1. to the nearest facility where You may receive appropriate care for an Emergency Medical Condition; and
2. Medically Necessary transportation within the United States by a professional non-air ambulance or on a regularly scheduled flight on a commercial airline to the nearest facility equipped to furnish the services, if Your condition cannot be adequately treated in the locale where the condition occurs.

D. **Diabetes Education Benefit:** Benefits are payable for outpatient diabetes self-management training and patient management, including medical nutrition therapy. Benefits will be paid at 90% of the Allowable Charge. The Deductible does not apply.

Benefits are available for such services provided upon Your diagnosis of diabetes; when a change in Your symptoms or condition necessitates a change in self-management; or when refresher patient management is Medically Necessary. Benefits payable shall not exceed \$500 in a two-year period.

Benefits are payable for Covered Services provided by an American Diabetes Association Recognized Diabetes Self-Management Education Program; or by a health care professional that is a diabetes educator certified by the National Certification Board of Diabetes Educators. Payment for patient management materials, such as brochures and booklets, will be included within the payment amount for the diabetic education program, as determined by the Administrator.

E. **Artificial eyes or prosthetic limbs.**

F. **Oxygen and equipment** for its administration. Benefits may be subject to the purchase versus rental provision as stated in paragraph G., below.

G. **Home Medical Equipment:** Rental or initial purchase, whichever is least costly, of certain items of Home Medical Equipment when prescribed by a Physician. Benefits for rental of Home Medical Equipment will not exceed the cost of purchasing of such equipment unless otherwise approved by the Administrator. We may Preauthorize a second or subsequent purchase of an item of Home Medical Equipment, if such purchase is made necessary by a significant change in Your condition, or as otherwise determined by Us to be reasonable and necessary. Benefits will not be provided for the repair, maintenance or adjustment of Home Medical Equipment or for sales tax on the purchase of such equipment unless repair or maintenance is determined by Us to be reasonable, necessary or cost-effective. Benefits will not be provided for Home

Medical Equipment rented, purchased from or used while confined to a Hospital, a Skilled Nursing Facility, an intermediate care facility, a nursing home or any other Licensed residential facility if such equipment is usually supplied by the facility.

Benefits for respiratory therapy, ventilation equipment, apnea monitor and continuous positive airway pressure device (CPAP) may be subject to review of the purchase versus rental provision, as determined by the Administrator.

H. **Renal Dialysis:** Services for renal dialysis including all charges for covered home dialysis equipment and covered disposable supplies. Benefits will also be provided for six sessions of dialysis training or counseling.

I. **Home Infusion Therapy.**

J. **One set of eyeglasses or contact lenses** or replacement of one set of eyeglasses or contact lenses, because of a change in prescription of at least one diopter as a direct result of ocular surgery or ocular Injury, if ordered by a Physician. Such Covered Services must be provided within 12 months of the date of the ocular surgery or Injury.

K. **Chiropractic or osteopathic manipulations or adjustments,** provided by a Licensed practitioner, within his or her scope of practice.

L. **Colorectal Cancer Screening:** Benefits are available for screening fecal occult blood test, flexible sigmoidoscopy, colonoscopy, or barium enema, or any combination, or the most reliable, medically recognized screening test available, and for related services.

M. **Breast Reconstruction:** If You are receiving benefits under the Policy in connection with a mastectomy, coverage will be available for a) reconstruction of the breast on which the mastectomy was performed, b) surgery and reconstruction of the other breast to produce a symmetrical appearance, and 3) prostheses and physical complications, including lymphedemas.

PART XXIII. PRESCRIPTION DRUG PLAN BENEFITS

A. **OVERVIEW:** This Part describes the benefits available for the purchase of prescription medications and other specified Covered Services purchased from a pharmacy, as listed on Schedule A, below. This Part does not apply to prescription medications and services prescribed or provided during or for Inpatient Hospital or Treatment Center care.

Benefits are available for a quantity of medication sufficient to treat the acute phase of a Sickness, or in the case of maintenance medication, a 30-day supply, unless otherwise limited. Benefits will be available for the purchase of a reasonable quantity of covered supplies. You may obtain Covered Services from either a Participating or Non-Participating Pharmacy.

The network of Participating Pharmacies is separate from the PPO network. Please refer to Your pharmacy directory, or contact the Administrator.

B. **Participating Pharmacies:** When You obtain Covered Services from a Participating Pharmacy, and present Your Identification Card at the time of purchase, You are responsible to pay the Copayment amount (or Deductible and Coinsurance if applicable to Your coverage) directly to the dispensing Participating Pharmacy. Participating Pharmacies will not bill or collect any amount for Covered Services from You in excess of these amounts, except as provided in paragraph E, Generic Drugs.

When You obtain Covered Services from a Participating Pharmacy, and present Your Identification Card at the time of purchase, the Participating Pharmacy has agreed to be reimbursed based on a Contracted Amount for the Covered Service. You are responsible for payment of the lesser of the Copayment (or Deductible and Coinsurance if applicable), and the Contacted Amount. If the pharmacy's charge is less than the Copayment amount, You are responsible for payment of the charge.

If You do not present Your Identification Card to the Participating Pharmacy at the time of purchase, the Participating Pharmacy may collect their usual retail price for the item from You. You are responsible to make payment of this amount, and to submit the claim directly to the Administrator for benefit payment. Benefits will be payable to You based on the lesser of the Contracted Amount or the retail price, less the Copayment amount and a 25% penalty amount, or less the Deductible and Coinsurance if applicable to Your coverage.

C. Non-Participating Pharmacies: When You obtain Covered Services from a Non-Participating Pharmacy, You will be responsible to make payment to the pharmacy of their usual retail price for the Covered Service. You are required to submit the claim directly to the Administrator for benefit payment. Benefits will be provided to You based on the Reasonable Allowance, less the Copayment amount and a 25% penalty amount, or less the Deductible and Coinsurance if applicable to Your coverage.

D. Deductible: Benefits for Covered Services identified on Schedule A may be subject to the calendar year Deductible, if indicated in the Schedule of Benefits (e.g., persons on the HSA-eligible high deductible option). Until the Deductible is met, You are responsible to pay the Contracted Amount for a Covered Service to a Participating Pharmacy, or the usual retail price to the Nonparticipating Pharmacy. Once the calendar year Deductible is met, You must pay the Copayment or Coinsurance and/or any penalty amount if applicable, as described paragraphs B. and C.

E. Generic Drugs: Whenever appropriate, generic drugs will be used to fill prescriptions. If a bioequivalent generic drug is available, reimbursement for the drug dispensed will be based on the price of the generic drug, unless such reimbursement is specifically prohibited by law. If You refuse a generic drug in favor of a brand name drug, the Participating Pharmacy may then charge You for the difference in cost between the generic drug and the brand name drug, and such difference will be Your responsibility. This difference will be in addition to the Copayment or Coinsurance amount.

F. In the event that the Administrator determines that a person's utilization of a prescription medication in a 6-month period exceeds certain threshold amounts, and that such utilization reasonably demonstrates a pattern of usage that is not Medically Necessary, We reserve the right to limit such person to a Participating Pharmacy of their choice, or deny mail order service. If the person is limited to such a Pharmacy, no benefits will be provided for prescription medications obtained from any other pharmacy.

G. CLAIM FILING:

1. Submission of Claims by a Participating Pharmacy: Participating Pharmacies will submit the claim for Your purchase of Covered Services, if You present Your Identification Card at the time of purchase.

2. Submission of Claims by the Covered Person: You must submit a claim for Covered Services purchased from a Non-Participating Pharmacy, or for purchases from a Participating Pharmacy when the Identification Card is not presented at the time of purchase.

A complete itemized statement identifying the Covered Service must be attached to an appropriate claim form. To process a claim, the Administrator must always have Your identification number, an itemized statement identifying each item purchased, prescription number, quantity and date purchased, and amount charged. They are entitled to any additional information needed to process the claim.

3. Time Limit for Filing a Claim: A claim should be filed within 90 days of the time the services are provided, or as soon thereafter as is reasonably possible. If You do not file a claim within 18 months of the date of service, and it was reasonably possible to do so, benefits will not be paid.

4. Claims should be sent to: Blue Cross and Blue Shield of Nebraska, P. O. Box 3248, Omaha, Nebraska 68180-0001.

H. PRE-EXISTING CONDITIONS:

The benefits provided by this Part **are not** subject to any Exclusion or Limitation for Pre-existing Conditions that may be applicable to other benefits provided by the Policy. Payment of benefits pursuant to this provision shall not waive such Exclusions or Limitations as they apply to other benefits provided by the Policy.

I. ADDITIONAL PROVISIONS:

1. By accepting benefits under this Policy, You authorize and direct the Participating Pharmacies and the Pharmacy Benefit Manager to furnish copies of all information and records concerning the Covered Person to the Administrator.

2. Neither the Administrator, the Comprehensive Health Insurance Pool, or the Pharmacy Benefit Manager will be liable for any claim, injury, demand or judgment based on tort or other grounds (including warranty of prescriptions) arising out of or in connection with the sale, compounding, dispensing, manufacturing, or use of any prescription or supply.

3. The prescription drug plan for the Pool may include mail order benefits, a selective formulary, tiered benefit design, reference-based pricing, maximum benefits or preauthorization requirements, as determined by Us.

4. If You have prescription drug coverage under more than one health plan, the coverage first used (for the purchase) becomes the primary coverage. When another coverage (or other drug card) is used first, the out-of-pocket expense You incur for the purchase may be submitted for consideration under this NECHIP Policy. Benefit payment will be subject to the benefit reduction provision stated at Part XXIV.F.1. You must submit an itemized statement for the service, as well as evidence of Your out-of-pocket expense or other plan's benefit. No additional penalty amount will be imposed for Your submission of a paper claim when this Policy is paying as a secondary payer for these services.

5. Services that are not Medically Necessary are Your liability, as the agreement the Participating Pharmacies have with the Pharmacy Benefit Manager does not include a hold harmless provision for these services, notwithstanding any other provision of this Policy.

6. Many drugs are subject to rebate arrangements between the manufacturer of the drug and the Pharmacy Benefit Manager. Rebates are not reflected in the cost paid by You for the drug. All or part of the rebates may be passed through to Us.

7. Benefits provided pursuant to this Part are subject to all other terms, conditions, definitions and limitations of the Policy which are not in conflict with this Part.

J. DEFINITIONS: The following definitions are applicable to the prescription drug plan:

Coinsurance: The percentage amount payable by You for the Covered Services identified on Schedule A. The Coinsurance amount is indicated in the Schedule of Benefits.

Copayment: The fixed dollar amount payable by You for Covered Services identified on Schedule A. The Copayment amount is indicated on Your Schedule of Benefits.

Contracted Amount: The amount the Participating Pharmacy has agreed to accept as payment for Covered Services under the Participating Agreement with the Pharmacy Benefit Manager.

Covered Services: Prescription medications, services and supplies identified on Schedule A, for which benefits are payable.

Formulary: A continually updated list of pharmaceutical products, which represent the current clinical judgment of Physicians and other experts in the diagnosis and treatment of disease and preservation of

health. This list is provided to You, and to Participating Pharmacies, Physicians or other health care providers.

Noncovered Services: Prescription medications, services and supplies as identified on Schedule B, for which benefits are not payable, or which are not payable according to other terms of the Policy.

Non-Participating Pharmacies: Licensed pharmacies which have not entered into written agreements with the Pharmacy Benefit Manager designated by Us.

Participating Pharmacies: Licensed pharmacies which have entered into written agreements with the Pharmacy Benefit Manager designated by Us.

Pharmacy Benefit Manager: Prime Therapeutics, Inc. has been retained by Us to administer the prescription drug plan.

Preauthorization: The process of obtaining authorization from the Administrator or Pharmacy Benefit Manager for specified medications or specified quantities of medications. This authorization may require obtaining certain medications from specified pharmacies. This Preauthorization involves appropriateness review using guidelines established by the Administrator.

Reasonable Allowance: The amount determined by the Administrator to be payable for a Covered Service from a Nonparticipating Pharmacy. This Allowance may be one of the following:

1. the lesser of the usual retail price or the applicable Contracted Amount payable for similar services by similar Participating Pharmacies;
2. as otherwise determined to be reasonable by the Administrator or the designated Pharmacy Benefit Manager.

SCHEDULE A

Covered Services

1. FDA-approved drugs requiring a Physician's or Dentist's prescription, dispensed in compliance with a permit to conduct a pharmacy or as otherwise permitted by state law. All FDA-approved drugs shall have a valid NDC number. Drugs listed on Schedule B shall not be Covered Services.
2. Compound prescriptions that contain at least one FDA-approved prescription ingredient. These prescriptions may be subject to review by the Administrator.
3. AIDS therapy drugs.
4. Anti-rejection drugs (immunosuppressants).
5. Covered diabetic supplies including, but not limited to needles, syringes, test strips, lancets and swabs.
6. Covered ostomy supplies including, but not limited to belts, dressings, pouches and skin barrier.
7. Injectables, including needles, syringes and alcohol wipes.
8. Insulin.
9. Prescription vitamins, including prenatal vitamins.
10. Covered blood glucose monitors and insulin pump supplies.

The following drugs require preauthorization of benefits:

- Dexedrine. This drug is covered through age 21. After age 21, preauthorization is required.
- IVIG
- Regranex
- Amevive and Raptiva
- Xolair
- DHEA
- Acute migraine medications. Maximum quantities apply.
- Other prescription drugs determined by the Administrator to require preauthorization.

SCHEDULE B

Noncovered Services

1. Diet or appetite suppressant drugs.
2. Nutritional or dietary supplements.
3. Drugs or medicinals for treatment of fertility/infertility.
4. Cosmetic alteration drugs and health or beauty aids, including but not limited to Vaniqa, Propecia, Renova, Restylane, and Solage, and skin bleaching drugs such as Avage and Benoquin.
5. Drugs and medications used in the treatment of acne.
6. Oral and transdermal contraceptives.
7. Drugs and medications used in the treatment of nail fungus.
8. Home infusion therapy. (Covered under the medical contract only.)
9. Home Medical Equipment or devices of any type, including, but not limited to: contraceptive devices; therapeutic devices; or artificial appliances.
10. Investigative drugs or drugs classified by the FDA as experimental.
11. Nicotine Polacrilex (Nicorette), Nicotine Transdermal System (Habitrol, Nicoderm, Nicotrol, ProStep) or any other medication whose primary purpose is to treat nicotine addiction.
12. Erectile dysfunction agents, including but not limited to, Viagra, Caverject, Muse, Cialis, Levitra and Alprostadil.
13. Growth hormones.
14. Non-prescription medications.
15. Over-the-counter medications.
16. Prescription medications determined to be "less than effective" by the Drug Efficacy Study Implementation Program (DESI).
17. Topical Minoxidil (Rogaine).
18. Prescription medications purchased in a foreign country. Exception: If You have an Emergency Medical Condition while traveling in that country, benefits may be available. Evidence of the condition must be provided with the claim, or the claim will be denied. This provision is subject to change with changes in federal laws regarding importation of drugs.

PART XXIV. EXCLUSIONS AND LIMITATIONS

Benefits are not provided by this Policy for the following:

- A. Services, procedures, drugs, supplies or Home Medical Equipment, which are determined by the Administrator to be not Medically Necessary.
- B. Services not specifically covered by this Policy, nor amounts above charges for Covered Services. If a Non-Covered Service is provided to You, the responsibility for payment rests with You. Non-Covered Services include, but are not limited to, any service for, or related to:
1. Services or supplies which are not actually provided while the Policy is in force.
 2. Orthodontics; dental splints or appliances; or the treatment, filling, removal, repositioning, replacement, or the movement of the teeth or tissues next to the teeth, except due to injury.
 3. Injuries or Sickness covered by Workers' Compensation or employers' liability laws, whether or not You assert rights to such coverage.
 4. Care or treatment in a hospital owned or operated by the United States Government or any of its agencies, unless You are obligated to pay such charges.
 5. Routine eye examinations, eye refractions, eyeglasses or contact lenses except as allowed in Part XXII.J.
 6. Refractive corneal surgery (except for corneal grafts); or eye exercises or visual training (orthoptics).
 7. Private duty nursing.
 8. Loss that results from an act of declared or undeclared war, or sustained while performing military service (upon notice to Us of entry into a service, the pro rata premium will be refunded).
 9. Routine audiological examinations; audiant bone conductors or hearing aids and their fitting.
 10. Normal Childbirth, Normal Pregnancy (unless You purchase the optional maternity endorsement); voluntarily induced abortion; or care of a newborn infant, except as specifically provided in Part VII.G.
 11. Complications of pregnancy when the pregnancy had its inception before Your Policy effective date (unless the Pre-existing Condition waiting period has been waived on Your Policy).
 12. Gender transformations or changes.
 13. Fertility treatment and related services, or the promotion of fertility, including but not limited to:
 - a. any procedure, treatment or drug designed to facilitate the production or transit of the ovum and/or sperm, and/or the implantation of the fertilized ovum,
 - b. reversal of surgical sterilization, and
 - c. direct attempts to cause pregnancy by hormone therapy, artificial insemination, invitro fertilization or embryo transfer.
 14. Routine physical examinations, procedures or tests, well-child care, except as specifically provided in Parts XIII. and XIV.
 15. Self-inflicted Injuries or Sickness; or charges as a result of Your engagement in an illegal occupation or Your commission of or attempt to commit a felony.

16. Expenses incurred for the transplant of a part of Your body to the body of another.
17. Treatment of a Pre-existing Condition or any complications of or resulting from such Pre-existing Condition (with the exception of prescription drugs, Part XXIII.) until the Policy has been in force at least six months (not applicable if the Pre-existing Condition waiting period has been waived on Your Policy).
18. Investigative or experimental services or supplies, or for any related services or complications.
19. Any expenses incurred that are covered by any local, state or federal programs.
20. Loss that is covered by any other insurance plan.
21. Therapy which is primarily of recreational or educational nature; music therapy; work-hardening therapy; pre-vocational training or forms of nonmedical self-care or self-help training, and any related diagnostic testing.
22. Treatment and diagnostic procedures primarily for obesity or weight reduction or modification, regardless of diagnosis, or surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass surgery.
23. Transplant surgery which is not Preauthorized.
24. Custodial Care.
25. Breast reduction or augmentation.
26. Services, drugs, medical supplies devices or equipment which are not cost effective compared to established alternatives or which are provided for the convenience or personal use of the patient.
27. Charges made separately for services, supplies, and materials when such services, supplies, and materials are considered by the Administrator to be included within the charge for a total service payable under this Policy.
28. Services by or for blood donors, except administrative charges for blood used for You furnished to a Hospital by the American Red Cross, county blood bank, or other organization that does not charge for blood.
29. Charges in excess of the Contracted Amount or Maximum Benefit Amount.
30. Charges by a health care provider for services which are not within his or her scope of practice.
31. Hospital or Physician charges for standby availability; charges made for filling out claim forms or furnishing any other records or information or special charges such as dispensing fees, admission charges, Physician's charge 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.
32. Personal expenses while hospitalized, such as guest meals, television rental and barber services; charges made while You are temporarily out of the Hospital.
33. Genetic treatment or engineering, including any service performed to alter or create changes in genetic structure.
34. Equipment for purifying, heating, cooling or otherwise treating air or water; the building, remodeling or alteration of a residence; the purchasing or customizing of vans or other vehicles.

35. Exercise equipment.
36. Orthopedic shoes, orthotics for the foot such as arch or heel supports, except when such podiatric appliances are necessary for the prevention of complications associated with diabetes.
37. Treatment or removal of corns, callosities, or the cutting or trimming of nails.
38. Nutrition care or supplements, supplies or other nutritional substances.
39. Food antigens and/or sublingual therapy.
40. Lodging or travel, even though prescribed by a Physician for the purpose of obtaining medical treatment, except as stated for ambulance services.
41. Interest, sales or other taxes or surcharges on Covered Services, drugs, supplies or Home Medical Equipment. This shall include taxes or surcharges levied by governmental bodies or subdivisions who do not have jurisdiction over this Policy.
42. Services for medical treatment and/or drugs, whether compensated or not, which are directly related to, or resulting from Your participation in a voluntary, investigative test or research program or study.
43. Services required by an employer as a condition of employment including, but not limited to immunizations, blood testing, work physicals and drug tests.
44. Services, procedures, supplies or drugs provided for treatment of sexual arousal disorders or erectile dysfunction, regardless of cause.
45. Acupuncture.

C. Mental Health Services, psychological or alcoholism and drug abuse counseling services by persons other than:

1. a qualified Physician or Licensed psychologist;
2. a Licensed special psychologist, Licensed clinical social worker, Licensed professional counselor, or Licensed Mental Health Practitioner;
3. Auxiliary Providers working under the supervision and billed by a qualified Physician or Licensed psychologist, or as otherwise permitted by state law.

Programs of co-dependency, employee assistance, probation, prevention, educational or self-help programs, or programs which treat obesity, gambling, or nicotine addiction are not Covered Services. Benefits are not available for residential treatment programs for Mental Disease or Disorders, or residential, halfway house or methadone maintenance programs for alcoholism or drug dependency, nor will they be provided for programs ordered by the Court.

D. No benefits will be paid for any service or supply for which there is no legal obligation to pay or which would be provided without cost to You in the absence of insurance covering the charge. Any charge above the charge that would have been made if no coverage existed, or any service which is normally furnished without charge will be treated as a service for which there is no legal obligation to pay. No benefits will be paid for any services performed by a member of Your immediate family.

E. Benefits will not be provided for services and procedures, and any drugs, supplies or Home Medical Equipment which are considered by the Administrator 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.

F. LIMITATIONS: In addition to all other limitations stated throughout the Policy, the following also apply:

1. **Reduction Due to Other Coverage:** Benefits otherwise payable under this Policy shall be reduced by all amounts paid or payable through any other health insurance or insurance arrangement and by all hospital and medical expense benefits paid or payable under any Workers' Compensation coverage, automobile medical payment or liability insurance whether provided on the basis of fault or no-fault, or any state or federal law or program.

If benefits have been paid under this Policy which have been paid by any other insurance, or which were erroneously paid, We have the right to recover any such excess payments from You or the appropriate party, as allowed by law.

2. **Cosmetic or Reconstruction Surgery Limitations:** Benefits for cosmetic or reconstructive surgery are payable only if for or due to:

- a. Injuries received while this Policy is in force;
- b. conditions that result from surgery for which benefits were paid under this Policy.

This limitation on injuries or surgery "*while under this Policy*" is not applicable if the Pre-existing Condition waiting period has been waived on Your Policy.

3. **Duplication of Benefits:** If a single item of expense is payable under more than one provision of this Policy, payment will be made only under the provision providing the greater benefit. This does not apply to Part VIII. If benefits are payable at a reduced percentage pursuant to Part VIII., We will pay benefits under the provision providing the smaller benefit.

PART XXV. HOW TO FILE A CLAIM

A. NOTICE OF CLAIM/PROOF OF LOSS: You must give the Administrator written notice of claim when You have received health care services for which this Policy provides benefits. The claim must give written proof of the services provided. The claim may be filed by You, the Hospital, the Physician or whoever provided the service. To process a claim, it is necessary to include Your name and Policy number as shown on the Schedule of Benefits or Identification Card. Notice should be mailed to the Administrator.

You must give written proof of Your loss within 90 days after the date or as soon as You can. Proof must, however, be furnished no later than 18 months from the date of service, except in the absence of legal capacity.

IT IS SUGGESTED THAT ALL CLAIMS BE FILED WITH THE ADMINISTRATOR AS SOON AS POSSIBLE AFTER EXPENSES ARE INCURRED.

PLEASE NOTE: CERTAIN EXPENSES MUST BE PREAUTHORIZED BY THE ADMINISTRATOR TO OBTAIN BENEFITS.

PART XXVI. GENERAL POLICY PROVISIONS

A. **ENTIRE CONTRACT CHANGES:** This Policy, and any attachments, is the entire contract of insurance between You and Us. Only the Board of Directors of the Nebraska Comprehensive Health Insurance Pool can approve a change. Any such change must be shown in Your Policy. No agent may change this Policy or waive any of its provisions.

B. **GRACE PERIOD:** Unless not less than 30 days prior to the premium due date We have delivered or mailed to Your last known address written notice of Our intent not to renew this Policy, a 31-day grace period for premium payment will be allowed. This means that if a renewal premium is not paid by the date it is due, it may be paid during the following 31 days. Your Policy will remain in force during this grace period.

C. **TIME LIMIT ON CERTAIN DEFENSES:** After two years from the date You become covered under this Policy, We cannot use misstatements, except fraudulent misstatements in Your Application, to void coverage or deny a claim for loss that happens after the two-year period.

No claim for loss incurred after six months from the date You become covered under this Policy shall be reduced or denied on the ground that a disease or physical condition existed prior to the effective date of Your coverage.

The above provisions also apply to Endorsements attached to this Policy. In applying them the word "Endorsement" will be used for the word "Policy."

D. **PAYMENTS MADE IN ERROR:** If benefits are paid which were not for Covered Services, or were made in error, We may seek reimbursement as provided by law. Duplicate or erroneous payments not recovered will be considered as benefits paid under the Policy and will remain applied to Your Policy Maximum Benefits. Payment for a specific service or an erroneous payment under this Policy shall not make Us liable for further payment for the same condition.

E. SUBROGATION RIGHTS:

If You are injured because of a third party's wrongful act or negligence:

1. We will pay Policy benefits for that Injury, subject to the conditions that You:
 - a. agree in writing to Our being subrogated to any recovery or right of recovery You have against that third party;
 - b. will not take any action which would prejudice Our subrogation rights; and
 - c. will cooperate in doing what is reasonably necessary to assist Us in any recovery.
2. We will be subrogated only to the extent of Policy benefits paid because of that injury.

Subrogation means Our right to recover any Policy payments:

1. made because of an Injury to You caused by a third party's wrongful act or negligence; and
2. which You later recover from the third party or the third party's insurer.

Third party means another person or organization.

F. **PHYSICAL EXAMINATION AND AUTOPSY:** We, at Our expense, may have You examined when and as often as is reasonable while a claim is pending. We may also have an autopsy done (at Our expense) where it is not forbidden by law.

G. MISSTATEMENT OF AGE: If Your age has been misstated, all benefits payable shall be in the amount of a prorata reduction between the actual age and stated age.

H. LEGAL ACTIONS: You can not bring a legal action to recover under Your Policy for at least 60 days after You have given Us written proof of loss. You can not start such an action more than three years after the date proof of loss is required.

I. ILLEGAL OCCUPATION: We shall not be liable for any loss to which a contributing cause was Your commission of, or attempt to commit a felony or to which a contributing cause was Your being engaged in an illegal occupation.

J. INTOXICANTS AND CONTROLLED SUBSTANCE: We shall not be liable for any loss sustained or contracted in consequence of Your being intoxicated or under the influence of any narcotic unless administered on the advice of a Physician.

PART XXVII. APPEAL PROCEDURES

You, or a person acting on Your behalf is entitled to appeal the Administrator's decisions regarding Preservice and Postservice Claims, and other determinations made regarding the Policy. The process for such appeals is outlined below.

A. DEFINITIONS:

Covered Person: You, the insured person under the Policy.

Preservice Claim(s): any claim when the terms of the Policy 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. In most cases, it is written notice of health care services received by the Covered Person.

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

1. Could seriously jeopardize the life or health of the Covered Person or the ability of the Covered Person to regain maximum function; or
2. 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.

B. PROCEDURE FOR FILING AN APPEAL:

1. First Level Appeal:

a. Requesting an Appeal: A request for a first level appeal must be submitted by the Covered Person or a representative on his or her behalf (the "claimant") within one year of the date the claim was processed, or determination made. The request should include the following information:

- 1) that this 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 the service/claim; and
- 6) if possible, a copy of the Explanation of Benefits (EOB).

This information should be submitted to the Administrator at the address and telephone number listed on Your identification card.

b. Decision: If the appeal involves a medical judgment, the Administrator will consult with appropriate medical personnel to make the appeal determination. Identification of the medical personnel consulted, if any, will be provided upon written request. The first level 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:

- 1) for appeals of Preservice Claims, within 15 working days; or
- 2) for appeals of Postservice Claims, within 15 working days, unless a written notification of an extension is issued to the claimant with the reasons for the delay on or before the 15th working day.

2. **Second Level Appeal:**

a. Request: If the Covered Person is not satisfied with the first level appeal determination, he/she has six months from the receipt of the determination to submit a written request for a second level appeal. The letter requesting the appeal must be submitted to the Administrator at the address listed on Your identification card, Attn. Health Service Programs.

b. Rights: The Covered Person and/or his representative may appear in person at the second level review and present the case before the appeal committee appointed by the Administrator. He or she may submit additional supporting material before and/or at the review meeting.

c. The Committee: When reviewing appeals requiring a medical judgment, the majority of the committee will be health care professionals with appropriate expertise. The committee will not give deference to either the initial determination or the first level appeal.

d. Decision: The committee will meet within 45 working days of receipt of the request. The committee will issue the decision within 5 working days after the meeting.

3. **Expedited Appeal:**

a. Request: In a case involving an Urgent Care claim, an expedited appeal may be requested orally or in writing.

b. Process: All information will be submitted by telephone, facsimile or the most expeditious method available. Expedited appeals will be reviewed by an appropriate medical professional in the same or similar specialty as would typically manage the case being reviewed.

c. Decision: The Administrator will make a decision and notify the claimant within 72 hours after the appeal is commenced. Written notification will be sent within 72 hours of the request for the expedited appeal.

d. Concurrent Care: In concurrent review situations, the appeal must be requested within 24 hours of the initial denial. If requested within this timeframe, the health care services shall be continued without liability to the Covered Person until the Covered Person has been notified of the decision. The decision timeframes will be the same as for other expedited appeals.

e. Options: If a claimant is dissatisfied with the result of the expedited appeal, he/she may request a Second Level Appeal, as noted above.

C. **ADDITIONAL INFORMATION:**

If after following the procedure for First and Second Level Appeals, You disagree with the decision(s), You may submit a request for review to the Grievance Committee of the NECHIP Board of Directors. This request must be made in writing within 60 days of the Second Level Appeal decision, addressed to:

Nebraska Comprehensive Health Insurance Pool
Board Grievance Committee
P.O. Box 3248
Omaha, NE 68180

The NECHIP Grievance Committee will review the prior documentation on the issue(s). Additional documentation which You would like considered may be submitted with Your request for review. The NECHIP Grievance Committee will consider Your request and respond to You in a timely manner. Their decision will be the final action of the Nebraska Comprehensive Health Insurance Pool.

PART XXVIII. DEFINITIONS

"Our," "We," "Us" means the Nebraska Comprehensive Health Insurance Pool, or the Administrator or other entity designated to act on the Pool's behalf.

"You," "Your" means the person named as the insured on the identification card and Schedule of Benefits.

Administrator: The insurer selected by the Board to administer the Pool, who has the authority to determine membership eligibility, benefit eligibility and payment, and to interpret the terms of this Policy.

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

Allowable Charge: Payment is based on the Allowable Charge for Covered Services.

Inpatient Contracting Hospital or Institutional Facility: The Allowable Charge for Covered Services provided by an Inpatient Contracting institutional facility is the Contracted Amount for such Services.

Outpatient Contracting Hospitals and Institutional Providers: The Allowable Charge for Covered Services provided by an Outpatient Contracting Institutional Provider is the lesser of the Contracted Amount or the billed charge.

Noncontracting Hospitals and Institutional Facilities: The Allowable Charge for Covered Services provided by a Noncontracting Inpatient or Outpatient institutional provider is the Reasonable Allowance for such Services.

Contracting Professional and Noninstitutional PPO Providers: The Allowable Charge for a Covered Service provided by a professional or other noninstitutional PPO Provider in Nebraska, 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 PPO Providers.

Contracting Professional and Noninstitutional Participating Providers: The Allowable Charge for a Covered Service provided by a non-PPO, 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 Noninstitutional Providers: The Allowable Charge for a Covered Service provided by Noncontracting professional and other noninstitutional providers in Nebraska will be the lesser of a Maximum Benefit Amount or the billed charge. In another Service Area, the Allowable Charge will be a Reasonable Allowance.

Ambulatory Surgical Facility: A certified facility which 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.

Application: The form completed by You to apply for coverage under the Nebraska Comprehensive Health Insurance Pool. This form includes the eligibility criteria for Pool coverage.

Auxiliary Provider: A Certified social worker, psychiatric registered nurse, Certified alcohol and drug abuse counselor who is performing services within his or her scope of practice and who is supervised, and billed for, by a qualifying Physician or Licensed Psychologist, or as otherwise permitted by state law.

Certified Master Social Workers or Certified Professional Counselors performing mental health services who are not Licensed Mental Health Practitioners are included in this definition.

Approved Provider: A Licensed practitioner of the healing arts who provides Covered Services within the scope of his or her License, or a Licensed or Certified facility or other health care provider, payable according to the terms of this Policy, Nebraska law, or the pursuant to the direction of the Pool's Board of Directors.

Board: The Board of Directors of the Nebraska Comprehensive Health Insurance Pool.

Calendar Year: Begins on January 1 and ends on December 31.

Certified/Certification: A determination by the Administrator 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 Policy.

Certified/Certification as used herein 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 Policy provisions or state law.

Contracted Amount: The Allowable Charge agreed to by the Administrator or the On-site Plan and their Contracting Providers, for Covered Services.

Copayment: A dollar amount payable by You at the time a Covered Service is received. Copayment amounts are indicated in the Schedule of Benefits. Copayments are separate from and do not satisfy either the Deductible or the Out-of-Pocket Expense Amount.

Cosmetic: 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 Service: Medically Necessary services and supplies listed in this Policy, and provided to You while this Policy is in effect. The services and supplies must be ordered or prescribed by a Physician as needed for diagnosis or treatment. Expense for a service or supply is considered incurred on the date the service or supply is received.

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 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, which will not exceed one year in any event.

A Custodial Care determination may still be made if the patient is under the care of a Physician, or the ordered services are being administered by a Registered or Licensed practical nurse.

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.

Home Health Care Agency: (a) a hospital; (b) a visiting nurse association Licensed by the state; or (c) a nonprofit or public home health agency or organization Licensed as such by the state.

Home Health Care: Continued care and treatment in the home of an insured person who is under the care of a Physician and who would need continued Hospital or Skilled Nursing Facility confinement without the Home Health Care.

Home Infusion Therapy: Medically Necessary Covered Services and supplies required for administration of a Home Infusion Therapy regimen when ordered by a Physician and provided by a Licensed Home Infusion Therapy Provider.

Home Medical Equipment: Equipment and supplies which are Medically Necessary to treat an Injury or Sickness, to improve the functioning of a malformed body member, or to prevent further deterioration of the patient's medical condition. Such equipment and supplies must be designed and used primarily to treat conditions which are medical in nature, and able to withstand repeated use. Home Medical Equipment includes such items as prosthetic devices, orthopedic braces, crutches, wheel chairs, hospital beds and respiratory or ventilation devices. It does not include sporting equipment or items purchased for the convenience of the family.

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 twenty-four (24) hour per day nursing services, to two or more nonrelated persons with a Sickness, Injury or Pregnancy, under the supervision of a staff of Physicians Licensed to practice medicine and surgery.

Injury: Accidental physical or bodily harm.

Inpatient: A patient admitted to a Hospital for bed occupancy for more than 24 hours to receive necessary medical care.

Investigative: A technology for a drug, biological product, device, diagnostic, treatment or procedure is investigative if it has not been scientifically validated as set forth below:

1. The technology for drugs, biologicals, 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 or a convincing argument 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 (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.

The Administrator will determine whether a technology is Investigative.

Licensed (Licensure): Permission to engage in a health profession which would otherwise be unlawful in the State where services are performed, and which is granted to individuals who meet prerequisite qualifications. Licensure protects a given scope of practice and the title. In regard to facilities, Licensed shall mean appropriate approval and licensing by the Department of Health and Human Services Regulation and Licensure (or equivalent state agency).

Maximum Benefit Amount: A benefit amount which is an amount determined by the Administrator to be reasonable. The maximum amount will be the amount agreed upon between the Administrator and their Participating Providers for the Covered Service. If no amount has been established for a Covered Service, they may consider the charges submitted by providers for like procedures, a relative value scale which compares the complexity of services provided, or any other factor deemed necessary.

Medically Necessary (or Medical Necessity): Services ordered by a treating physician exercising prudent clinical judgment, provided to You for the purposes of prevention, evaluation, diagnosis or treatment of a Sickness, Injury, Pregnancy, Mental Disease/Disorder or Alcoholism or Drug Dependency, that are as follows:

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.
2. Clinically appropriate in terms of type, frequency, extent, site and duration for the prevention, diagnosis or treatment of Your condition. 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, Your medical symptoms and conditions must require that treatment cannot be safely provided in a less intensive medical setting.
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 condition, without adversely affecting your medical condition.
4. Not provided primarily for the convenience of the following:
 - a. You;
 - b. the Physician;
 - c. Your family;
 - d. any other person or health care provider.
5. Not considered unnecessarily repetitive when performed in combination with other prevention, evaluation, diagnoses or treatment procedures.

The Administrator will determine whether services are Medically Necessary under the terms of the Policy. Services will not automatically be considered Medically Necessary because they have been ordered or provided by a treating Physician.

Mental Health Services: Treatment, assessment, psychotherapy, counseling, or equivalent activities to individuals, families or groups for behavioral, cognitive, social, mental, or emotional disorders, including interpersonal or personal situations. All Mental Health Services must be provided under appropriate supervision and consultation requirements as set forth by state law.

Noncovered Services: Services which are not payable according to the terms of this Policy.

Non-Participating: A provider which has not contracted with the Administrator.

Non-PPO Hospital: A Hospital which has not contracted with the Administrator to provide services as a part of the PPO Provider network.

Non-PPO Physician: A Licensed Physician who has not contracted with the Administrator as a part of the PPO Provider network.

Non-PPO Provider: A Licensed practitioner of the healing arts, or qualified provider of health care services, supplies, or Home Medical Equipment who has not contracted with the Administrator as a part of the PPO Provider network.

Normal Childbirth or Normal Pregnancy: Childbirth or pregnancy free of complications.

Complications of Pregnancy:

1. Conditions (when pregnancy is not ended) whose diagnoses are distinct from pregnancy, but are caused or adversely affected by pregnancy. These include acute nephritis, nephrosis, cardiac decompensation, and missed abortion. Similar medical conditions of an equally serious nature are included.

2. Cesarean section.

3. Spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible.

Complications of pregnancy **do not** include:

1. False labor, occasional spotting, doctor-prescribed rest, morning sickness.

2. Post partum depression, psychosis or any other mental disease or disorder.

3. Similar conditions which occur in a difficult pregnancy.

Outpatient: Care or treatment provided to a person not admitted as an Inpatient, but in the Outpatient department or emergency room of a Hospital, an Ambulatory Surgical Facility, Urgent Care Facility, Physician's office or home.

Participating Provider: A Licensed practitioner of the healing arts, or qualified provider of health care services who has contracted with the Administrator under its traditional (Non-PPO) program network.

Physician: A person holding an unrestricted license and duly authorized to practice medicine and surgery and prescribe drugs. He or she must be providing services within the scope of his or her license.

Pre-existing Condition: A condition which manifested itself within six months before the Policy effective date, in such a manner as would cause an ordinarily prudent person to seek diagnosis, care or treatment,

or for which medical advice, care or treatment was recommended or received during the six-month period immediately preceding the Policy effective date.

Preferred Provider Organization: A panel of hospitals, physicians and other providers who participate in a panel developed by the Administrator to more effectively manage health care costs.

PPO Hospital: A Hospital which contracts with the Administrator to provide services as a part of the PPO Provider network.

PPO Physician: A Physician who has contracted with the Administrator to provide Covered Services as a part of the PPO Provider network.

PPO Provider: Any other Licensed practitioner of the healing arts, or qualified provider of health care services, supplies or Home Medical Equipment who has contracted with the Administrator to provide Covered Services as a part of the PPO Provider network.

Reasonable Allowance: The amount determined by the Administrator 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 services by similar providers in Nebraska or in another geographic area, or
- a percentage or other discounted amount based on the billed charge, or
- an amount otherwise determined to be reasonable by the Administrator.

Schedule of Benefits: A document issued by the Administrator which provides summarized information about Deductibles, Copayments, Coinsurance, Policy maximums and limitations of Your coverage. It also indicates whether or not Pre-existing Condition waiting periods are in effect.

Sickness: A illness, disease or physical condition which deviates from or disrupts normal bodily function or body tissues in an abnormal way, and is manifested by a characteristic set of symptoms. A Sickness is one which causes loss beginning while this Policy is in force, or is not excluded under a Pre-existing Condition limitation.

Skilled Nursing Facility: A facility Licensed to provide room and board, 24-hour Skilled Nursing Care, and other related non-custodial services for the care and rehabilitation of injured, disabled or sick persons. The facility may be a Licensed or Medicare-Certified Skilled Nursing Facility, or a part of a Hospital with designated Skilled Nursing or swing beds.

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ENDORSEMENT

BlueCard Program

This Endorsement is a part of Your Policy.

Blue Cross and Blue Shield of Nebraska is the Administrator for the Comprehensive Health Insurance Pool. Pursuant to the Plan Administration Agreement between the parties, the Administrator is given the authority and responsibility to perform all administrative claim/payment functions on behalf of the Pool, and all necessary functions to assure timely payment of benefits to covered persons under the Pool.

Blue Cross and Blue Shield of Nebraska participates in a national program through the Blue Cross and Blue Shield Association, called the BlueCard® Program. Payments made for Covered Services under this Policy by a Blue Cross and Blue Shield Plan in another state (On-site Plan) 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. **The responsibility for not Medically Necessary services received in another state will also be governed by the agreement between the On-site Plan (BlueCard) in that state and its Contracting Providers.**

BlueCard: Whenever You access health care services outside the geographic area Blue Cross and Blue Shield of Nebraska (BCBSNE) serves, the claim for those services may be processed through BlueCard and presented to BCBSNE for payment in conformity with network access rules of the BlueCard Policies then in effect ("Policies"). Under BlueCard, when You receive covered health care services within the geographic area served by an On-site Blue Cross and/or Blue Shield Licensee ("Host Blue"), BCBSNE will remain responsible to You for fulfilling Our contract obligations. However, the Host Blue will only be responsible, in accordance with applicable BlueCard Policies, if any, for providing such services as contracting with its providers and handling all interactions with those Contracting Providers. The financial terms of BlueCard are described generally below.

Liability Calculation Method Per Claim:

The calculation of Your liability on claims for covered health care services incurred outside the geographic area BCBSNE serves and processed through BlueCard will be based on the lower of the provider's billed charges or the Contracted Amount BCBSNE pays the Host Blue.

The methods employed by a Host Blue to determine a Contracted Amount will vary among Host Blues based on the terms of each Host Blue's provider contracts. The Contracted Amount paid to a Host Blue by BCBSNE on a claim for health care services processed through BlueCard may represent:

- a. the actual price paid on the claim by the Host Blue to the health care provider ("Actual Price"), or
- b. an estimated price, determined by the Host Blue in accordance with BlueCard Policies, based on the Actual Price increased or reduced to reflect aggregate payments expected to result from settlements, withholds, any other contingent payment arrangements and non-claims transactions with all of the Host Blue's health care providers or one or more particular providers ("Estimated Price"), or
- c. an average price, determined by the Host Blue in accordance with BlueCard Policies, based on a billed charges discount representing the Host Blue's average savings expected after settlements, withholds, any other contingent payment arrangements and non-claims transactions for all of its providers or for a specified group of Providers ("Average Price"). An Average Price may result in greater variation from the Actual Price than would an Estimated Price.

Host Blues using either the Estimated Price or Average Price will, in accordance with BlueCard Policies, prospectively increase or reduce the Estimated Price or Average Price to correct for over or under estimation of past prices. However, the amount paid by You is a final price and will not be affected by such prospective adjustment.

Statutes in a small number of states may require a Host Blue either (1) to use a basis for calculating Your liability for covered health care services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or (2) to add a surcharge. Should any state statutes mandate liability calculation methods that differ from the Contracted Amount methodology or require a surcharge, the Host Blue would then calculate Your liability for any covered health care services consistent with the applicable state statute in effect at the time You received those services.

Return of Overpayments:

Under BlueCard, recoveries from a Host Blue or from Contracting Providers of a Host Blue can arise in several ways, including, but not limited to, anti-fraud and abuse audits, provider/hospital audits, credit balance audits, utilization review refunds, and unsolicited refunds. In some cases, the Host Blue will engage third parties to assist in discovery or collection of recovery amounts. The fees of such a third party are netted against the recovery. Recovery amounts, net of fees, if any, will be applied in accordance with applicable BlueCard Policies, which generally require correction on a claim-by-claim or prospective basis. Unless otherwise agreed to by the Host Blue, Home Licensees may request adjustments from the Host Blue for full provider refunds due to the retroactive cancellation of membership only for one year after the Inter-Licensee financial settlement process date of the original claim. In some cases, recovery of claim payments associated with a retroactive cancellation may not be possible if the recovery conflicts with the Host Blue's state law, provider contracts or jeopardizes its relationship with its providers.